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Sports medicine: Strategic vision and planning are everything, experts say

Mark Hagland

If you want to succeed in the sports medicine arena, you'd better be ready to "skate to where the puck is," as some sports types might say. Diverse hospitals across the U.S. have built sports medicine programs that enhance their standing in the community and help build volume in key areas such as orthopedics and rehab medicine. But, as one CEO admonishes, sports medicine can't just be a "marketing ploy." It has to be an integral part of your business strategy, and success depends on basic clinical strengths.

Sports medicine brings younger patients into inpatient hospitals. It provides an opportunity to package service lines in a fresh way, around vigorous themes such as injury prevention and wellness. And the new packaging can boost market awareness dramatically, positioning an organization for the new decade in healthcare.

A few intriguing variations on the sports medicine theme are being implemented at Jewish Hospital Healthcare Services in Louisville, KY, the University of Wisconsin Hospitals, Huntsville (AL) Hospital, and Florida Hospital in Orlando.

The fundamentals

All the executives interviewed at these hospitals agree on a few essential keys to success. Above all, everyone agrees it's absolutely crucial for any sports medicine program to

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Consumer-directed health plans: The emerging template for private health insurance

Jeff Goldsmith

Despite strong recent financial performance, America's private health insurance plans continue to struggle with the legacy of the managed care backlash. A marked reduction in their bargaining leverage with hospitals and physicians, combined with limited options for coping with the recent surge in health costs, pushed premium renewal rates into the mid-teens—a level not seen in a decade.

Jeff Goldsmith

Now a new, consumer-directed health product has emerged that appears to be challenging the sources of rising costs successfully, and putting new pressure on healthcare providers.

Demand surge driving costs

The current surge in health costs has been driven by rising procedure volume. This is evidenced by a surge in imaging volume—recent projections suggest a compound growth rate for both MR and CT scanning of more than 16% per year! Cesarean section rates are rising again after a mid-1990s dip, and now approach 25% of all live births. Physicians have responded to rising

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tient services firms as HealthSouth.

Still, in head-to-head competition against such outfits, "hospitals usually do a good job with sports medicine programs, because they have more services consumers can benefit from," says Dewayne Manning, sports medicine coordinator at Huntsville Hospital's Sports Center. "If we were a freestanding physical therapy provider, it would only be therapy visits we could build on."

To provide this mix of services conveniently to a busy and demanding professional market, the hospital constructed a large modern "Medical Mall," which houses the Sports Center and associated therapeutic/fitness/wellness amenities such as cardiovascular equipment, weight training, aerobic classes, aquatic activities, classrooms, and lab testing.

The Sports Center offers the specialized services of doctors, physical therapists, athletic trainers, exercise physiologists, personal trainers, and dietitians. A series of similar but smaller "Wellness Centers" are being constructed at outlying sites.

All of these services are extensively cross marketed. For example, the Huntsville Hospital Web site invites site users to arrange for and print out/e-mail gift certificates for any amount. Recipients can apply these toward any sports/therapy/wellness service offered at the Medical Mall or Wellness Centers.

Many paths to similar goals

If the Jewish, Florida, UW, and Huntsville sports medicine programs differ in terms of structure, services, and situations, they are similar in that they're being used to:

- Help brand the organization in its target market.
- Reach younger and active populations.
- Strengthen business partnerships.
- Build inpatient and/or outpatient utilization.

And the leaders of all these programs agree that overall business strategy and goals must dictate sports medicine partnerships and services, not the other way around. Given the right fit, they attest, success is quite possible. "We're only going to grow," says Jewish Hospital's Berryman, enthusiastically. "We're on a roll, and every day we're getting other groups wanting to work with us. This program has really helped us pivot into many areas."

Mark Hagland is a freelance healthcare writer. He may be reached at MHagland@aol.com

Consumer-directed health plans

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practice costs, particularly for medical liability insurance, and Medicare fee limits by doing more for patients.

In 2002, the federal government reduced physician fees by 4.7% across the board for services provided Medicare patients. Physicians responded to the fee reduction by increasing the volume of services provided to Medicare patients a stunning 8% in a single year. There is strong circumstantial evidence that physicians have lowered the threshold of acuity of illness needed to justify intervention.

