KATHRYN MARTIN: We're just waiting for one more panelist. While we're waiting for him to arrive I just thought I would welcome all of you back from lunch and say that this panel has an especially challenging mission in that it has to follow lunch. Challenging partially because all of you would rather still be in there chatting, eating lunch, and partially because in about half an hour food coma's going to set in and we're going to start seeing heads nod. But that's why we've assembled this stellar panel after lunch to keep us all engaged and to fight through food coma. This session is where we turn to the first and most important word in the concept that we're discussing to today, the consumer. Without them we would be discussing driven healthcare and that would just sound goofy. And so with that this panel's really going to look at what happens when consumers take the wheel of their healthcare. What do they think? How do they use the information? Do they use the information, et cetera? And to do that we have four distinguished panelists beginning with Jon Christianson, who is a researcher at the University of Minnesota, followed by a fellow Minnesotan in Jinnet Fowles, who is at Park Nicollet Institute -- and now that we've distributed the more complete bios you can read all about them -- followed by Judy Hibbard whose research on consumers' use of information is well known, and she's from the University of Oregon. And finally we have David Lansky who's from the Foundation for Accountability,

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otherwise known as FACCT. So since we're on a pretty tight timeframe I thought we would just – I would just turn it over to Jon and we'd get underway.

DR. JON CHRISTIANSON: The – actually the order that the presentations that would make more sense probably would be have Jinnet come first because she talks about the use of information by consumers in making choices, and I talk about consumer experience in the plan. But Katie alerted me to this lunch induced coma that she referred to, and so I cleverly got my presentation scheduled first to get it out of the way beforehand. And Jinnet's just learning about this. Well, we, as Roger already discussed this morning, did a survey of consumers. There really have been a lot of conflicting opinions if you read this literature on consumer-driven health plans about consumers and their role in all of this and whether they're going to be up to the job of playing their intended role. Certainly the consumer-driven health plans themselves emphasize the consumer involvement, they emphasize the decision support tools that are available for consumers, help lines and so forth, to enhance their experience in this model. Employers that are offering consumer-driven health plans and as part of my work with the Center for Studying Health Systems Change, I've been able to last year talk to dozens and dozens of employers around the country about this, and they really have expectations about their employees, are they going to use

different features of the plan? There was some language earlier from one of the presenters about skin in the game and how consumers were going to care a lot more about cost, they were going to be reactive consumers because of that. There also have been concerns that consumers, as I implied before, wouldn't really be up to all of this. That they would be confused by the plan design, that they wouldn't make full use of the Internet tools. And all of this has been informed by no information. So the two prototype consumers. There's the savvy consumer here who calculates the expected values of different plan options, makes an informed choice, then accesses the consumer-driven health plan website to compare provider price and quality information when choosing a provider. Then if the consumer gets sick, goes back to the website, looks for disease management advice, pharmaceutical price data, regularly tracks expenditures and status of personal care on the Internet -- personal care will come on the Internet -- makes wise tradeoffs on the margin, coordinates spending with possibly the spending from a flexible spending account, and then after all of this happily rolls forward a balance from the personal care account into the next year. So that's one model of how this is all going to work for consumers. The extreme, the other end of the continuum, is the naïve consumer. Doesn't understand the structure of the plan relative to more traditional plans, makes an uninformed selection, gets in this plan, says oh, my gosh,

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what's going on here? I don't have Internet access at home. I have a strong provider relationship so I really don't care about this price quality data anyway. I'm an Internet illiterate so disease management advice and information available on the Internet really doesn't have any effect on me. I don't understand this personal care account. I unwittingly spend money that the personal care account that – I think I'm spending money from the personal care account for services which in fact aren't covered so it comes out of my own pocket. I exhaust the account before I realize I've exhausted the account because I never really do figure out how to get onto this online care account manager system that's set up. And I don't have a flexible spending account because I really don't understand how that works either. And at the end of the year I have no funds left in my personal care account. I have out-of-pocket expenditures that exceed what they would have been otherwise in my – and I have less care management coordination. So you kind of, you know, if you would take both stories in terms of expectations about how consumers will care under this system you can, you know, get to one of those two extremes. You've got the survey basics discussion that Roger played out for you earlier, so I'll just quickly go over the topics that I want to discuss today. First of all for all plan enrollees we have the following kinds of information. We have whether they use a flexible spending account, and I'll come back to that in

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a second, why that's kind of an interesting question. We have their use of plan customer services and their evaluation of the helpfulness of those services, both for people in Definity and for other consumers. We have their experience of plan paperwork and how they view that, and we have their overall rating of their health plan. Then for Definity enrollees only we have their rating of the ease of use of their personal care account, their expectations about their rollover account, their use of Internet tools and whether they would recommend Definity to family and friends. So in analyzing these data we look at subgroups of enrollees in Definity. We don't have comparable data for people in other health plans. The subgroups that we used in our analysis of Definity only data, first of all this debatable measure of chronic illness. We used that to classify people into two groups. We also have age, which we get from the employee information data set, and we have job classification. Roger alluded to this before. We have four job classifications and this is something that I really wanted to do because I always think that faculty at the University of Minnesota particularly are kind of weird. And so I wanted to break out faculty responses. And, you know, since there are three faculty from the University of Minnesota here and I'm not one of the weird ones, reach your own judgment on that. Okay, so what did we find out? This is stuff that Roger talked about earlier, the percentage of respondents listing features in -

