Consumer-Driven Health Care: Implications for Health Information Technology & Personal Health Records

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Cost Increases Not Sustainable For Employers or Nation

Increases in Premiums vs. Other Indicators

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…
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.
Selected Clients

Staples
National Office Supply Company

Abbott Laboratories

AAM

Banta Corporation

Pacificorp

Fujitsu

STANFORD UNIVERSITY

URS

Clorox

PaciﬁCorp

Rockwell Automation

NCI

Rockwell Automation

Frost Bank

Werner

JJMA

DTE Energy

EnPro Industries

Gerber

Quest Diagnostics

Frost Bank

Pivotal

Baylor Healthcare System

Belo

Komatsu

Foth & Van Dyke

Cadbury Schweppes

harp

Federated Department Stores, Inc.

macy's

Lumenos

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Selected Healthcare Clients

CIBA Vision
BAYLOR HEALTH CARE SYSTEM
KGH
KENNEWICK GENERAL HOSPITAL
Abbott Laboratories
Quest Diagnostics
Acadian Ambulance Service
ManorCare
KADLEC Medical Center
United Surgical Partners
HealthTrust
Novartis
Sandoz
Account-Based Products

**HRA Product**
- Health Reimbursement Account
  - Employer "Funded"
- Bridge
- Health Coverage
  - XXX% Coinsurance
  - $$$ OOP Max

**HSA Product**
- Health Savings Account
  - Up to $5200 Family Employer or Employee Funded
- Health Coverage
  - XXX% Coinsurance
  - $$$ OOP Max

**HIA Product**
- Health Incentive Account
  - $0 Allocation
  - Incentives earned by EE
- Deductible
  - $$ xxx
- Health Coverage
  - Xxx % Coinsurance
  - $xxxx OOP Max
Trend Mitigation: Value Health Care Imperatives

Health Reimbursement Account

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

Bridge

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

Traditional Health Coverage
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 and costs came from choices THEY made in how they lived their lives (they do)
- 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 a health plan that made the **right** thing to do . . . The **easy** thing to do (they can, even with imperfect information . . And they will drive better info faster)
The Cost: $1,700-$2,000 Per Employee Per Year

• Overuse
  – Antibiotics
  – Tranquilizers
  – Lifestyle drugs
  – Antiinflammatory drugs
  – Hysterectomies
  – Cardiac caths
  – GI endoscopy

• Misuse
  – Multiple uncoordinated visits
  – Duplicate tests, procedures
  – Medical and hospital error

• Underuse
  – Vaccination
  – Chronic care management e.g., diabetes, asthma, heart failure, cancer

*Midwest Business Group on Health, Juran Institute study, 2002
“Engaged Consumer” Vision, Strategy, Tactics and Integration

- **Vision:** Create engaged consumers vs. passive patients
- **Strategy:** 5 elements of integrated health improvement
  - Assess and enroll high risk (3 or more, chronics, “poor”)
  - Reduce demand for demand
  - Optimize evidence-based practice
  - Link to non-medical health producing resources
  - Measure and improve consumer-centric performance
- **Tactics:** 3 “engaged consumer competencies”
  - Seek info, seek care, seek help
- **Integration:** “high tech” and “high touch”
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

Seek Information

Seek Help

Seek Care

Lumenos Consumer

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

High Touch

High Risk Population Analysis
Identification and Stratification

Health Care Marketplace

- Providers
- Hospitals
- Pharmacy
- Lab/Ancillary

Claims & Hospital Registration Data

Health Risk Appraisal and Consumer Contributed Data

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HIT/PHR Considerations In Consumer-Driven Health Care I

- Provider-centric data requirements do not capture critical consumer/patient outcomes
  - “Disease-specific patient competencies” for 15 IOM conditions not defined (but could be) and hence cannot be measured as “outcome” of care or quality of provider
  - Functional status and satisfaction with care

- Multiple vendors, proprietary systems make data integration even in rudimentary PHR, impossible
  - Health risk appraisals at worksite vice “integrated” Lumenos IT platform with WebMD and other tools
  - Onsite clinic occ med interactions with other physicians
  - Outpatient, inpatient, rehab (disability) transitions
Consumer-Focused
“360 degree” Hospital Quality Vision

Accreditation Data
JCAHO/CMS/NQF and Leapfrog Standards

Peer “Expert Opinion”
US News, Consumer Checkbook, etc

Provider Data
Claims, Rx, Lab

Evidence-based Care Management
Risk- and cost-adjusted outcomes by facility and provider

Consumer Survey
“My hospital/doctor did and how I was treated”

Medpar, All State Payer, Purchasing Consortia and Regional Efforts
Consumer-Focused
“360 degree” MD Quality Vision

Certification Data
Licensed, certified, sanctioned
ADA, AHA MD designation

Provider Self Report
Peer Review
“I think I or I plan to”
“Best Docs” as judged by other docs

Evidence-based
Care Management
Do her patients know, follow & “own” behaviors & best care practices . .
At a reasonable price?

Consumer Survey
“My doctor did”

Provider Data
Claims, Rx, Lab
Ordered, billed, paid, dispensed

MD

“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 office-based quality tools/practices
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
HIT/PHR Considerations In Consumer-Driven Health Care II

- CDHC will drive quality movement and HIT/PHR faster than other benefit designs
  - “My money: I don’t want to pay again when I don’t have to”
  - Disease competency, outcome and satisfaction measures sought as “quality”
- Connectivity and transparency ARE valued and will make consumers “vote with their feet”
- “Pay for Performance” will only work if consumers know and understand outcomes they are differentially paying for “matter” to them: health, fewer mistakes, lower cost, greater “value”
Impact on Health Care Stakeholders?

- “Medical-industrial complex” disruptions with “my own money”
  - Is the convenience worth 10X the cost? – Generally “no”
  - New emphasis on “breakthrough” vice “copycat” R & D
  - All “middlemen” redefining value
  - Surgical hospitals and “Centers of excellence”: lower (and transparent) unit costs and better outcomes?

- Hidden, shifted costs (& value questions) become explicit faster
  - How much are you willing (or should you) pay for GME?
  - Societal questions accelerated: end of life care, evidence-based vice usual care, “total cost of illness” vice “med loss ratio”

- Consensus on best of breed private, market-based functions vice public, “safety net” functions of government
National Lab Test Provider: Strategic Consumer-Driven Thoughts

- More testing may not be better particularly when I “see” and “pay” for each
  - Prescription drug use as “canaries in the mine”?
- Genetic and “biotech” revolution will be tempered by more sophisticated decision support tools
- Connectivity, technology, patient & provider joint visibility and ease of testing may be more valued
  - These products and support services well-positioned
- Consumers will become forces to remove legislative, regulatory, and “usual practice” barriers to greater convenience and lower costs
Integrated Health Improvement and Productivity (HIP) Components

- Absences
- Wellness Programs
- ST/LT Disability
- Safety/Occ Health
- Medical Costs
- HR Benefits & Policies
- EAP
- “Presenteeism”
- Worker’s Comp
HIT/PHR Considerations In Consumer-Driven Health Care III

• Next generation integrated health and performance models will require integration beyond “medical care”

• Uniform federal or “public sector” data standards are necessary for widespread PHR adoption portability & connectivity
  – Lumenos employers urged to become proactive

• Consumers can drive PHR adoption once they understand value to them personally . . Not “system”

• HIT/PHR infrastructure a public good – not proprietary competitive advantage
  – Plaque in Union Station!
Thank You!

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