GALLAGHER INTEGRATED PRESENTS

HEALTHCARE CONSUMERISM 3D

Rise of the Consumer

Healthcare has a new partner

Starring Bill Jessee and Susan O’Hare

The story of three unlikely partners—patients, payors, and providers—rising to the challenge of the new normal of healthcare consumerism. Now playing everywhere in 3D.
They have been quiet for many years. They have accepted treatment and passively paid for healthcare. They have even taken a supporting role to providers. But in this epic blockbuster, the consumer will rise. With technology on their side, patients now demand more transparency than ever before, while payors want bang for their buck, proving that providers can no longer work alone. From the same producer that brought you *Raising the Bar: Decreasing Payments and Increasing Risks*, Integrated Healthcare Strategies (Gallagher Integrated), a division of Gallagher Benefit Services Inc., presents *Healthcare Consumerism 3D: Rise of the Consumer*. It’s the story of three unlikely partners—patients, payors, and providers—rising to the challenge of the new normal of healthcare consumerism... an issue so big, it’s in 3D. Critics agree: *Rise of the Consumer* flies off the screen with insight, tackling the issue from all three dimensions. And when patients, payors, and providers become partners, healthcare will never be the same.
The following articles provide vital information about the origins of this change, the modern-day impacts on providers, and solutions for the path ahead. These insights will help arm you with knowledge about the rise of consumerism in healthcare and what lies ahead. 3D glasses not required.
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HEALTHCARE CONSUMERISM 3D
RISE OF THE CONSUMER

From Passive Patients to Proactive Participants

Authored by Dr. Bill Jessee, Chief Medical Officer and Senior Advisor

If you think healthcare has changed a lot in the last few years, then fasten your seat belt—it’s going to be an even bumpier ride as Baby Boomers become senior citizens and the Information Age transforms the doctor/patient relationship.

Healthcare costs have escalated at an unsustainable rate, and employers, who still provide insurance for 50% or more of Americans, have responded by shifting more costs to employees. Initially, this meant employees paid a greater share of the premium, but in recent years the cost-shifting has taken a different form. The fastest-growing segment of the health insurance market is the High-Deductible Health Plan (HDHP) with a savings option, which is more affordable for employers and healthy employees.

With the advent of the Affordable Care Act, the dominant type of health insurance sold through the insurance exchanges became a HDHP with a savings option. In one sense, this is a return to the early days of health insurance when indemnity plans covered hospitalization and little else, while patients paid out-of-pocket for doctor visits and routine care. Under the HDHP design, patients pick up the first $5,000 or $10,000 of medical expenses and, other than certain wellness and screening benefits, the insurance doesn’t kick in until costs go above the threshold. This plan design has had the effect of re-introducing a supply-and-demand mechanism into a market that has operated for many years outside the sphere of common economics.

Patients Becoming Price-Conscious Participants

Today, more Americans are insured for catastrophic medical expenses. This is good news, because it will surely mean fewer medical bankruptcies and fewer defaults on big hospital
bills. But more Americans are paying for routine medical care—even care that is pricey compared to a weekly paycheck. This means providers may have a tough time with smaller collections. It also means that the consumer has a vested interest in getting good value for the healthcare dollar.

The emphasis on value from a consumer’s perspective has the potential to shake up the delivery of medical care. Why would a consumer choose to pay $3,500 for an MRI if he or she can get it for $1,600 at a radiology center? A hospital may feel that a state-of-the-art MRI machine that delivers the highest-quality diagnostic image is a better value, but the consumer will likely prefer a lower cost option if the image is “good enough.”

**Patients Seeking Convenient Care**

Cost is not the only issue for today’s busy healthcare consumer. Convenience is also a factor in choosing where to go for care. Why would someone with the flu wait three days to see his or her primary care physician if he or she can get a walk-in appointment at an urgent care center? The patient/physician relationship is no longer an exclusive one. Today’s consumer is inclined to see his or her primary care physician as a partner in long-term health monitoring, but will seek care for minor ailments in the most convenient setting.

Some non-traditional providers see a competitive advantage in this consumer-driven market. Walgreens, for example, has developed a strategy based on the fact that 82% of Americans live within a 20-minute drive of one of its stores. Walgreens is expanding beyond the pharmacy to offer services ranging from urgent care clinics to chronic disease management for people who value the convenience of receiving timely care closer to home.

**Enlisting Patients as Partners**

In this Information Age, patients often arrive at the doctor’s office having made a self-diagnosis with the help of the Internet. The educated consumer with information at his or her fingertips may seem like a problem patient to a traditional physician who isn’t accustomed to answering questions. Doctors must not think of this as a challenge to their authority, but rather as an opportunity to enlist the patient as a partner in his or her own medical care. The patient who understands what he or she is being told to do is more likely to follow through on the treatment plan, leading to better outcomes and a lower long-term cost of care.