However, an equally significant contributor to procedure activism has been the declining "real" cost of health services to the end user, the patient. The consumer's share of overall health costs declined steadily since 1960, when it represented almost half of all health costs. Significantly, it declined steeply during the explosion in managed care enrollment. In 1980, patients bore almost one-quarter of health costs. By the year 2001, the latest year for which we have national data, that share had fallen to 14%. What that means in practical terms is that employers, through their private health plans, absorbed nearly all the risk of increased health costs.

Though employees' out of pocket contributions have risen, the increase fell well short of inflation. The perception that the real cost to the patient of a $175 physician office visit is only $20, or that the real cost of an $85 prescription is the $20 copay has lowered patients' resistance to seeking care that may have marginal benefit to them.

Changing this perception is the most important contribution of the movement toward consumer-directed health plans.

Consumer-directed health plans: A complex answer to the cost surge

Consumer-directed plans are a complex answer to the current health cost surge. To characterize them as "cost shifting to patients" misses the fundamental point. This formulation implies that all medical care has equal value. If health plans are not to be in the business of deciding from a distance which services are needed, patients need to play an increased role as arbiters of value. They

cannot do this if they are completely anesthetized to the cost consequences of their care decisions.

However, merely shifting costs to employees without their permission is correctly perceived by many employees as a unilateral deprivation of benefits by their employer. The responsibility for weighing the economic value of health benefits cannot be imposed on employees; it must be chosen voluntarily in exchange for some other perceived economic benefit—increased wages, reduced premiums, or other benefits. Consumer-directed health plans are "permission based."

How they work

Consumer-directed plans contain three key elements: customized benefits design, consumer spending accounts, and transparent and continuous communication with the carrier. In all three cases, Internet connectivity and Web utilities play an indispensable role in supporting the members' interactions with the health plan. These three elements work together to enable members to control their and their family's definition of and use of their health benefit.

1. Customized benefit design

Imagine how the personal computer industry would have evolved if the only way to obtain a personal computer was through one's employer. The employer would buy in bulk from the cheapest supplier. Everyone would get the same PC, and it would have minimal features and functions. Reliability would suffer because the people who purchased the PCs were different from those who used them. Unfortunately, this is how health benefits are purchased—wholesale, from the lowest bidder, on a one-size-fits-all basis, by someone different than the user.

Dell revolutionized the PC industry by enabling customers to design their own personal computers to their specifications through a Web browser. Sophisticated Web-based coordination of computer assembly not only enabled Dell to guarantee a delivery date, but also allowed customers to track the assembly of their computer on the Web. This capability to offer custom design while "controlling" delivery dramatically expanded the market for Dell's product, and forced competitors to match their offerings.

This is why customized benefit design is so important. Individuals and families differ markedly in their healthcare needs. A significant number never use the benefit, and roughly 60% use less than $500 worth of care per person in a year. Others can anticipate a major health need in the coming year—having a child or correcting a long deferred medical problem like the need for hip replacement. Still others need continuous medication, or continuous, complex care for a chronic condition such as cancer. Some families have the financial flexibility to absorb a large unanticipated medical expense, or support higher levels of routine cost sharing, while others have tight financial constraints and legitimately need more insurance coverage.

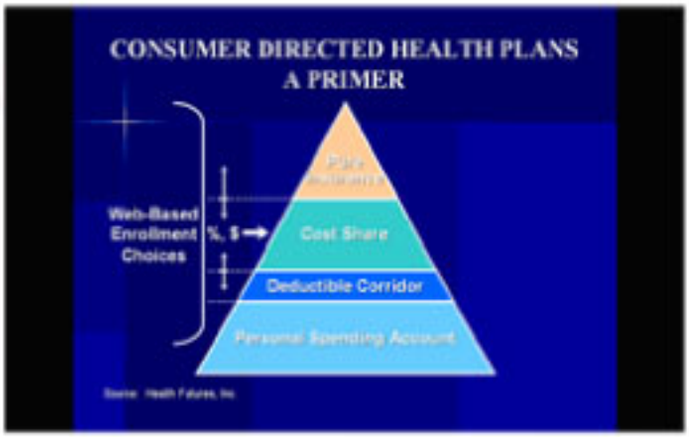
Consumer-directed health plans use a Web browser to help people match health coverage to their anticipated needs. A wizard—a sophisticated, actuarially-based decision support tool—helps people frame their anticipated healthcare needs, and match these likely needs to a plan that provides the "correct" amount of health insurance, and a tolerable level of out of pocket financial exposure. That is, actuarial tools inside the wizard help "users" estimate their risk, and match the level of insurance to that risk.