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their top three important features in choosing a plan, so I won't spend time on that because he's kind of covered this. What we did find out is that the top three features were comparable across subgroups of people with chronic illness. We did find out that the national network of providers was very important to Definity versus all other subgroups. And then small out-of-pocket expenses and co-payments were less likely to be among the top three features for Definity members. And again this just kind of goes over some data that Roger presented earlier. Are Definity enrollee's more likely to have flexible spending accounts than enrollees in other health plans? The answer is yes. Now, why would you think that? Well, if somebody is sort of thinking about the personal care account they start thinking about what about this gap between when the personal care account money is spent and when I go through my deductible. You could cover that gap with a flexible spending account so you could spend – you get the tax advantages of the flexible spending account if you could stage that wisely. And it turns out that people that choose Definity are more likely to also have flexible spending accounts. It's interesting that, you know, fewer than 50% of our survey respondents have flexible spending accounts at all. So our Definity enrollee's more likely to understand the critical limitation of these accounts. Are these really savvy consumers, they've got this all figured out? And the critical

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limitation is that you've got to spend all the money in these in the given year or you lose it. And the answer is no. Twenty-five percent of Definity enrollees with these accounts believe they can roll them over. And only 18% of enrollees in other plans believe that. So there's clearly some confusion about this. There are some people that have thought a lot about this. In the written comments on the survey there was one person who said really the way to improve the plan design would be to let me spend my flexible spending account first and then go into the personal care account. Because if that happened, of course, then you're accumulating the employer's money, it gets rolled over and you spend through the money that you know you're going to have to spend. So I thought that was pretty clever. Now there's nothing in the design that says you couldn't do that or couldn't, you know, if an employer wanted to do that then they could do that. How does customer service compare to other plans? Definity enrollees are more likely to call customer service for information – 65% versus 49 other plans. You know, I think partly what we're seeing here is this phenomenon of everybody's in this plan for the first time and they're trying to figure out how it works. So you would expect to see use of a customer service line there. For those call – and it's impressive whether you're in one other plan or whether you're in Definity, for those that call 90% say they got help. That there was no problem getting help or only a small problem

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getting help, which is think is, you know, a very positive finding both for Definity and for the other plans. Paperwork was more likely to be considered a big problem by Definity enrollees – 19% versus enrollees in other plans, 12%. While there is more kind of paperwork in terms of keeping track of the personal care account and what's in and what's out. How accurate are Definity members? In other words as you're going – if you're enrolling in Definity you've got some expectations about whether you're going to use your personal care account or not, and how accurate does that turn out to be? Seventy-six percent who thought they would have money left at the end of the year in fact did. And 75% who – 76% who thought they would not have money left at the end of the year in fact were correct as well. Twenty-five percent of the people in each case – or 24% were somewhat surprised. But actually pretty good feeling going in, whether they were going to go through that account or not go through the account by the end of the year. How easy was it to use the personal care account to pay for health services? Ninety percent said very easy or somewhat easy. Well, the people that enrolled in this plan really seem not to have much trouble with the personal care account in terms of its use. Younger enrollees were more likely to say it was very easy. Eighty-one percent of the younger enrollees under 35 said it was very easy, versus 69% of other enrollees. There was some variation in the assessment of ease of using the

personal care account by job category. And not surprisingly to me the faculty thought it was the least easy to use. And I think faculty are basically just big whiners anyway, you know, so I was kind of impressed that 83% said it was, you know, pretty easy to use. Skip over this one. Forty-four percent of Definity's used Definity's Internet site to monitor their personal care account, so less than half the people that enrolled in Definity actually went on the Internet to check what the status was of their personal care account during the – either they knew they were just going to go through it and why bother? Or maybe they knew that they weren't going to go through it and they weren't concerned. Slightly different –some very small differences by our subgroups, chronic illness. By age, if you're over 55 you were at 37% of people over 55 used that Internet site to monitor their personal care account. If you were under 35, 59% of enrollees under 35 went onto the Internet to monitor their personal care account. Again with – only 33% of faculty did it versus 55% of union civil service. That's another comparison I like. Of course the fact that they've just hooked the faculty up to the Internet last year, early – oh, never mind. Now remember it's a public university. We're in a budget crisis. How did Definity members feel about their experience in the plan? This is the classic would you recommendation the plan to a friend question that you see in all surveys of consumers. And we broke out the results by our

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three different classifications – chronic versus no chronic, age of employees, or job classification. Really there's not much going on here. I think you'll agree if you look at this. There's really not a great deal of difference in terms of how people responded to this question. We also then did a multi-varied analysis of this question. We used two different specifications for the variable of interest. In one specification we said, okay, you said yes and put the maybes and the no's in another category. And we did another run where we put the yeses and the maybes in one category and put the noes in another category. And basically the only thing that predicted, you know, the only factor that really predicted a higher probability that you would recommend Definity to a family member or friend is if you had money left in your personal care account. If you have money left in your personal care account you were more likely to tell a family member or friend that they should like Definity. And then we also did an analysis of rankings for all health plan members – not just Definity but all enrollees in other health plans. And we gave them this very broad scale. Again this is a scale typically used when asking people about how they feel about their health plan. It goes from zero to ten. Is your plan the worst plan possible? Is it the best plan possible? The overall mean was 7.5 - same for both groups if you broke it out by Definity and other plans. And the – in that multi-variable analysis the

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variable for plan chosen was not a significant variable. In other words whether you're in Definity or not really had no significant impact on how you would construct this rating. So in general employees are neither savvy or naïve. There's really no indication based on our survey responses of any huge major issues related to the use of the plan or satisfaction with it. One way of looking at this is, you know, this could be kind of surprising. If you expect it, if you were somebody who had this mental model of, you know, the aggressive, savvy consumers enrolling in this plan, you would think, wow, they finally found a plan that they like. And their rating would be much higher than people who were in other plans. And it wasn't. Or you could sort of interpret this – you interpret that as saying, well, maybe just all these plans look kind of alike and people aren't, you know, all that into differentiating health plans and it's really the doctor that gets, you know, access to your doctor that's getting reflected in these health plan ratings anyway. And if you think about the plans that are available, except for the health partners plan, very broad wide range of providers, easy access to your doctor. Maybe that's what was going on. On the other hand you could argue people are sorting very well into plans and so you get people that are essentially very happy with – or relatively happy with the plans they sort into. You know, another way of looking at this is maybe this whole notion of consumer-driven