Consider the experience of a company called MedEncentive, which works with self-insured employers to reduce the cost of care by providing financial incentives to the patient and provider. The provider is expected to follow a set protocol for a diagnosis and offer patient education, while the patient is expected to follow the treatment plan. If both parties do their part, and the result is better care at a lower cost, the doctor and patient share the savings. The MedEncentive program has been shown in independent audits to reduce healthcare costs.
Embracing Family-Centered Care

It is important to consider the impact that an involved family can have on a patient’s care. Children’s hospitals have traditionally done a good job of including the family in patient appointments and caregiving, but facilities treating adults have been slow to embrace the family as part of the medical team. A patient who brings a spouse or friend to a doctor’s appointment may be more likely to understand and follow instructions when he or she leaves the office. If a treatment is frightening, like a biopsy, radiation, or chemotherapy, having a loved one to hold the patient’s hand can make it less stressful. In short, allowing a family member to be with the patient throughout the caregiving process can lead to a better outcome and a quicker recovery.

Offering Enhanced Customer Service

Baby Boomers’ experiences of caring for their aging parents are profoundly influencing their expectations of customer service as they grow older. Baby Boomers will demand to make their own decisions about what care is appropriate, whether to address issues through a procedure, medication, or lifestyle changes. They will also demand to stop extraordinary measures and focus on quality of life instead of quantity of life.

With patient satisfaction scores impacting reimbursement, health systems need to focus on providing better customer service, and they need to define customer service and value from the consumer’s perspective. In the past, providers primarily considered what was best for the hospital; now it is all about what is best for the patient, which means the system needs to be changed to accomplish the following:

- Eliminate backlogs and time lags in the system to quickly deliver information in minutes or hours, not days
- Provide care in settings that are convenient for the patient
- Deliver value rather than more services than necessary
- Form genuine partnerships with patients by understanding their concerns and wishes when devising a treatment plan
- Provide family-centered care by embracing the family as part of the care delivery team

Providing better customer service wherever and whenever the patient receives medical care will require a paradigm shift for many physicians, administrators, and board members. It will also require a culture of customer service that has not always been the tradition in hospitals. Health systems can create a culture of great customer service by engaging all physicians and employees in the process and putting incentives in place to encourage and support people who do the right thing. Health systems that create customer service cultures will succeed in the new consumer-driven healthcare marketplace.
Employers As Healthcare Payors

In the new normal of post-reform, the impact on providers couldn’t be clearer. Today, approximately 90% of employed, non-elderly, non-poor Americans receive their healthcare benefits through their employers. Within this group, 20% subscribe to a High-Deductible Health Plan (HDHP) with a savings option—a triple tax-advantaged opportunity that can be used for any purpose (i.e., not just healthcare) and a great way to supplement a 401(k). Approximately 50% of employers offer such plans and the numbers are growing at an impressive rate; Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point-of-Service (POS) plans are all in decline; HDHPs with a savings option increased market share an astonishing 17% between 2006 and 2014. There is every reason to expect them to continue their stratospheric rate of growth.

“the United States is unique in offering employer-based insurance”

To understand the role that employers play as payors, a little context is helpful. The United States is unique in offering employer-based insurance, the origins of which go back to World War II, when President Franklin D. Roosevelt and big business became bitter adversaries over issues having nothing to do with healthcare. The rest of the developed world had already either nationalized healthcare or was rapidly moving in that direction. With vigorous support from the First Lady, Roosevelt was leaning in that direction as well.

Being the savvy politician he was, however, Roosevelt recognized he couldn’t enter the war at an impasse with corporate America, apoplectic over wage and price controls. The way forward, he realized, was to solve both the national healthcare challenge and the big business entanglement
with a single solution: employers could entice employees with a new form of compensation—healthcare benefits. Indemnity plans proliferated, first dollar coverage was universal and, while Eleanor may not have been happy, the war was won with an unprecedented ramp-up in production of armaments, munitions, and assorted war materials.

Half a century later, corporate America began its nascent venture into consumerism. There was no way to budget, even a year ahead, for continually escalating healthcare benefit expenses that often contributed more to the cost of a General Motors car than the steel that went into it. Corporate executives saw the data and knew there was enormous variation, not just between the United States and other developed nations, but within the United States as well. It could not be explained away by geographic differences, epidemiology, or any other factor. It was blatantly obvious that healthcare in the United States was bureaucratic, bloated, greedy, and either incapable or unwilling to heal itself.

Frustrated, the same executives turned to the nation’s leading healthcare providers and policymakers, imploring them to “fix it.” One particular encounter—part fact, part folklore—stands out as the turning point: having been turned away by yet another group of healthcare experts (A kind of “It’s all very complicated, don’t you know? People’s lives are at stake; we’re not making widgets here. Go back to your smokestacks and we’ll let you know when we find a solution” thinking), the executives reported to the airport bar to drown their frustrations.