2. Consumer spending accounts

Consumer-directed health plans provide consumers who anticipate limited medical expenses with spending accounts that cover those expenses with minimal or no cost sharing. If the plan member's personal spending account is not exhausted within the plan year, some benefit designs allow the funds to roll over into a subsequent year, tax free. Above the amount in their spending account, plan members may select differing levels of cost sharing, up to a set ceiling amount above which there is pure insurance against catastrophic medical expense (see Exhibit 1).

Consumer decisions about how large their personal spending accounts will be, how large the deductile corridor is, how much cost sharing they are willing to tolerate above that amount, and how high the threshold above which they'll have pure insurance will all affect their monthly premium contribution, the amount deducted from their paycheck. These decisions are the employee's personal option.

Having made their decisions, employees are then responsible for managing their own health costs, and health, in a way fundamentally different from traditional health insurance. Technology helps here too. Some plans enable them to use a personal Web page to track how much of their personal spending account they have used. Other plans give members a debit card to debit the amount of a given health expense such as an office visit or prescription. When the personal spending account is exhausted, the



card "flips" and becomes a credit card that enables them to charge the copay for their health services.

3. Interactive link to health plan

If Federal Express can provide customers with a Web utility to help them locate their own packages, instead of tying up a customer service representative on the telephone, why can't health insurers enable their members to track the status of a medical claim, or verify that they are eligible for a given health benefit? Internet technology has enabled health plans to make their policies and operations far more transparent to their members.

It has also enabled them to reduce or eliminate clerical and call center employees, by offering "self service" options for an increasing proportion of member-plan interactions.

According to Cap Gemini Ernst and Young, deployment of Internet technology across the broad range of health plan functions could reduce administrative expenses by up to 30%.

However, the Internet has enabled far more than the relatively mundane reframing of administrative activities. It has also created a new opportunity for plans to interact with members about their own health—by opening channels for accessing health information and creating a platform for disease management for those with complex or chronic health conditions.

In a permission-based health insurance system, disease management is not something imposed by the employer or plan on an unwilling member. Rather, it is part of the toolset that members can use to manage their own health, and contain their own medical expenses. Health plans can also use intelligent, speech recognition-based outbound calling systems to remind members to renew their prescriptions, or to have mammograms or pap smears, or other preventive tests.

The good news: It's working

If all these things did was improve member satisfaction with the health plan, they would be worth doing. However, preliminary evidence suggests that consumer-directed health plans have markedly reduced the escalation in medical expenses in groups that have chosen to use them. Humana tested its health plan on its own employees, in two stages:

⟨ In the first stage, with six health plan options, including two with personal spending accounts, the company reduced its own health benefits cost-increase trend from an unsustainable 19% to 4.9%. Humana's non-Louisville associates saw a 3.7% *decrease* in health costs under the new plan.

⟨ In the second year, when the company switched to a more thoroughly customized approach with, ultimately, 44 options, the cost trend remained steady at 4.8% for a second full year. The first-adopter commercial customers have reduced their cost trend by more than half, and the trends appear to be holding into the second year, a number consistent with reports from other carriers.

Consumer-directed health plans appear to fundamentally change the way members use health services: 70% of the savings relative to trend appear to be changes in how health services are used, including fewer tests and procedures, fewer hospitalizations, and more preventive care such as primary care physicians visits, Pap smears, and mammograms. Consumer-directed health plan members appear to make rational health purchasing decisions—decisions consistent with weighing the value of the services provided them.

Barriers to adoption

As with many technologically enabled products, the consumer-directed health plan has been a difficult sell. Best estimates are that as of mid-2003, a little more than 500,000 of the 160 million privately insured people in the United States were covered by these plans.

There are several barriers to adoption.