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health plans from the standpoint of the consumer isn't as big a deal as we're worried about. In other words, maybe consumers look at this and say this is a major medical plan, it's got a deductible, it's got some co-insurance, and our employer's giving us some money up front to pay against the deductible. Okay? How complicated is that? And we've got – and we all use the Internet. You know, we're on the Internet, we're off the Internet, we use it when we want. Those of us who use it, use it. Those of us who don't use it, don't use it. And the fact that there are all these Internet tools really don't make this – make a lot of difference to me as a consumer. But maybe this, from the consumer's point of view, we're just obsessing a little too much about this kind of plan. Lots of follow up research needed. Do these new perceptions of individuals who are enrolled in this plan change over time once they have more experience with use? It would be very interesting to see whether, for instance, people that like the plan because they had money in their personal care account at the end of the first year didn't like it at the end of the next year if they spent that money. You know, there's a lot, you know, it's how will people's perceptions be affected over time? We're going to redo this survey in about a year so we'll have, you know, sort of a small snapshot, a little bit of an answer to that question. Do the perceptions of late adopters differ from early adopters? If we think back to the HMO literature, when

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HMOs were first offered alongside other options people that selected HMOs were pretty happy in them. They had a lot of choices, they could move out if they weren't happy. But as the non-managed care options were removed, the average happiness of people in managed care plans sort of went down. They didn't have the choice of opting out. And what happened – so we really need to look at situations where individuals don't have other options. Where there's total replacement and how do people feel in those situations. And that gets to the last point, how you feel is likely to depend on the options that you have and your ability to sort out and select into options that you think are going to work the best for you. So this is very early stuff, survey who came out of the field mid-summer. We haven't had a lot of chance to look at the data or combine it different ways. We plan on doing that but that's sort of initial observations.

DR. JINNET FOWLES: Okay, so where's the coma hit? Or do I have a – do I have your attention for just a few minutes? The first thing that I'd like to ask you to think about is this concept of consumer-driven. When some of us started in this field back two or three years ago, it was called a defined-contribution plan. And somewhere along the line the name got changed and it became a consumer-driven plan. And I've always found that if not odd at least maybe wishful thinking, and wonder, if you can't think of anything else during the course

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of my talk, if you could come up with a few other names? I've thought about consumer-confused or consumer-dismayed. But I'll leave it to you to think through what might be the best title here. Another point that I want to make here from this very first slide is that this was not funded by Robert Wood Johnson and it wasn't funded by the Commonwealth Fund. It was – this study was funded by Humana and I think that's an extraordinary thing, that a for-profit organization would decide that it needed to investigate and publicly lay out its first goal out of the block and I think we should commend and suggest that this is a role-model behavior for for-profit organizations and that others could follow in this suit. So thank you. This particular product that I'm talking about, the Coverage First product, is the same one that Laura talked about in her talk when she was using the claims base data to look at it. And I've just reprised some of the characteristics here to point out that while this consumer-defined product was being offered there were a lot of other changes going on in the system and you can't disentangle all of these effects. We had – or I'm going to report on three research questions here for doing a survey. We wanted – Humana wanted to know who was choosing these consumer-driven options. How did they differ from others? What did the employees think of the enrollment process? We did a survey right at the end of the initial enrollment process in contrast with John's, which was done

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after the employees actually had experience with the product. And were all the employees affected equally by this enrollment process? We did a mailed survey that again is different from John's. It was a telephone survey. And as I mentioned it was conducted just after open enrollment. Now they – employees had already had a chance to respond to an internal survey conducted online by Humana, but the response rate had been quite low to that particular survey. Our response rate was about two-thirds of the eligible respondents responded to this mailed survey, which we were pleased about given that we didn't have our ordinary cash incentives. Somehow Humana felt that it might be seen as a - wondering why Humana was spending its money on a survey when it wasn't putting its money into its benefits. So we could understand where they were coming from. Who chose the consumer-driven plans? I'd like just briefly to talk about four different areas of characteristics -- things that we have touched upon here in previous presentations today -- the demographic characteristics, their health – all important health status, what it was they were looking for in a plan, and how they had experienced enrollment. In terms of their demographics, these people who chose this plan were half as likely to be Black. They were much more likely, obviously, to be in the dominant racial category. And this second bullet is a really interesting one. They were almost twice as likely to have associate-only coverage. And that is significant because

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they weren't – it isn't necessarily the case that they were families. They may well have been families with coverage – the spouse covering all of the family. They could select to do this experiment on themselves. Here, as I mentioned in a comment I made earlier, in terms of health status they were half as likely to report having a chronic health problem covered by anyone that they were trying to cover with their health insurance. And they were all – we had a number of other health status measures included. They were three times more likely to have had no visits in the – healthcare visits in the past four weeks. So we felt from our data, given what you can find out in a survey, we had a lot of data suggesting they were, in fact, healthier. In terms of plan design preference and enrollment experience, they announced themselves as having – being more likely to know a lot about plans, so there were a minority of people who did know a lot about plans. And I would remind you that among the people who had this option were the actuaries who designed the plan option. And in fact it doesn't show up here but people in the building with the actuaries were more likely to select the plan. This suggests what your family and friends may be telling you, as opposed to what you get off the web. They were much more likely to think that the premium was the most important consideration. That's consistent with this cost sensitivity that we've seen in this particular environment. And they liked having the choices and they were

