LEADERSHIP '06: TAKING THE LEAD ON HEALTHCARE
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Engaging employees and their families in consumerism strategies to improve their healthcare decision-making and create a culture that appropriately moderates total healthcare costs.

Background

In essence, this session is about what employers can do to cause employees and their families to *change* behaviors relating to preventing illnesses and injuries and being more involved in decisions affecting their health care to reduce costs, improve quality and reduce medical errors.

Since 1980, when they first became alarmed about health care inflation, employers have tried a wide range of strategies from health promotion to managed care to slow delivery of, and demand for, health services. So far the results have not been good. Just a few weeks ago government researchers estimated the nation's health care bill will *double* by 2014, from $2 Trillion to $4 Trillion annually and quality and patient safety, the focus of much collective effort of employers have only slightly improved.

Over the past four years, employers have focused their attention on *engaging* employees and their families in the battle against cost inflation, poor quality and medical errors. This is a good strategy according to medical experts, who for the most part believe "good patients get good results." The question is not about the *goal* but about the *strategies* used by employers to achieve the behavior changes that will reduce the necessity for care and elevate the cost effectiveness of care when it is needed.

Changes Sought and the Steps Needed

As we see it, engagement by plan participants requires a minimum of a three step process:

1. Helping participants understand more about the nature of health and health care, for example:
   - The extent of personal power they have over their health and health care and that such power will extend over their entire lifetimes.
   - That in many ways, the health care system is dysfunctional and that disconnects in the expected continuum of care are frequent and the main cause of medical errors. At least in the short term it will be necessary for participants to do much of the connecting.
   - That misdiagnosis is the #1 reason for malpractice claims and that good communications by *both* doctors and participants is essential to effective diagnoses.
   - That there are few absolutes in diagnosis and treatment for groups of patients and that personalization and supporting people's basic psychological needs for autonomy, competence and relatedness, will help people become more ready to change their behavior and achieve a sense of well-being in their lives.
2. Target information about the individual's health status, clinical indicators and health care that is pertinent to their condition and ability to absorb such information on a "*just in time*" basis (versus 3-6 months later when claim data is available) – with multiple delivery methods to accommodate those without internet access AND where other support and methods are more effective for given points in the health and care decision making continuums.
3. Assign a (nurse) mentor to assist individuals in using and applying the newly delivered information and tools to the choices they must make and ensure application of the personal "intangibles" (values, preferences, life goals etc.) in the decision making process.

Sorting out and investing in the appropriate sequenced mix of targeted training, decision tools, phone support, early detection resources, communications, web-based and other resources that can truly accomplish the above steps (plus prevention and other steps that can affect demand and other performance goals) is of critical importance.

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How Far Have We Progressed in Engaging Consumers?

Health care consumerism is spreading, especially among larger employers. While technically any type of plan change that raises premiums/deductibles/co-payments and/or ramps up health promotion programs falls into the broad category of consumerist changes, when consumerism is the topic it's usually in the context of Consumer Directed Health Plans (CDHPs) — plans that are derivatives of Medical Savings Account plans and combine either Health Savings Accounts or Health Reimbursement Arrangements with High Deductible Health Plans (HDHPs) and are usually accompanied by prevention benefits, disease management services access to health web sites and 24 hour nurse lines.

In fact President Bush has made CDHPs the centerpiece of his health policy: "We need a consumer-driven health care system. And we need better information about health care prices. And a consumer-driven health care system with better information will help control the cost of health care. That's the rationale of the health savings accounts. The best way to empower citizens is to let them save and spend their health care dollars as they see fit. In other words, start to empower people to make the right decisions with their health care dollars."

It seems the jury is still out on the question of what we have accomplished:

- "The success of the consumer-directed approach rests on a basic assumption: if consumers are given financial incentives, choices, and information to support those choices, they will take charge of their health and health care and make prudent and wise choices. Being "in charge" (or "activated") implies more than just having the right information. It means understanding and accepting a higher level of responsibility and possessing the knowledge, skills, and confidence to take this on…*The key unanswered questions are: what will it take to activate more consumers; and what will happen to those who do not become activated?"* AARP May 2003 http://www.aarp.org/research/health/privinsurance/aresearch-import-570-2003-05.html
- "Consumer-directed plans' high deductibles and out-of-pocket costs can prevent patients from receiving necessary and effective care, potentially costing the health care system more in the long run." Commonwealth Fund August 2004 http://www.cmwf.org/topics/topics_show.htm?doc_id=235966http://www.cmwf.org/topics/topics_show.htm?doc_id=235966
- "Individuals with CDHPs and HDHPs were significantly more likely to avoid, skip, or delay health care because of costs than were those with more comprehensive health insurance, with problems particularly pronounced among those with health problems or incomes under $50,000. About one-third of individuals in CHDPs (35 percent) and HDHPs (31 percent) reported delaying or avoiding care, compared with 17 percent of those in comprehensive health plans. Few health plans of any type provide cost and quality information about providers to help people make informed decisions about their health care. The study also found very low levels of trust in information provided by health plans." EBRI December 2005 http://ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3606

There is much more that's been published about CDHPs. There is evidence that CDHPs can cost employers less in the short term, but questions remain with regard to the personal health implications of choosing to delay or avoid care for cost reasons and long term total costs regarding increased severity problems and corresponding treatment costs. "Despite the fact that more than half (of Americans) agree that more direct involvement in health care decisions would improve health care, a majority of Americans do not currently seek to take up this responsibility. EBRI November 2004 http://ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3507

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