Complexity

It is difficult to explain in a sentence how a consumer-directed health plan differs from conventional health insurance. Much of the technology is invisible to the purchaser or user, buried in the sofrware and net-

work connectivity the plans require. The ability to customize coverage, incorporate spending accounts, and provide consumer decision support and real-time administrative services fundamentally changes the health insurance customer experience. For conservative benefits managers and insurance brokers, still smarting from the managed care backlash, promoting a new concept they do not entirely understand or trust has certainly slowed the adoption of this new idea.

Resistance to higher cost sharing

No one willingly surrenders a "free" benefit. Many employees feel intensely that their health benefits represent a perpetual promise from the company that granted them. Corporate human resource executives and employees look warily on the consumer-directed health plan as a disguised "take back" of a free health benefit.

The reality is that the health benefit is not "free." Employees are paying for sharply higher health insurance premiums with reduced wage increases! It really *is* their money being spent on higher premiums, and to the extent that this is so, employees ought to have more control over how those premiums are spent, and what they are buying in coverage. In one-size-fits-all plans, many employees are buying more health insurance than they need or will use.

Giving employees control over how much and what type of health insurance they buy is key to their making more responsible use of the benefit. Given the choice between a lavish first dollar plan and a wage increase, many employees will opt for the cash. They ought to be given a choice.

Broker skepticism

A significant fraction of employer-based health insurance is mediated by the insurance broker community. Brokers have become accustomed to viewing health insurance as a commodity, and decisions to place insurance are often based on a feature/cost comparison, or on prior relationships with specific carriers. Brokers are skeptical of new forms of health coverage that do not fit their models, and which they do not understand operationally. Brokers played a significant role in slowing the adoption of medical savings accounts, and appear to be a source of channel resistance to the adoption of consumer-directed health plans.

Despite these concerns, Forrester Research forecasts a quintupling of consumer-directed health plan enrollment, to 2.7 million subscribers, by the end of 2005. I believe this adoption curve will continue to steepen, as consumer-directed plans are used to phase out traditional HMO coverage—by enabling plans to price the rich benefits more accurately to their cost, and letting subscribers decide if the benefits are worth the increased premium cost.

Provider implications

These plans have significant implications for providers. Because they target procedure volume, they strike at the growth portion of the health services market. Imaging, outpatient surgery and diagnostic procedures, and branded pharmaceuticals are vulnerable both to volume and pricing pressure as consumer-directed plans spread.

Providers can take several steps to prepare for the emergence of this new type of health plan.

1. *Price intelligently.* Because they will be asked to pay more of the bill, consumers will be increasingly sensitive to the discretionary use of health services. Price increases should be avoided for elective outpatient services, and be concentrated in the services that are not discretionary: emergency services, critical care, and acute inpatient services. Hospitals have historically underpriced their highest intensity services, and have been punished for it economically.

2. *Offer consumers alternative pathways for resolving medical problems.* If discretionary inpatient services can be rendered on an outpatient basis, consumers are likely to welcome the opportunity to save money. Physicians can also help consumers save money by offering generic substitution for prescriptions and by performing more services in their offices, where costs are lower. Overall, providers should expect patients to be more skeptical and questioning of the need for procedures and services, and for them to actively seek alternatives.

3. *Price for quality.* Patient safety and clinical effectiveness differ markedly from hospital to hospital and physician group to physician group. Health plans will increasingly share this information with patients. Hospitals and physicians who waste fewer resources treating patients may be able to charge more for the services that are used, and still save their patients money versus competing alternatives. Providers who avoid medication errors, infections, and unnecessary readmissions can easily demonstrate the

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value proposition to patients who are, increasingly, spending their own money on medical services.

4. ***Experiment with consumer-directed plans for their own workers.*** The best way to understand how consumer-directed plans work is to use them! They save money, increasing the resources available to pay healthcare professionals more for their services, and enable hospitals to compete more effectively in tight labor markets. Healthcare professionals are uniquely equipped to make better choices about their healthcare needs, and will appreciate the flexibility consumer-directed plans provide them. Healthcare providers have been among the early adopters of this approach.

I believe that consumer-directed plans are a timely response by health insurers to the surge in cost, and the increasing demand by consumers for involvement in the healthcare decisions that affect their lives. ¶

Jeff Goldsmith is president of Health Futures, Inc., Charlottesville, VA, and author of a new book, Digital Medicine: Implications for Healthcare Leaders, *Health Administration Press. Contact him at hfutures@healthfutures.net or 434/979-9524*

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