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extremely likely to think that there were big differences in the plan premiums. Those premium differences meant a lot to them. Well, what did the employees think of the enrollment process? They had written communications and the written communications tried to help the enrollees prepare for enrollment, but they also tried to explain why Humana was beginning to develop this product. And the employees felt that they were more helpful and understanding about enrollment, and less so about understanding where this new product was actually coming from. There was an enrollment tool as well as a website and a wizard that gave advice about – or at least suggested where you might find your happiest match-up with the available plans. And the enrollment tool was somewhat easier to use than either the website or the wizard. And we'll get into a little bit of their responses to that a little bit later. Employees in general were starved for more information because their plans were changing and the change to a four-tier pharmacy benefit was particularly problematic I think for people. Now I'm going to compare those who selected the consumer-driven plan options with those who didn't. The people who selected them were more likely to have enough time at work to review options, and they were more likely – but they were more likely to think there wasn't enough information about the choices. Because they were choosing the new kid on the block. Then there are a few more comments in terms of using this wizard to

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help select a plan, and they were generally sort of predisposed toward all of that, and to find the online enrollment easy and to like online enrollment. These are the techies out there, at least in part. Now, when we contrast employees in fair or poor health, we find that they indeed had the hardest time during this enrollment period. In comparing those with better than fair or poor health we find that people in fair or poor health were much more likely to find the communications less helpful, the benefits less understandable, and that they didn't have enough time to enroll. This is it. If you're sick you are at the bottom of the pile. In terms of comments I was amazed. Over half of the respondents to our survey wrote comments, which is an unusual level of comments for us. It was really a torrent of comments. And we were told by Humana staff that, gee, these comments were more negative than those that they had received in the online survey. I guess I'm not totally surprised that these that they were sending out to an independent researcher and if you weren't happy with the online enrollment process you might not leave a comment there. But it did reveal a huge digital divide in the Humana employee population. They wanted a lot more information about all different dimensions of their plan. Here's some sample quotes that I thought you might be interested in. These were actually selected by Humana staff. And I thank God that my husband has real insurance. I hope I never have to purchase the medical

benefit that's provided to Humana associates. It's embarrassing to tell people what poor benefits are given to our associates. There were some very strongly held feelings, so as employers go through and think about how they're going to position these changes you have to be prepared to deal with the responses of your employees. On the other hand not everybody was upset. The last comment – I love the concept of having less expensive options that suits our current above-average health status. No need to be over-insured. It works for some people. At least it works at the time that they enroll. In terms of benefit information, there was this interesting phenomenon and we think about going to a paperless enrollment process. The reality is people are out there printing out all of these plan comparisons so that they can set them up to look at them side by side the way they would have had they been printed. Just putting the burden and time of that printing on somebody else. I was interested that nobody asked about quality. Nobody said how can I find a better quality hospital, a better quality plan? That was not a question that was even raised. Here's some quotes about benefit information. They were very interested in having some more ways to figure out how these – how they would do in the plan option. And a lot of people preferred printed material for some of the specific parts, like the plan-to-plan comparison. They wanted to have it on paper. They found it hard to follow on a web page.

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There was – the online tools had been developed and put out there. They didn't function technologically perfectly all the time and so there was a wide array of responses. Some people found it extremely easy to use and some people wanted more. The wizard told me what plan was the cheapest for payroll deduction but really did not help me understand what my true annual cost would be when considering deductibles, cost-shares, and non-covered service. Here's somebody that's really thinking it through. I could not fully understand my out-of-pocket expense. There were issues about access to the online system. The bottom line comment here is a good system that needed a little more time in testing before going live. I'm sure that that's probably a common phenomenon that everybody who puts up an online system has to deal with. So in looking at this overall response to offering these consumer-driven plans in the context of other options, there were a lot of specific concerns that came up. We've mentioned the fact that working for an insurance carrier itself carries special feelings of entitlement. The changes in pharmacy benefits, because they affected many, concerned many. I actually have a belief that it is through pharmacy benefits that people are really learning firsthand what choices and what kinds of price sensitivity are there, because that's the thing we encounter most frequently and most of us encounter. The transition from print to online doesn't work for everybody. And that coupled

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with the fact that there are still people -- many people in fact -- who do not like to transact business online, even if they're willing to read information online. So in my opinion these plans present a troubling trio of threats. They increase costs, they increase confusion and the need for information, and at least in this case I think we can see some pretty dramatic risk segmentation, which may or may not be a problem depending on whether you have a total product replacement or you're just picking off some good risks. All that said the times for employees are definitely changing and in our history of doing surveys we found that in 2001 that 63% of Humana employees stated that the decision was extremely important. This is a huge change from a number of surveys that we had done only five years before where fewer than 25% of employees stated that the decision was extremely important. So at least in terms of one part of the equation we have got people's attention. Now we have to deliver on what they need.

DR. JUDITH HIBBARD: I don't really understand the dynamics of this but I'm often invited to be on panels where everyone else is tall. Can you all see me back here? I'd like to acknowledge my co-authors on this work and the AARP Institute for Health Policy. Well, as you know, the success of the consumer-driven approach rests on one key assumption. If we provide consumers with financial incentives and we provide them with cost and quality information, then consumers will

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make cost-effective choices. What I'd like to do today is really look at what it will be required of consumers to be able to do this and what kind of challenges they'll face, and also to look at some strategies that may help them meet these challenges. On a day-to-day basis enrollees will have to make a number of different types of choices. They will have - make different types of demands on them. For example, when to seek care, when they can use self-care, and what type of self-care they can use. What providers to choose, what treatments to choose, whether to spend their HRA account, and whether to seek care once this account is exhausted. There is a further assumption here that enrollees will use comparative information to make all of these choices. And there's a further assumption that they'll be to comprehend this information and be able to use it to inform choice. Now the first challenge will be simply to be able to understand how the plan works. And there are some new features to these plans that are quite different. If we look at the experience with consumers in other more conventional and familiar plans we know that many consumers do not understand how those plans work, so moving into this more unfamiliar territory is likely to be challenging. In the area of consumer use of comparative performance information, when it is available we know that consumers have difficulty understanding it, and again using it in choice. Treatment choices using comparative information may present different

