Will Consumer-Directed Plans Work for People with Chronic Conditions?

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EVP/Chief Health and Medical Officer
June 22, 2005
Overview

• Consumer-driven market review
• Account-based model overview
  – Adverse selection
  – IOM Quality Chasm imperatives
• Challenge of chronic disease(s)
  – What isn’t working now
  – Behavior change: risk factors and “compliance” vs “competence”
• Consumer-driven advantage: Incentivized and integrated health strategy
  – Results to date
• Chronic care model revisited
• Future considerations and directions
Chronic Care Model*:
Consumer/Patient-Driven & “Owned”?

- Self-management
- Decision support
- Delivery system design
- Clinical information systems
- Health care organization
- Community resources

“Jackson Hole Group reconsiders approach . . “

*Bodenheimer, Wagner, Grumbach JAMA 2002
Cost Increases Not Sustainable For Employers or Nation

Employers are Tweaking Benefits and Increasing Employee Costs

- Increasing & adding deductibles (hospital)
- Increasing copays (office visit, Rx)
- Moving away from copays
- Increasing contributions
- Decreasing benefits

Growing realization that a fundamental change is needed…

Legislative/policy changes will help transform the market…
**Consumer Driven Care Today**

- Approximately 5 million enrolled in a consumer driven programs\(^1\)
  - Estimated to be up to 90 million by 2007\(^1\)
- 12% of jumbo employers (4% of large) offer CDH now; 14% will in 2005 and 26% by 2006\(^2\)
- Employees’ cost share will increase by 15% in 2005\(^3\)
- Market consolidation and large carriers employees ALL on plan
- CDHP premium growth from $7B today
  - Estimated to be $192B in 2008

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\(^1\) Ed Hanway, Chairman & CEO of Cigna, December 2, 2004 Press Release
\(^2\) Mercer 2004 Health Plan Cost Survey Press Release November 2004
\(^3\) Towers Perrin – Monitor November/December 2004
CDHC Market Forecast: Growth in Membership

Source: Forrester Research, 2003
Inside Consumer-Directed Care, December 17, 2004

* Breakdown of total between HRAs and HSAs is only available for 2005.
Employers: Consumerism & CDHP’s *

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Large (500+)</th>
<th>Jumbo (20K+)</th>
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<tbody>
<tr>
<td>Part of strategy</td>
<td>30%</td>
<td>49%</td>
<td>67%</td>
</tr>
<tr>
<td>Website on cost/quality</td>
<td>32%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>“High performance networks”</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>CDHP in 2004 offered</td>
<td>1%</td>
<td>7%</td>
<td>12%</td>
</tr>
<tr>
<td>CDHP in 2005 offered</td>
<td>12%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>CDHP in 2006 likely</td>
<td>16%</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Used HRA in 2004 (if CDHP offered)</td>
<td></td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Will convert to or add HAS 2005</td>
<td></td>
<td></td>
<td>35%</td>
</tr>
</tbody>
</table>

*Mercer 2004 National Employer Survey
Employer CDHP Feedback To Date: “Most Important Objectives Met”*

- Did your consumer-driven plan promote health care consumerism and lower cost?
  - 53% Agree
  - 41% Too soon or neutral
  - 5% Disagree

*Mercer 2004 National Employer Survey
Lumenos Client Growth 2001-2005

- **Optional Offering**
- **Full Replacement**

<table>
<thead>
<tr>
<th>Year</th>
<th>Optional Offering</th>
<th>Full Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2002</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>2003</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>2004</td>
<td>43</td>
<td>15</td>
</tr>
<tr>
<td>2005</td>
<td>62</td>
<td>25</td>
</tr>
</tbody>
</table>

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Lumenos Clients by Industry

Clients by Sector

- Service: 24%
- Manufacturing: 17%
- Retail: 10%
- Public/Government: 10%
- Technology: 15%
- Associations/Trust: 4%
- Healthcare: 20%
“The Third Party’s Over”*

- Even modest Health Savings Account adoption will revolutionize industry
- Creates new threats and opportunities for industry incumbents and new entrants
  - Underwriting
  - Payment transaction specialists
  - “Infomediaries”
  - Asset managers