And that’s when inspiration took hold. They realized they didn’t need policymakers or clinicians to fix the problem; in fact, they would be better off without them. They had the data, the certainty of being right, and their stockholders were hungry for results. They knew they had to take action. And with that, the LeapFrog Group was formed, offering objective and comparative information on providers. Not long after, employer consumerism was born, with employers serving as policy payors.

Though the size varies, $5,000 deductibles, exclusive of certain benefits such as an annual physical or a mammography screening, are not unusual. Where it gets particularly interesting is in the case of an elective procedure, such as arthroscopic surgery on the serving shoulder of a 50 year-old weekend tennis player. Under indemnity coverage, there was little to consider: have the surgery, complete the rehab, and get back in the game; however, if the first $5,000 is coming out of your own pocket, the math changes. Now the decision is between surgery and that trip to Paris you’ve long dreamed of when you finally retire. You can buy a lot of Advil and ice for $5,000. The other option, for the unethical, is to stiff the provider for the out-of-pocket costs, saddling them with bad debt.

An unforeseen consequence of the Affordable Care Act was that employers realized they, too, could set up (private) insurance exchanges, finally abandoning the legacy of Roosevelt and enabling them to actively budget for healthcare premium expenses. The process couldn’t be simpler. Pay a visit to Human Resources, where they will educate you on how to access the exchange (which, unlike the ACA, actually works) and you make your selections on a comparative
basing from the plans that are offered. After receiving a voucher for, say, $7,000 (tax-free), you’re on your way. You may even receive additional incentives aimed at wellness and prevention. The nation’s leading benefits consultants have already set up these exchanges, and insurance companies recognize them for what they truly are: redundant.

Furthermore, employers are pursuing other initiatives. Consider some of the following key initiatives from Walmart, with 1.4 million associates in the United States; Disney, with current healthcare spending of more than $1 billion a year; and the California Public Employees Retirement System, with health and retirement benefits being offered to more than 3,000 public employers:

- Increased HMO offerings
- Broad and narrow networks
- Limited PPO reference pricing
- Chronic disease management
- Intensive case management
- Wellness strategies
- Integrated care delivery
- Affordable primary care clinics
- Channeling the highest quality providers with systems and processes supporting efficient care
- Payment tied to outcomes
- Leveraging volume

Additionally, the Dartmouth Atlas has been delivering providers and employers information on cost and quality variation within the United States for more than three decades. The sons and daughters of the LeapFrog Group have this information and direct their employees to the highest quality, most efficient providers. Incentives may vary, and unique arrangements may be constructed between select providers and employers, but in the simplest form, incentives arguably work best. The private exchange isn’t just a source for comparative healthcare premium shopping; it’s also the place you go to assess providers. If the quality outcomes are 10% better and the cost is 15% lower at Medical Center X compared to Medical Center Y, then the choice is pretty clear.

“employers are pursuing other initiatives”

1Health Forum, The Voice of the Purchaser: A Time of High Change; Barbara Wachsman, Senior Executive, Employee Health Benefits, Disney and Chair, Pacific Business Group on Health; Ann Boynton, Deputy Executive Officer, Benefit Programs Policy and Planning, CalPERS; Sally Wellborn, Senior Vice President of Benefits, Walmart; July 1, 2014
The journey comes full circle with what has come to be called “domestic healthcare tourism.” In 2006, The Bumrungrad Medical Center in Bangkok was simultaneously featured on 60 Minutes and the cover of Newsweek. With JCAHO International accreditation, Western trained physicians, extraordinarily beautiful facilities, proven clinical outcomes and jaw-droppingly low costs, the prospect of international healthcare tourism (not only with Thailand, but also India, South America, and others) sent a shock wave through the United States provider community. As it turns out, change most often comes from the outside.

For a variety of reasons—legal, regulatory, and prejudicial—the threat never fully materialized. But it hasn’t gone away, and many of the United States’ leading medical centers are now supporting the efforts. If it ever, as it most likely will, becomes about cost (i.e., in time, poor quality providers will be rooted out), it’s game over for U.S. providers. Don’t believe it? Drive into Bethlehem, Pennsylvania from the South. I recommend dusk in the late fall for a particularly eerie experience. Take a look at the rows upon rows of idle, rusting smelters. It looks like something out of Stephen King’s imagination. Bethlehem Steel, in its heyday, had two golf courses: one for the exclusive use of its executives and one for the “little people.” You won’t have any trouble getting a tee time on either course today.