sorts of challenges. Now using the information to inform choice requires that people process a lot of different types of variables. That is not just understand it but process it and be able to apply it in choice. And some of this requires that people differentially weight different factors and be able to bring them all together. Now we know from cognitive sciences that these are things that are hard for people. We are not wired to do these kinds of tasks very well. We also know that decision support tools, if they're well designed, can reduce some of the burden in here. Now I want to make a caveat on all of this, is that when we ask people did they understand and did they use information and choice, it's not always the same as finding out if in fact they did understand. People sometimes think they understand when in fact they don't and sometimes are not able to really report well on what they've weighted in a choice. So when you go back and empirically examine that you may find there's real variance. So a caution in just asking people how easy was this or how much did you understand. It may not be in fact what you think they're understanding. So our experiences to date suggest that consumers will have some difficulty both using and understanding information. Another new type of challenge here is that their decisions around using the HRA account require people to balance current wants against possible future needs. For example, should I buy some new contact lenses, which I want, or should I save my HRA account

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for some possible serious future health event? If we look at evidence from other arenas we see that consumers do have difficulty deferring current wants for future needs. For example look at the savings rate for retirement where we know – consumers know that that's an almost certain future need, but have difficulty balancing that against current wants. The other thing it implies here is the ability to predict one's own risk. And we know from cognistic (misspelled?) psychology that if a person has very little experience with a risk -- personal experience with it -- they tend to underestimate that their risk for this in the future. So that means that someone who hasn't had a serious health event is likely to underestimate their risk for that sort of event in the future. This is called the optimism bias and it's really quite robust and been found in a number of areas of decision-making. Now there are many new features here for consumers to understand and to become familiar with. And I think that we can assume that there's going to be kind of a steep learning curve. So what choices and behavior that we observe in the early experiences are likely to be different from the choices that we see consumers make after they become more familiar and experienced. And this has implications for how we monitor and evaluate consumer experiences in these plans and also how we evaluate the performance of these plans. I think that we need to have a longer window of opportunity to observe what goes on before we

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can really understand because I think there's going to be a lot of change in these early - in the early period. Now there are things that can be done to help consumers meet the challenges that we've reviewed here, and many of them have to do with how information is presented to them. One important thing that can be done that would make a difference in whether information gets used is if the information is presented in a way that lowers the cognitive burden or the effort required to use that information. We have seen in several studies that if you make it easier for people to use the information they're more likely to do it. So if you do some of the work for them, and that could be how the information is displayed and/or how well the decision support tools do some of the work for them. We also know that if we had a better idea of what it might feel like to live with any given decision, we'd all make better decisions. And so whatever can be done in the way that information is presented, it will help consumers understand how a choice - what a choice might mean for them in their daily lives -- a cost choice, a quality choice, or a treatment choice -- we will be helping them. And this can be done through narratives or stories that help place the decision into a context and help people see how the outcomes of that choice might play out. We also know that people tend to leave out important factors when they make choices. And if information is presented in a way that highlights the meaning and the significance of this often

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overlooked but important information that, again, that will help improve the decision process. So there are a number of strategies that can be done to help consumers use the available information more effectively and all three of these strategies have been shown to do that. How successfully consumers use these health plans will depend to a large degree on the quality of the information and the decision support tools that they have. And recognizing this as a key issue, the Robert Wood Johnson Foundation has funded Shoshana Sofaer and myself to look at the adequacy of the information and the information tools available and – to make some recommendations about what it is that will be required. In summary I'd say that there are many potential advantages here for consumers. The more choice and the more control are attractive for many consumers, but in order to realize them they really need appropriate educational and informational supports to make it happen. Thank you.

DR. DAVID LANSKY: Good afternoon. I really appreciate being here and joining you to discuss this. I find myself very much challenged by today's meeting and my own exposure to this field. We actually – FACCT, my organization, does provide the comparior (misspelled?) care tool that Roger mentioned this morning to Definity. So we have some immediate interaction with this set of products and the consumers' use of those products. And I think early on I was intrigued by defined contribution plans and their successors and felt that they

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really provided a new and valuable option to consumers. And now as I thought about what I would do here today and talk with you about how consumers see it, I really want to sort of fixate on this question that I put on my title -- what information do consumers want -- and build upon some of the things that Judy said and Jon said. But it's been hard for me and I've been asking myself why I feel this cognitive dissonance between the work that we do in talking with consumers about quality of care, and their decision-making in real life, and the infrastructure experimentation we're doing here with financing. And I think I'm stuck on asking myself whether they way we actually, as people, make care decisions does map into the way we make insurance decisions. And the premise I think of this discussion today is that those two things are aligned, or could be aligned, with the proper structure. And I think I'm – my sense from hearing our discussions today is for me the jury is still out. And in part it takes me even further back into my managed care quality days and asking myself whether the shopping paradigm is really the right paradigm to use in thinking about consumer healthcare decision-making. I think we've taken an idea about 10 or 15 years ago and migrated it through several iterations to think about rational, economic decision-making as the basis of the way people make care decisions – selecting providers, treatments, and so on. And I'll give you a couple examples where I think we need to step

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back a little bit and ask some more questions about that. I'll try to make two points in my couple minutes here. One, that I think in reality consumers make care decisions based on relationships, not on attributes that are measured in the traditional way we've been doing it so far. And secondly, that in particular given that bias that most of us have in the way we see care, the database on which to make those decisions is totally inadequate. So that our ability of the consumer-directed plans or others to provide relevant decision-making tools for consumers to support this model is really inadequate at this point. Now let me try to back that up a little bit. The premise I think of the information strategy that supports the consumer choice model is that employees of course have more cost responsibility, therefore they are more likely to seek and use care management information tools. And I took these three phrases from the Definity website. The tools and resources they offer are care, support, and coaching, a personal website for the patient to remember, and then the pricing and quality information. And I asked myself whether this theory is consistent with what we know about how consumers –how each of us, actually, make our decisions. First of all, the premise that cost-sharing and cost discretion in the use of the health reimbursement account will lead to more thoughtful decision-making or greater information seeking. I'm not sure it's true. Clearly Medicare beneficiaries throughout its history has a