*Mango and Riefberg (McKinsey and Co), Wall St Journal, 18 Jan 05, p B2
“Medicare’s goal is consumer-directed, patient-centric, prevention-oriented health care. We need to encourage, support and reward continuous high quality care in which the consumer is actively involved because data shows that it increases compliance with evidence-based medicine, improves outcomes and reduces costs”

Remarks to National Consumer Directed Health Care Congress, May 2005
Medicare Modernization Accelerates Consumerism

- Hospital quality and “service” metrics
  - [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
- Hospital risk-adjusted payments to be phased in
- Standardized ambulatory metrics soon
- Incentives for hospital IT enhancements
- P4P and “Disease Management” demos
- Health Savings Accounts: “transformational”
- Medicaid consumer-driven discussions
Principles Behind Lumenos/CDHP

- Focus is on the consumer
- Properly aligned financial incentives
- Price Transparency
- Enable consumers to better manage their health
- Educational and health decision tools
- Personal assistance in managing health issues
- Renewed emphasis on preventive care
- Significant investment in consumer centric technology
Consumer-Driven “Account-Based” Products

HRA Product

- Health Reimbursement Account
  - Employer “Funded”
  - Health Coverage
    - XXX% Coinsurance
    - $XXX OOP Max

Bridge

HSA Product

- Health Savings Account
  - Up to $5200 Family
  - Employer or Employee Funded

- Preventive Services 100%

HIA Product

- Health Incentive Account
  - $0 Allocation
  - Incentives earned by EE

- Deductible $xxx

- Preventive Services 100%

- Health Coverage
  - Xxx % Coinsurance
  - $xxxx OOP Max

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## HSA Compared to HRA

<table>
<thead>
<tr>
<th>Feature</th>
<th>HRA</th>
<th>HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Contributes</td>
<td>Employer only</td>
<td>Employer and/or Employee</td>
</tr>
<tr>
<td>Account Funded</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Funds Availability</td>
<td>Immediate</td>
<td>When deposited in the account</td>
</tr>
<tr>
<td>Ownership balances at termination?</td>
<td>Return to employer</td>
<td>Remains with consumer</td>
</tr>
<tr>
<td>Contributed maximums</td>
<td>Dictated by plan design</td>
<td>Lesser of than the annual deductible or a maximum of $2,650 single, $5,250 family per year</td>
</tr>
<tr>
<td>Additional Contributions Allowance</td>
<td>N/A</td>
<td>Age 55 or older $600 annually</td>
</tr>
<tr>
<td>Roll-over</td>
<td>Yes - employer determined</td>
<td>Yes</td>
</tr>
<tr>
<td>Allowable medical expenses</td>
<td>213 expenses – employer discretion</td>
<td>213 expenses – employee discretion</td>
</tr>
<tr>
<td>Account ownership</td>
<td>Employer</td>
<td>Employee</td>
</tr>
<tr>
<td>Tax Treatment - Employee</td>
<td>No employee tax deduction</td>
<td>Contributions may be pre-tax or tax deductible</td>
</tr>
<tr>
<td>Tax Treatment - Employer</td>
<td>Reimbursements tax deductible</td>
<td>Contributions tax deductible</td>
</tr>
<tr>
<td>Cash-out options (non-medical)</td>
<td>None</td>
<td>Taxable pre-65 with a 10% penalty</td>
</tr>
<tr>
<td>Portability</td>
<td>Yes – employer discretion</td>
<td>Yes – completely</td>
</tr>
<tr>
<td>Claims Adjudication</td>
<td>Required</td>
<td>Not for HSA – will need it for high deductible plan</td>
</tr>
<tr>
<td>Financial partner requirement</td>
<td>No</td>
<td>Bank or Trust</td>
</tr>
<tr>
<td>Investment options</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Combined with FSA/HRA</td>
<td>Yes</td>
<td>Not for medical – may use FSA for Dental or Vision</td>
</tr>
</tbody>
</table>
Why a Personal Health Coach? Educate, Coordinate, Motivate

RWJF/FACCT Portrait of Chronically Ill in America Survey, 2001
Why A Personal Health Coach?  
Partner, Engage and Activate

• Does your doctor:
  – Offer choices in medical care?
  – Discuss pros and cons of each choice?
  – Ask you your choice or preference?
  – Take your preferences into account when making decisions?