In the end, healthcare expenses are on the rise in today’s post-reform era. In order to economize on employee benefits costs, employers as payors are moving away from a defined benefits model, where they carried the financial weight and risk, to a defined contribution model. The healthcare environment is changing at a rapid pace and, as a result, moving some of the costly burden onto employees through the offering of HDHPs with a savings option is the wave of the future.
Providers: Delivery is Now Your Product

Authored by Susan O’Hare, Senior Vice President

Twenty-five years ago, half of every dollar spent on healthcare in the United States went to a hospital for inpatient care. But things have changed a lot since then, and the hospital is no longer the focal point of care that it once was. For a variety of reasons, medical care is delivered today in all kinds of settings: outpatient facilities, clinics, pharmacies and grocery stores, by phone and Internet—just to name a few. And while the leaders of health systems have generally come from the hospital-side of the business, they need to think outside the four walls of the hospital to answer the central question that will determine their success or failure: how can our system deliver the best possible healthcare to the people around us?

Society has changed. Habits have changed. Expectations have changed. People are now used to looking up information on their smartphones and getting immediate answers to their questions. They have become accustomed to comparison-shopping online for hotels, airfares, and all kinds of consumer goods. They check Angie’s List to find out who does the best plumbing work. They order toilet paper from Amazon and get it delivered in 48 hours.

Healthcare is not immune to societal trends. Patients can buy cell phone apps that perform EKGs, monitor heart rates, or check blood glucose levels. Health systems that are measured on patient satisfaction can no longer take 48 hours to deliver the results of a blood test or...
biopsy, and physicians cannot expect patients to accept what they say without a thorough explanation and many follow-up questions. And, in the very near future, hospitals will not be able to attract patients if they try to obscure information about costs and quality.

In fact, similar to how they may search for online ratings and reviews of hotels, restaurants, and handymen, today’s healthcare consumers have tools at their fingertips that make it easier to search, compare, and assess healthcare providers. Healthgrades and Yelp, two well-known and popular user-review websites, offer consumers the opportunity to share their experience, satisfaction, and the quality of individual providers and their facilities. And, in today’s evolving healthcare environment, presenting people with the opportunity to comparison shop for health services creates a new and essential level of transparency. Consider what happened when the Surgery Center of Oklahoma began publishing its prices online for a wide range of procedures. Soon, patients were coming from Canada and out-of-state, attracted by low prices and high quality. Before too long, other providers in Oklahoma City began to list their prices online so patients could comparison shop. The simple act of one provider in one community choosing to compete on price transformed the market for surgical services in that city.

What happened in Oklahoma City may seem like an anomaly, but it may one day become the norm. Today, patients can go to the CMS Hospital Compare website to look for quality information or NewChoiceHealth.com to compare prices at different facilities in the same city. Hospitals will soon be required to release a standard list of prices for their medical services under a new rule proposed by CMS.

So how can a system of providers with hospitals at its core compete in this new Information Age?

• By shifting the focus from hospital-centric definitions of “value” to consumer-centric definitions of “value”
• By thinking more entrepreneurially and rewarding risk-taking
• By making information about price and quality readily available and easy to understand
• By meeting the consumer at the place where he or she makes healthcare decisions
• By recognizing that the means of delivering care is perceived by patients as important as the care itself

HaysMed in Hays, Kansas, administers what may be the largest critical access hospital network in the country. Located in western Kansas, HaysMed has set a big, hairy, audacious goal (BHAG) of being the best tertiary care center in rural America. To meet this BHAG, HaysMed has decided that it must not only provide high quality medical care, but also demonstrate its commitment to quality by posting superior data online. As a result of this and other
initiatives, HaysMed is flourishing in a geographically dispersed marketplace, maintaining high market share, and helping local citizens get the medical care they need without having to travel to larger population centers.

HaysMed is only one example of a health system taking entrepreneurial, consumer-centric approaches to delivering healthcare in ways that meet the specific needs of people in their service area. There are many more examples out there, and what these innovative organizations have in common is a commitment culture that supports the vision and goals of the organization and rewards excellence.

As 21st century healthcare evolves along the lines of other markets in the Information Age, and as it becomes more of a commodity—more price sensitive, and more quality-driven—these are some steps your health system can take to stay ahead:

- Create a diverse board with a range of experiences and skillsets to help your organization envision a future that meets the needs of the population you serve
- Hire senior managers who can create transformative change, and challenge them with incentive plans that reward excellence, entrepreneurial thinking, and creative problem solving
- Build a culture that supports your mission and vision and serves the community; not just your bottom line
- Engage, not direct, your entire workforce in achieving the mission and vision

There is no doubt that the future will be taxing, and the challenges that lie ahead will be very different from those in the rearview mirror. But excellent healthcare is fundamental to our quality of life, and it will be achieved in this country despite the challenges. The systems that focus on delivery as the number one product will make it happen.
HEALTHCARE CONSUMERISM 3D
RISE OF THE CONSUMER

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