great deal of choice of providers and a great deal of cost responsibility – a lot of out-of-pocket costs for the most part. And they find various ways to support that. The rate of increase of cost out-of-pocket is actually relatively low and the proportion of out-of-pocket is relatively low compared to 20, 30 years ago. But I don't know that this model is introducing a new and disproportionate responsibility for cost-based decision-making on the patient. As several people have mentioned today, report cards that we've seen up in the last ten years have had very low use rates, which suggests that across a variety of circumstances, managed care selection and otherwise, people are not yet using what we think of as a ratings methodology to make decisions about where to seek treatment, where to get care. The online health information services that health plans have been making available in the e-Health paradigm have also had very low use rates. Their largest use is by people with chronic illness who have active need for information of that kind. Then it's a little bit – the risk selection issue we've talked about today is a little paradoxical. If these plans are selecting -- we've heard various opinions -- slightly younger, somewhat healthier, lower using populations, then they are in fact less likely to be needing and wanting the consumer support tools than people who in Minnesota example are staying in the high cost, Preferred One PPO. So actually the need for these support tools may be

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greatest in the populations that are less likely to seek and select these plans. And finally the plans themselves and their motivation. Certainly we hit our group health in Kaiser representation this morning. The classic managed care plans were the most motivated to implement and support care management systems. That is systems that would provide both top down information and bottom up information to patients to reduce the utilization. It's not clear to me that the incentives in this model will reward a serious investment in information tools for members. Now from research we've done with consumers about what they want to know, these four things come up very often. People want help choosing treatments and providers, they want good communications, they want to pick doctors especially and other providers who excel in communication. That's a very high valued attribute for patients, especially patients with chronic illness who see their doctors frequently and very much need to learn how to self-manage and support their own chronic illness. Thirdly, we do find people are very interested, once they know that best practices exist, the guidelines exist, people do want to know which guidelines or which best practices apply to them. And fourthly they want to know what the economic incentives are for their providers. What decisions are being made that may affect the care that is offered to them or reimbursed for them? To try to get at this we've done a variety of studies and tools.

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This is just to illustrate just how complex this information needs for the patient with diabetes really are. If you've got - like me you can take off your glasses and look at the handout I gave you, there's a huge amount of detail here. This is just people with diabetes going from left to right, from early onset, diagnosed - period of diagnosis, through to long-term management of the illness. And this stuff in the boxes is what people say they want to know. So to truly satisfy the information needs for provider selection, treatment selection, adherence and so on, is a very daunting proposition. And people very greatly - when one has diabetes, where one is from left to right on this spectrum and where one is from top to bottom is - varies a great deal. So I want to suggest it's not a trivial proposition to claim that we're going to support the care-seeking decision-making of patients in these plans. It's a very complex and, I would add, highly segmented. Several people this morning have talked about the differences in the populations. I don't think we've been explicit enough about the different types of people out there and the way different kinds of people seek and use information. There will be segments of people who will respond well to the kinds of information offerings that are now being made available, and others who will respond less well. And I think we need to do some tailoring of these tools to meet that need. This is a sample of one screen from the comparior (misspelled?) care

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product that Roger mentioned this morning that's available through Definity and some other plans. And this is just – the mechanism for this tool is the patient answers a number of questions about the care they're actually getting for their diabetes or their asthma, whatever it is, and those are matched against recommended guidelines-based care. And then they're told how well their care is matching up with what's recommended. So in this example this person got an 83 on their diabetes quality of care -- I think that's diabetes -- and the norm for their community was 79. So they're getting better care than average. If they're getting worse care they get some feedback saying go ask your doctor about these tests or these services that should be done better for you than they have been so far. This is just a simple way of giving people some direct feedback. We did this – taking this a step further we can create doctor ratings. We can have individual doctor profiles. This is just diabetes and it's broken down for several doctors, and you see different categories of quality – patient satisfaction, whether they're providing appropriate guidelines-based care, whether their education and partnership with the patient's good, and whether they're helping the patient achieve good outcomes. So we can take this model down pretty far toward the paradigm that all of us are talking about. And the goals for this strategy were the same goals we're talking about here today, and that the consumer-directed plans have talked

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about. Engaging consumers in quality, increasing awareness of quality issues – especially in people with chronic illness. And we have a concern about creating a public demand for quality care by means of this education. I'll come back to that in a second. Well, when you take this model out and test it with real people, they love using the tool and they get a lot of information and they enjoy it very much. But they have almost no interest in this. And the reason that they tell us they have no interest in this, they like the immediate tailored feedback. They like being told, gee, your doctor hasn't checked your feet lately if you're diabetes. Go ask her to do that. They like that. That's very practical, it's personal, it's immediate. What they don't like is they don't like seeing low scores about their doctor. And the scores have to be incredibly low for someone to change doctors. Now there's a feedback about quality of care does not alter the trusted relationship patients build with their providers, especially sick patients who, of course, are in a more active relationship, seeing their doctor very often, high level of trust, of intimacy and so on. So the threshold for switching doctors, if you have an existing relationship, when it comes to quality performance data seems to be – I'll say very low, or very high. You have to score very, very poorly to justify a transition. Instead what people have said consistently -- we've done this all over the country now -- is this next point.