No = 50%

RWJF/FACCT Portrait of Chronically Ill in America Survey, 2001
And more . . “Does Your Doctor . . . ?”*

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen carefully to you?</td>
<td>58%</td>
<td>25%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Explain things so you understand?</td>
<td>58%</td>
<td>25%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Give clear instructions?</td>
<td>60%</td>
<td>24%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Provide choices and ask your opinion?</td>
<td>29%</td>
<td>23%</td>
<td>44%</td>
<td></td>
</tr>
</tbody>
</table>

*Schoen et al, Adults Primary Care 5 Country Survey, Health Affairs 23: sup 2, 2004; W4 487-503
Employee Satisfaction and Behavior Change

**Lumenos 2004 Customer Satisfaction Survey**
- Mail survey administered to all 2003 members
- There was a 24% response rate to the survey

**Key Findings**
- 95% understood how the CDHP plan works
- 93% of customers are satisfied (compared to 87% for competitive health plans)
- 92% are likely to renew (compared to 78% for competitive health plans)
- 93% cite the ability to roll over money
- Customers report health- and cost-related behavior changes since joining Lumenos
  - 44% report increased knowledge in managing their health care
  - 27% report that they are more actively involved in health-related behaviors
    - 77% report improved diet/nutrition
    - 71% report increased exercise
Incentivized and Integrated Health Management
Imagine If . . .

- Individuals saw the money spent from their paychecks and in their taxes for healthcare . . . As their own (it is)
- Individuals knew that 50% or more of health outcomes and costs came from personal health behaviors
- Individuals were incentivized to know and improve those behaviors (they never have been)
- Individuals knew that 35% of all care was wasteful . . And came ultimately from their pocket (it is and does)
- They had health plans that incentivized prevention-oriented, evidence-based and appropriate care
- Willing patients and willing physicians had information on price and quality to better inform decision-making?
Primary Drivers of Health Care Costs

- 50-70% of all health care costs and premature death, illness and disability are related to behaviors
- Health and health care are only remotely related
  - 35% of all health care costs are wasteful or inefficient
  - Only 50% of high dollar claimants are predictable in any given year from previous
- Effective health plan MUST simultaneously deploy
  - broad, population approach (don’t get near the cliff!)
  - targeted, high risk/cost approach (near or over cliff!)
  - decrease costs and improve health
- Quality costs less, not more
## The 50% Story . . Again*

<table>
<thead>
<tr>
<th>Condition</th>
<th>% Receiving Recommended Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>76%</td>
</tr>
<tr>
<td>Heart attack &amp; coronary artery disease</td>
<td>68%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>66%</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>65%</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>57%</td>
</tr>
<tr>
<td>Asthma</td>
<td>53%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45%</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>41%</td>
</tr>
<tr>
<td>Sexually transmitted diseases</td>
<td>37%</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>29%</td>
</tr>
<tr>
<td>Counseling and behavior change</td>
<td>18%</td>
</tr>
</tbody>
</table>

*McGlynn et al, NEJM 348:2635-2645 2003*
Benefit Design Imperatives To Attract High Utilizers and Chronic Disease

- Preventive services 100% covered
- “Clinically credible” – for most of the time, does this amount meet my and my families needs?
- Bridge is “speed bump” not real or perceived “barrier” to traditional health insurance

- Highest users solve for Max OOP
- Must be “compassionate” not to bankrupt individual and “competitive” relative to other options and/or previous years experience
IOM and Health Care Imperatives

- Reduce need for health care
- Reduce demand for health care
- Reduce inappropriate, inefficient care
- Increase appropriate, efficient care

- Continue “empowered consumer” engagement with skills and coinsurance
- Value purchasing with market share moving to higher value systems

Health Reimbursement Account

Bridge

Traditional Health Coverage
Preventive Services

• Financial
  – Incentivized either “carved in” or “carved out”

• Clinical and evidence-based effectiveness criteria
  – Excellent (USPSTF, ACIP/AAP etc)

• Coverage policy issues
  – Widespread acceptance post managed care
  – Enrollee marketing and communication “must do”
  – New FDA-approved screening technologies awaiting review
  – Commercialized “total everything” screening, more costly and less pressure currently: negative or absent evidence

