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Planners, Shoppers, Contenders, and Cavaliers: How Consumerism Is Changing the Health Insurance Industry

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Planners, Shoppers, Contenders, and Cavaliers: How Consumerism Is Changing the Health Insurance Industry

David Cordani, president of CIGNA HealthCare, describes how his company is responding as individuals take control of their medical benefits.

by David Knott

For more than 60 years, health care has been largely employer-sponsored. But skyrocketing insurance premiums are forcing employers to cut back on health benefits. According to a study conducted by the Kaiser Family Foundation, insurance premiums have risen 73 percent since 2000, roughly quadruple the rate of inflation. The result, according to the Kaiser study, is that more employers are opting not to offer their employees coverage; just 60 percent of employers offered health benefits to their employees in 2005, down from 69 percent in 2000.

Consumer-driven health care (CDHC) initiatives are one promising solution. In consumer-directed health plans (CDHPs), employers typically deposit a sum of money (perhaps $2,000 for an individual or $4,000 for a family) into a health savings account (HSA) to be used as the individual sees fit for medical expenses. Usually paired with those HSAs are high-deductible major medical plans that cover expenses higher than, say, $5,000 in any given year. Any balance left in the HSA at the end of the year will roll over to the next year, in effect creating a lifelong incentive for people to safeguard their health and spend less on health care. At the World Health Care Congress in Washington, D.C., last April, Booz Allen Hamilton Senior Vice President David Knott discussed the emerging trend with CIGNA HealthCare President David Cordani. Based in Philadelphia, CIGNA Corporation is a leading provider of employee health-care services in the U.S.

S+B: We see consumer-driven health care as a way to give customers the power to make informed decisions, but this requires health-care providers to respond in a way that enables competition. What is your prognosis for the next three to five years?

CORDANI: Consumerism combined with health advocacy will be the dominant trend. In the next few years, we expect that up to 25 percent of our employer-sponsored members will be covered under CDHPs with HSAs and health reimbursement accounts (HRAs). These health plans empower employees to make their own decisions. We expect to see a greater percentage of our members exposed to some dimension of health advocacy, which means, in essence, that plan members — whether at CIGNA or elsewhere — will have access to clinicians acting on their behalf, evaluating their needs, and providing them with resources and information to lead healthier lives.

S+B: So consumerism will change even the more traditional offerings?

CORDANI: Absolutely. The industry's winners will be

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those that differentiate by engaging, educating, and enabling their members to navigate the health-care system independently. We define consumerism broadly and have identified four critical elements that will make it work: financing vehicles, which incorporate new health plans; choice and convenience, which will be the key to making services easier to access through a variety of channels, whether it is online, through mini-clinics, or otherwise; member engagement, which is the linchpin of consumerism; and, last, information transparency around the quality and cost of services. These give consumers the insight into the market forces that they need to make informed decisions.

Who Pays and How?

S+B: What are your thoughts on the role of the employer?

CORDANI: Broadly, employers view benefits as an important factor in being considered an employer of choice, but they need relief from carrying so much of the financial burden. Today, the average employer bears about 85 percent of the cost of health care, up from about 60 percent in the 1960s. Employers are looking to rebalance that equation. We think employers will start to move from fully-funded benefits to sponsored or voluntary benefits. We're seeing burgeoning demand from employers for a recently launched set of CIGNA capabilities called the Custom Benefit Builder. Employers can use this system to identify the levels of subsidy and choice they want to provide employees and their dependents. They don't have to offer the same package of benefits to all employees.

S+B: Do you see alternative financing mechanisms like health loans, health credit, or health annuities coming to the market over the next three to five years?

CORDANI: As people shoulder more responsibility for their health-care choices and go from an entitlement model to an activist model, to an ownership model where consumers decide how much to spend for a particular service, there are opportunities for multiple new financing vehicles. These include consumer health credit and loans, which would allow individuals to borrow against the assets they've accumulated in an HSA to pay for high deductibles, an unexpected illness or accident, and other gaps in insurance coverage. Additional annuities and health savings and credit vehicles may be offered to help consumers prepare for future health needs. As the consumer takes on more responsibility, there will also be a blurring between health and retirement savings vehicles.

Role for Advisors

S+B: What will be the ongoing role of the health plans versus that of financial-services plans, and who will own the consumer relationship?

CORDANI: We think there are very few entities that engage health-care consumers as advisors or advocates. Physicians could do it, but they don't have the resources to accommodate that role. Financial-services entities such as banks and credit card companies have frequent interactions with consumers, but consumers won't likely go to them for advice on health care. That's where we come in. We can offer consumers health advocacy based on their medical needs. When a person is in perfect health, the needs are few, but when anything happens — even good things, like the birth of a child — a person's needs increase substantially, and there are few parties in the marketplace that can serve as a trusted

advisor. That's a sweet spot for us.