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People feel a responsibility to help their doctors do better. They want their doctors to see the ratings information. They want their doctors to know where their quality performances fly. And they, the patients, want to be engaged in fixing the quality of care that they, the patient, are getting and their doctor's providing. So this I think is consistent with a lot of things most of us have probably experienced ourselves, which is that – what a colleague of mine, Chuck Tyliss (misspelled?), some of you know, calls relationship-based care is what a lot of people are seeking, especially if they have chronic illness. And they are seeking to develop that relationship, to change that relationship over time. This is an example of a tool we did for pediatrics in Vermont. And I know you probably can't see much of the detail here, but instead of a report card like I showed you two slides ago, this is a brochure that – it's a personal brochure given to in this case a parent of a child with chronic illness that says here -- the upper left hand corner in orange it's circled -- it says areas of excellence in office X. So Doctor Jones, say. The first thing parents told us, they want to know what their doctor's doing well. Then they want to know what their doctor's doing not so well. Then they want to know what they can do about it. So what we're hearing from real consumers, real patients who are actively using care, is they want tools to improve the quality of care they get. They reject, actually, the shopping paradigm.

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That's a device for improving care in their own experience. And what I'd suggest from that last illustration is, I think in our field broadly we all should take just a half step back and ask ourselves why the ratings, report card, paradigm that many of us, including me, have worked a long time in, we continue to see as a prevailing tool for supporting improved quality of care and consumer involvement in care. What patients and families tell us is to be involved in improving of their care requires a much more intimate set of tools than the kind that many of us have talked about so far. So to conclude, some of the things I think the consumer-defined and directed health plans need to think about as they evolve and continue is to segment the population more precisely by the kinds of information, use habits, people have. If, as we've heard, is so far not happening so much, if the chronically ill population selects in we should ask them what tools they really need and what tools they really want. And we should sort out to what end those tools are purpose. Is it to save the patient, the member, money? Is it to save the plan money? Is it to improve quality? Is it to increase retention? And there may be others. If we answer these questions with some precision and from a consumer-centered point of view by asking members, we may come up with a different set of tools than we've so far been entertaining, and they may prove more – of greater interest than the ones we've been using so far. Personally I

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don't know if the consumer-directed health plan should focus so much on provider selection tools of the health grades kind of variety. And if they are I think they should be looking at a different set of matrix or parameters that we've been using so far. Those that are focused really on the quality of the relationship between patients and providers or people of a certain – of a particular kind. Finally I think we should ask whether members want coaching from their health plans, in this case from the consumer-directed plans, and if they do, do they want it from the plan and is the web the right medium for that? Again I think we need to back up from some of the fairly natural assumptions we've made until now and rethink the model a little bit. Thank you.

KATHRYN MARTIN: We now have time for questions so whoever has questions should just step up to the standing mic. And please identify yourself and where you're from.

KATHERINE ROST: My name is Katherine Rost (misspelled?). I'm from the University of Colorado and I appear to be the token mental health person here. I was very intrigued and gratified by Judy's presentation that moved us away from this kind of rational decision-making process into what the literature shows is a much more complex set of factors that are going to drive whether patients use – what patients use this benefit to purchase. I guess I'm concerned in that 30% of Americans have lifetime psychiatric illness in this

country, that we know that really jars their ability to make a cognitive – to kind of put things together. Or in the case of, like, depression it just erodes their ability to be optimistic that services provided are going to amount to anything. So our field has worked really hard for the last 10 to 20 years to get health plans to adopt the first visit is free kind of plan so that there is no financial barrier to getting in and they can actually get some good – get a better sense of what they're purchasing. And now I see this whole thing is potentially eroding that and it concerns me.

KATHRYN MARTIN: Okay. Thank you for that comment.

KATHERINE CAPPS: My name is Katherine Capps (misspelled?) from Health Two (misspelled?) Resources and I'm interested in hearing about your perspective of the value, the interrelatedness of the cost and quality of healthcare. A lot of what you've talked about is the dimensions of the relationship and how one would select a provider, but in moving forward with consumer-driven healthcare there's a void of information of not only what healthcare costs in general, but how to select are they a quality provider or how to select a system of care. So I'm interested in blending in some of the – or hearing from you what your views are about bringing in the cost – the price. If not cost of care, the price of healthcare.

DR. JUDITH HIBBARD: I think this is a really important

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question and the quality of the decision tools are going to make a difference here. If consumers are presented with over here cost information and then go through many, many pages and find quality information over here, that's tough to bring that together. It's tough to bring it together even when you're looking at it on the same page. And so the degree to which the information, the way it's presented and the decision support tools, help consumers really integrate that. For example presenting performance information within cost strata. Now that is usable and you can use both types of variables when you do that. But that is rarely done. So the challenges for consumers will be great unless it's very well done. Now the other issue is that cost is very familiar and people know what it means. So many dollars, what it's going to actually mean in their lives. Quality information is much squishier and it may not be well understood. So when there's – when those are presented and – a trade-off has to be made. That the variables that are less well understood will get less attention. And if quality is not well understood or it's absent, what we've observed is that some consumers will use price as a proxy for quality. So they'll choose higher price in hopes that they're buying higher quality. So that connection between those – doing a good job and how we communicate it is absolutely essential to this working.

DR. JINNET FOWLES: If I could just add a dimension

that we really haven't talked too much about directly, and that is there is a whole role for information brokers for people who will do the digesting of various kinds of information. My allusion to – reference to the actuaries and more people in their building choosing consumer-defined health plans. It's because we do turn to other people and sometimes I think in healthcare if your car is parked in the hospital parking lot you get called on. But we need to think more systematically about who those agents are and how we can work with them, because not everybody is going to be able to integrate cost and quality information. And asking your physician to do it may or may not be the wisest choice. So we need to think more about what kind of an infrastructure we need to support those people who will serve that function.

KATHRYN MARTIN: Thank you.