• Likely utilization impact
  – Drive optimal receipt with other strategies
HRA/Bridge and Health Savings Account

• **Financial**
  - “My money” with accumulation potential increases threshold before “traditional health coverage” and attendant behaviors
  - Market vice insurance forces may predominate as HRA and Bridge amounts increase to reflect rising costs and utilization
  - Health Savings Account likely more “powerful” than HRA

• **Clinical and evidence-based effectiveness criteria**
  - Many underutilized effective care practices (IOM, RAND) exist
  - Overutilized, ineffective but never evaluated practices likely persist

• **Coverage policy issues**: geographic variation around alternative care

• **Likely utilization impact**
  - Fewer visits, interventions and Rx drugs
  - More convenient but costly if not of greater “value” may not be selected
Traditional Health Coverage

• **Financial**
  – Hospital charges/costs transparency initially less
  – High rollover amounts or “richer” HRA’s likely will increase cost awareness in higher cost procedures and care

• **Clinical and evidence-based effectiveness criteria**
  – Must rely on tech assessment groups

• **Coverage policy issues**
  – Hi cost, marginally effective practices still problematic
  – Gastric bypass, genetic drugs, stents/ICD’s: “societal” challenges

• **Likely utilization Impact**
  – “Hey, that $400 was supposed to be paid by the clinical trial”
  – “Engaged consumer” skills may improve use because of concern about medical effectiveness, not cost initially
## Medical Practice Today: “Hamster Health Care”

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inadequate time with patients</td>
<td>• Waiting times for appointments</td>
</tr>
<tr>
<td>• Administrative hassles</td>
<td>• ER for non-urgent visits</td>
</tr>
<tr>
<td>• Patients who know and demand more</td>
<td>• Managed care backlash</td>
</tr>
<tr>
<td>• Greater accountability</td>
<td>• Inadequate management of chronic illness</td>
</tr>
<tr>
<td>• Decreasing reimbursements</td>
<td>• MD burnout and retirement</td>
</tr>
<tr>
<td>• Rising overhead costs</td>
<td>• “System” collapse?</td>
</tr>
</tbody>
</table>
Patient-Physician Cost (non) Communication*

- 63% of patients want to discuss out-of-pocket costs with their doctor
  - Only 15% of patients actually have
- 79% of physicians believe their patients want to discuss these costs
  - Only 35% of doctors actually have
- Smaller, community-based practices where physicians more aware of financial burden more likely to discuss

*Alexander et al, JAMA 2003;290:953-958
Early Physician and Health Care System Response

- Supported by AMA and leading medical associations
- Clinical
  - Provides information, tools and personal support for patients to understand and follow care management
  - Supports more efficient physician-patient and system interactions
    - at no cost to medical practice
  - Prevents “Google Syndrome”!
- Administrative
  - Decreases administrative hassles at point of care
- Baylor MD leadership: “Best news in 25 years of practice”
- Texas Hospital Association endorsed Lumenos consumer-driven plan
What the “ROI” Evidence Shows . . .
And What Lumenos Does

- Risk factor decrease in pre- or post-disease management leads to reduction in medical & disability claim expenses
  - Within 1-3 years post reduction
- “DM” proven for diabetes, asthma, CAD, CHF and +/- depression, low back pain, and early prenatal care
- Incentives “work” and “matter” – AHRQ 2004 study
- Lumenos creates incentives for consumers to identify and reduce risk factors and improve chronic disease outcomes
- Ultimate “ROI” is total cost reduction/mitigation from deployment of care management strategy and integration
Consumer-Centric Health Improvement Model

Online Health Tools
- Health Assessment Profile
  - Health Risk Appraisal
  - Condition Assessments
  - Family Health File
- Health Library & News
- Self Care Tools
  - Improvement Programs
  - Condition Guides
  - Hospital Care Guides
- Physician/Hospital Profiles

Lumenos Consumer

Seek Information

Seek Help

Seek Care

Health Care Marketplace
- Providers
- Hospitals
- Pharmacy
- Lab/Ancillary

High Risk Population Analysis
Identification and Stratification

Personal Health Coach
24/7 Nurse Advice and Proactive Outreach, Education and Support for High Risk Individuals

High Touch

Claims & Hospital Registration Data

Health Risk Appraisal and Consumer Contributed Data

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Integrated Health Improvement
Incentives

• **Identification: Health Risk Appraisal**
  – $50-$100 HRA allocation for online completion

• **Engagement: Personal Health Coach Enrollment**
  – Additional $50-100 HRA allocation for chronic disease or high risk
  – Agrees to participate in Personal Health Coach Program after initial assessment
  – Commits to engage with Personal Health Coach through regularly scheduled meetings to identify goals, become educated and skilled in working effectively with their physician to manage their disease.