Today, most consumers make critical health-care decisions based on the type of health care they've had in the past or services available in their immediate vicinity. Many don't realize they have other options. There is an opportunity to help consumers navigate the health-care system. Our members have told us that they don't want seven points of contact and they don't want to be their own aggregator, but they do want a credible party that can aggregate and vet information for them, assist them as they navigate the system, and help them find the best care for their needs.

We currently employ about 3,000 clinicians — more per member than anyone in the industry — who work as health advocates. In most cases, these clinicians are nurses. That means they have a level of medical knowledge that members can trust. We then provide them with a complete picture of an individual, with risk assessment, diagnostic data, diagnostic scores, and so on. They can be very intimate when assisting members in understanding their health alternatives.

S+B: **But everyone has different needs when it comes to health care. How will you give each member the right level of service?**

CORDANI: Consumers have different needs, methods of processing information, and ways of valuing services received. To better identify consumers' attitudes toward health, we conducted extensive research, and based on that research we divided the population into four major segments.

The first major segment is assured planners, who represent about 34 percent of the population. They are relatively thoughtful and make sure they have what they need. Price isn't a driver for them; what matters are comfort, security, and even status. They are also the most affluent.

The second segment, enlightened shoppers, makes up about 16 percent of the population. They do their own research online, read Consumer Reports, and figure out exactly what they want. They then spend time and energy finding the best deal. They're also likely to experiment with alternative medicine, as well as other new products and services.

Next are the steady contenders. This group makes up 28 percent of the population, and they tend to be content with what they have and would prefer to stick with it. They need a very compelling reason to change.

Last are the cavaliers. They want nothing to do with health care. They're the most likely to smoke and are in the worst physical condition. Cavaliers account for a little more than a fifth of the population.

Based on this segmentation, we interact most with the assured planners and the enlightened shoppers. Each has a lot of touch points and teachable moments. We mapped 264 touch points, which include everything from health ID cards, to an explanation of benefits (EOB) sheet, to a health statement. For enlightened shoppers, Web-based information and fact-based touch points are the most meaningful. The assured planners are most likely to call on trusted advisors.

For the steady contenders, it's a different approach. To have an impact on someone in this group who has suffered a trauma, for instance, a nurse might call him every week to make sure he's taking the right medication and monitor his progress. The cavaliers are probably lost to our services; trying to reach them is a challenge.

Moving the Industry

S+B: How important is provider competition?

CORDANI: It's essential to driving meaningful change. Several things have to happen: There must be considerable variance in both the cost and quality of the medical services provided to overcome any bias or convenience factor, and to drive a change of behavior based on choice. The competing services must allow enough time for the consumer to compare offerings and make an informed decision. Of course, this isn't possible in an emergency, but for something that's a nonemergency, such as having an MRI scan, it's ideal to be able to compare the services available to the patient. And, finally, there must be an adequate supply of services offered in a given region.

Based on that framework, CIGNA has embarked on an aggressive path to create information transparency on cost and quality for various services. For example, we have the only point-of-consumption pharmacy pricing tool. Members can identify, based on their benefits, the out-of-pocket costs for pharmacy A versus B versus C. We are also working to create transparency in diagnostic services. We have already identified the highest-performing specialists and the average-performing specialists for about 20 specialty types in specific geographies. If the employer wants, we can provide different benefit coverage programs that create incentives for members to use the higher-performing providers.

S+B: How receptive have providers been?

CORDANI: They have been quite receptive. Their major concern is that there are no standards for quality, so they want to see how we're handling the provider evaluation. But they're happy we don't go just on cost.

Before providers can be rated, they need to have fulfilled an adequate number of procedures. We don't start tracking quality until they've completed at least 20 cases, and we track their performance throughout the entire process, not just what takes place in the provider's office. That's why creating quality measurements for specialists is so important. For example, a patient who has undergone coronary bypass surgery will be monitored for the duration of his hospital stay and throughout his rehab, as well, to assess the level of care he's receiving.

What you won't see us do is take a provider fee schedule, look at it in a vacuum, and put it on our Web site. Similarly, we won't take a hospital charge master — the list of prices for every procedure and supply — put it on our Web site, and declare that we're the transparency leaders. Why? Because we don't think it's actionable in isolation. It doesn't make sense to pay more for a service unless you know that service will be high quality. That's why we believe it's important to evaluate quality and cost together. We follow a restaurant review approach: one, two, or three stars with financial ranges attached.

S+B: Do health plans need to collaborate on uniformity or standardization?

CORDANI: Absolutely. The quicker the industry is able to move to a consistent definition of clinical quality for services, the better off everyone is going to be. But the financing of health care is still complex. There's a lot of cost, tension, and time related to paying for a health-care event, and there's a lot of opportunity for improvement. Doctors and other health-care providers need help reducing the time it takes them to get paid and the administrative costs for managing their revenue, and controlling their bad debt. Addressing these issues will make the system easier and more seamless. Instead of forcing providers or consumers to review complex EOB forms, there could be a monthly statement that resembles a financing-vehicle statement, which is easier to understand. The consumer would know where his or her money is going and get a more rapid settlement. ✚

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