DAN WALDO: Dan Waldo from Centers for Medicare/Medicaid Services. I have actually two questions. One follows up on the issue that you just mentioned about actuaries. I'm sort of representing actuaries – or CMS's actuaries today. I guess maybe Mark also. They couldn't be here today because it would have meant going out in public. But I guess the question is what message we take from the fact that actuaries sign up for the consumer-driven plan. I mean is that something we should be following because they're shrewd? Or because they're cheap? Well, yeah. Shrewd and cheaply

shrewd. And then the second question maybe goes a little bit broader cast. If we think about the elderly population in consumer-driven plans and the whole issue about cognition and the cognitive processing that has to go on in order to really take advantage of this stuff. I'm interested in hearing what the panel and the audience at large has to say about the possibility of extending CDHPs to the Medicare population, or even to the Medicaid population, whether there are particular challenges that have to be overcome in doing something like that in terms of – the opposite of that is sort of the unrealistic optimism. There's also some unrealistic pessimism in the population because you see your friends getting sick and declining. I was really serious about the actuary, too.

DR. JUDITH HIBBARD: I'm not going to answer the actuary question. We did some work for CMS where we looked at how well Medicare beneficiaries could use comparative performance information. And we actually compared them to employed age population. Now what we showed them in our tests were very simplified versions of what would actually – the types of decisions people would have to make in the real world. They were, like, one performance measure comparing like four plans. We asked beneficiaries to do a number of tasks and in the process we learned a lot about how well they understood the information. What we observed was that 25% of our sample, which was a higher functioning, younger, better health sample

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than the larger population. They thought that the tasks that we gave them were reasonable and easy and fine. But it turned out that they made 50% errors in interpreting them. That they had a lot of difficulty in using this kind of comparative information. So I have very serious reservations about an older population being able to do the kind of tasks we're talking about here of using comparative information to inform all of the kinds of choices, and particularly if the assumption is that it's on the web and [off-mic].

DR. JON CHRISTIANSON: I'll differ a little bit from Judy. I feel that we have for 40 years now asked the Medicare population to make decisions about providers within a very open structure, for the most part – 85% of them anyway. And I think we know, and as Jinnet just said, a large number of older people, as they face more limitations in their ability to understand this information, whether it's due to cognitive reasoning or other things, rely on spouses, adult children, and others to support them as well as organized intermediaries who support them. We have not done a great job of systematically supporting the caregivers, the others, decision-makers, as part of these strategies. We've thought of it in a very individualistic way. And it's been a concern to me that Medicare will print off 35 million copies of an information booklet and somehow assume that that has a uniform ability to reach the population of interest. So what I said earlier about

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segmentation, I think we've got to be a lot more serious -- like marketers in communications theorists -- about understanding these audiences, finding both media and channels to reach people. And that is true with or without the consumer-directed health plan paradigm. In America, in this society, we live our entire lives making a very large number of difficult decisions and we find mechanisms for doing that. I think as those of us supporting the insurance decision or the care decision, we have to be stepping up to the challenge of using media and messages in a much more creative way than we have and not push the solution off the table because of the communications challenge.

KATHRYN MARTIN: Great. Thank you.

LARRY KIRSH: I'm Larry Kirsh (misspelled?) from IMR Health Economics. I had a question about one of the findings in Jon's take – in Jon's research and that is it surprised me that folks with chronic disease seem to be as satisfied and willing to recommend the model as folks without chronic disease. And I – one which seems to me paradox. It just doesn't seem to me to make a whole lot of sense, unless one thinks that in fact these are people with chronic disease are happy with the way care is being delivered right now. Or that in fact there's really been some modification in the way in which clinical care is being organized and delivered to people with chronic disease in these kinds of models along the lines

that David has been talking about, which is really in the literature has been suggested as people wanting and liking the fact that either they're in charge of their own self-management or peer-management, or that in fact they're establishing more – better teamwork with their providers. Does anybody know anything about the way care is being delivered in this model?

DR. JON CHRISTIANSON: Well, I think we're going to hear a little bit more about that. But I just could speculate a little bit about your question. If you think about the features of the Definity plan in our group, that people who chose it placed the highest weight on it was having your doctor in the plan and it was no referrals. So if you're somebody that has a chronic illness and you want to make sure that you have access to your doctor and you want to be able to refer yourself to specialists and other folks, that may in fact be an attractive feature of a plan like Definity. But we obviously don't – we just started looking at these data and we don't have the answer to those kinds of questions yet.

TOM BELDIVIA: Hi. I'm Tom Beldivia (misspelled?). I'm from Definity Health and just felt like I got the intellectual equivalent of a proctoscopic exam today. I just had to acknowledge that white elephant in the room. I appreciate the comments up here. I just – I had a question for Jinnet. In your presentation you titled your conclusion consumer-driven health plans, and then you wrote a statement

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about what some concerns that you had about that. To what degree do you think the findings that you have here, given that the nuances of the Humana plan and the very aggressive way that they've priced the premiums in that plan, that these are generalizable (misspelled?) across all consumer-driven healthcare plans?

DR. JINNET FOWLES: Well, I think the answer is obvious and we've talked about it a lot. That is so far we've seen two plans I think and they're quite different and they're different in any number of attributes. So I would not generalize. I would use them as thinks that we would want to measure and mark as additional plans get offered and evaluated.

TOM BELDIVIA: Thank you.

KATHRYN MARTIN: One last question?

MALE VOICE: The results of the survey showed that one of the most important factors with respect to whether someone would recommend Definity Health was whether there was expected to be -- or in fact consumer-directed health plan in general -- whether there was going to be money left in the account. That would probably not be true with a flexible spending account with a use it or lose it provision. My question is, would you call a plan that only offers a flexible spending account with a use it or lose it provision, would you call that consumer-directed healthcare?

DR. JON CHRISTIANSON: Whatever you want.

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KATHRYN MARTIN: Definitive answer there, Jon.

DR. JINNET FOWLES: I'm not a big fan of this title in the first place, whether or not you get to have a – to rollover the HRA. I think we don't know how directed these plans are. You know, we're just learning. And I think Jon has laid out a reasonable research agenda to know whether or not they deserve this name at all.

KATHRYN MARTIN: Unfortunately that's about all the time we have so I would encourage any of you with questions to attack our panelists during our 15 minute break. So let's reconvene at 2:15, and thank our panel.

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