• **Graduation: Competencies Mastery with Personal Health Coach**
  – Additional $100-200 HRA allocation for mastering HealthModels
  – Consumer achieves predetermined goals and documentation of competencies for disease(s) with knowledge, skills, functional provider-patient relationship and clinical outcomes
## Incentives Work and Matter: Assessment and PHC Enrollment*

<table>
<thead>
<tr>
<th>Incentive Status</th>
<th>Participation Average (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>Incentive ($25-250)</td>
<td>36.3% (14.8 – 80%***)</td>
</tr>
<tr>
<td>No Incentive</td>
<td>4.3% (3.3 – 10%)</td>
</tr>
<tr>
<td>Increased Risk Assessment completion</td>
<td>8-9X (up to 20X)</td>
</tr>
<tr>
<td>Personal Health Coach Enrollment**</td>
<td></td>
</tr>
<tr>
<td>Incentive ($50-200)</td>
<td>2.3% (0.9 – 7.9%***)</td>
</tr>
<tr>
<td>No Incentive</td>
<td>1.3% (0 – 2.8%)</td>
</tr>
<tr>
<td>Increased Health Coach Enrollment</td>
<td>2X (up to 14 X)</td>
</tr>
</tbody>
</table>

### Notes:

- 2004 Clients
- **Full replacement 2004 client ($250/$200/$200)
“Active” PHC Enrollment Routes Growing With Integrated Incentives

Referral Source

- 2002 - No Incentives
- 2003 - HRA Incentive Only
- 2004 - Integrated Incentives
Earlier Enrollment In Personal Health Coach Program With Incentives

Quarter of Personal Health Coach Enrollment

Percent of PHC Enrollees

0 20 40 60 80 100

1st Quarter 2nd Quarter 3rd Quarter 4th Quarter

Integrated Incentives
No Incentives
IOM 15 Priority Conditions

• Cancer
• Diabetes
• High Cholesterol
• Hypertension
• Ischemic Heart Disease
• Stroke
• Arthritis

• Asthma
• Emphysema
• HIV/AIDS
• Gall bladder disease
• Stomach ulcers
• Back problems
• Alzheimer’s disease & dementia
• Depression & anxiety disorders
We Want to Attract the Sicker, Highest Utilizers

- “Integrated” and “incentivized”
  - Identification, intervention, high tech and high touch
- “Competency-defined,”
  - Evidence-based guidelines translated into consumer competencies to know, develop and “own” the skills to master their unique condition(s) in concert with their physician and specialized RN Personal Health Coach
- “Software-supported,”
  - HealthModel software tailored to the patient’s condition, clinical needs and physician relationship
- “Behavior change curriculum”
  - You need a coach/teacher using a curriculum, motivation and support to improve care management and behaviors
Personal Health Coach
A 4 - 5 Month Partnership

• Assessment with comprehensive interview
  – Medical history, medications, review of systems, lifestyle behaviors, depression screen
  – Functional assessment (SF-12) pre-, post-
• Basic education about disease/condition
• Comparison of treatment plan with current guidelines
• Clarification of patient’s belief and value system
• Assessment of self-management motivation and capability
• Specification of principle care physician and next appointment
• Creation, support and adoption of self-management plan
Diabetes Measures and Recommended Data Sources

- HbA1c management
  - Record or admin
- Lipid management
  - Record or admin
- Urine protein testing
  - Record or admin
- Eye examination
  - Record or admin
- Foot examination
  - Record or pt survey
- Influenza immunization
  - Record or pt survey
- BP management
  - Record
- Office visits
  - Record or admin

AMA, NCQA, JCAHO Core Measurement Set for Adult Diabetes, April 2001
Consumer-Oriented Diabetic Competencies: The “Flip Side” of EBM

• “Did you receive a HbA1c and what was it?”
  – Report: Yes/No and within what range
• “Do you know your cholesterol and lipid levels?”
• “Was your urine tested for protein?”
• “Were your eyes examined and dilated with drops by an ophthalmologist?”
• “Did your physician or her staff examine your feet?”
• “Did you receive your flu shot?”
• “Do you know your blood pressure?”
• “How often did you visit your doctor for your diabetes last year?”
“Pay for Performance” Perspectives

• WHO has to perform?
  – Lumenos pays consumers and believes that the market will then reward the best providers with volume and pricing
  – Consumer incentives should reflect provider incentives

• HOW should it be paid?
  – “Cash is King” and prompt rewards reinforce behaviors

• WHAT measures?
  – Consumer “mastery” of disease competency = “graduation”
  – Provider level metrics currently not uniform
  – Lumenos posting NCQA provider level recognitions for heart disease, diabetes and QI procedures
Pay For Performance Strategic Alignment Possibilities

• Align incentives, strategy and tactics
  – Consumer and provider “P for P” alignment
    • HRA, PHC enrollment and graduation incentives
    • Provider reimbursement and identification based on provider-focused methodologies
      – Many different programs and measures currently hamper widespread adoption
      – Lumenos consumer-focused competencies “matches” ALL and measures what MOST matters in near term
Pay for Performance and Tiering Rollout
“Feedback on Version 1.0”

• Employees and consumers*
  – 70% don’t believe such programs result in better quality
  – 51% believe it’s a good idea to offer “bonus pay” to docs (vs 84% for teachers and 87% for sales clerks”
  – “I wouldn’t BE with my doctor, if she was poor quality” (patient who’s doc didn’t make UHC’s “top tier”)**

• Physicians and providers**
  – No prior notice, 40% eliminated from process for “not enough data”, proprietary claims methodology not shared, disrupting trusted specialty referral patterns

*Managed Healthcare Executive, December 2004
** “Health insurance program aimed at efficiency brings confusion, outrage”, St Louis Post Dispatch, 2/13/05
Importance of Considering the Purpose of the Quality Measurement*

Meyer, G – submitted for publication

The stakes get higher as the purpose moves towards accountability.
Public Disclosure of Performance Data*

Information Needs  
Attitudes  
Resources

Performance Data for Public Release
- Content
- Presentation Format
- Rigor
- Mode of Release

Physicians  
Organizational Providers  
Group Purchasers  
Consumers

Impact on Quality of Care Outcomes

*JAMA 2001; 283:1866-74
Begin With The End In Mind

• Rapid and accurate payment
  – Simplified fee schedule and coding
  – Cash discount
  – “All inclusive fee” pricing?

• Competitive pricing
  – Potential for innovative payment structure
  – Web-based consultations and reimbursement

• Transparency
  – Cost
  – Quality
    • NCQA physician-level designation (CQI, diabetes, cardiac)
IOM Principles for Payment Methods to Improve Quality

• Fair payment for good clinical management
• Providers share in benefits of improved quality
• Promote consumers and purchasers to “buy quality”
• Align financial incentives with best practices
• Reduce fragmentation of care
• Some possibilities
  – “Blended” payment methods
  – Multiyear contracts and bonus incentives
  – Risk adjustment
  – Electronic interactions payment
  – Bundled payments
Today’s Challenges
Unchanged From 20 Years Ago

- Adverse selection
  - Yes it happened, particularly with HMO’s
  - Can be mitigated with benefit design
  - Full replacement: a non-issue and it’s happening

- Care coordination for chronic disease

- Optimal payment mechanisms

- Performance measurement systems

- Provider and “system” response

- “Individuals can’t do it”

- Insurance function vs “routine care”
Leaders in health care delivery should lead the consumer-driven movement

- Shape your market and use platform to innovate
  - “Product line” assessment of competencies and best value critical to growth
  - Value-added innovations for improved outcomes and service should START with providers who know challenges
    - Implement consumer-driven for OWN employees as start for bottom line savings, in-house feedback and strategic input

Embrace data transparency, cost-effective innovations and value-added business practices

- Consumers will ask why not . . And vote with their feet and dollars
Thank You!

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