



Consumer Driven HEALTHCARE

Value-based insurance design

Employee compliance rises as medicine copays drop

Incorporating a value-based insurance design (VBID) can increase the use of important medications, according to a new study. The approach complements not only disease management programs but CDHPs as well.

The study, led by a team of University of Michigan and Harvard University researchers and published in the January/February *Health Affairs*, showed that a large private employer significantly increased its employees' use of important chronic-disease medicines by making some free and reducing copays for others. Another employer that kept its copays the same (the control group) didn't experience the same increase.

"Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment" was the first rigorous, controlled trial of VBID. Until now, there have been several positive reports about VBID involving Pitney Bowes, the city of Asheville, NC, and other

employers, but all used a pre-/postdesign of a single organization. The publication of a controlled study puts weight behind the earlier reports of VBID success.

(A subsequent study by Brown University and Harvard Medical School researchers published in the *New England Journal of Medicine* reinforces these findings. It found that, when faced with even a modest copayment for a mammogram, significantly fewer women receive the potentially life-saving screenings. Screening rates were more than

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—A. Mark Fendrick, MD

8% lower among women required to pay something compared to those for whom the exam was fully covered.)

About the study

The *Health Affairs* study involved more than 35,000 employees and dependents at the company where copays were reduced (Company A), and more than 70,000 employees and dependents at the control group (Company B). Participants in both groups had regular phone contact with nurses in their disease management programs; these nurses offered help based on each person's test results, medication use, doctor visits, and other health information.

ActiveHealth Management's clinical decision support technology (the CareEngine System) reviewed data for both employer groups and identified the employees who would benefit from reduced copays for the following five drug classes:

- ▶ ACE inhibitors and angiotensin-receptor blockers (ARB) for the heart



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- Beta-blockers for the heart
- Diabetes medicines, including blood sugar-reducing drugs and insulin
- Cholesterol-reducing statins
- Inhaled steroids for asthma

As part of the disease management program at both companies, participants not already taking the necessary drugs were contacted and informed about the importance of those specific medications. At Company A, they were also informed of the copay reductions, which were made automatically at the pharmacy.

In one year, the appropriate use of the preventive medicines at Company A increased significantly in four of the five drug classes (with inhaled steroids for asthma the exception). Overall, nonadherence decreased 7%–14%, depending on drug class. The increase in the use of statins was more modest than the increases in the use of ACEs/ARBs, beta-blockers, and diabetes drugs, but still

meaningful. The lack of a significant increase in the use of asthma medication may be related to how it is administered: It's harder to measure dosing when an inhaler is used, so it was harder to assess whether the individuals were compliant, says **Stephen Rosenberg, MD**, senior vice president for outcomes research at ActiveHealth Management in New York City and a study coauthor.

But steroids notwithstanding, the results demonstrate that by cutting even a few dollars off the copay, employers can increase the likelihood that employees with chronic illnesses will take certain preventive medicines.

Such compliance will likely pay off in the long run, with fewer hospitalizations and emergency department visits. (And, Rosenberg notes, a forthcoming study suggests that it could pay off in the short term as well.)

Small change means big change

Copays at Company A dropped from \$5 to \$0 for generic drugs, from \$25 to \$12.50 for name-brand drugs on the company's preferred drug list, and from \$45 to \$22.50 for nonpreferred name-brand drugs. Copays at Company B stayed around \$29 for brand-name drugs and \$16 for generics. So, for many employees, a barrier of just a few dollars is enough to keep them from using the medicines they need most, the study found. In some cases, however, the changes weren't all that small. For individuals with multiple conditions (e.g., diabetes, high blood pressure, and a history of heart problems), the difference in how much they pay for their medications could be much more than a few dollars. But even with this caveat, Rosenberg was surprised that such a seemingly small amount of money could make such a big difference.

CDH & VBID

At first blush, VBID and CDH may seem to be in opposition. After all, VBID involves removing consumer financial responsibility for certain interventions. But in fact, they have much in common, says **Alexander Domaszewicz**, principal at Mercer in Newport Beach,

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CA. The evidence-based approach of VBID is already present in many CDHPs. “The goals line up perfectly,” he says. CDHPs emphasis on—and first-dollar coverage of—preventive care has already had a measurable effect: CDHPs report higher use of preventive services than traditional plans, he adds.

Likewise, Rosenberg and coauthor **A. Mark Fendrick, MD**, professor of internal medicine and health management and policy and codirector of the Center for Value-Based Insurance Design at the University of Michigan in Ann Arbor, view CDH and VBID as complementary approaches that, used together, could address concerns about healthcare costs and health outcomes.

A CDHP incorporating VBID could continue to foster consumer responsibility while providing safeguards against adverse clinical effects resulting from misaligned financial incentives, says Rosenberg. It would help address the concern that patients may forgo necessary interventions. Incorporating VBID into CDHPs could also help ensure that cost sharing is done appropriately and not in ways that risk discouraging the use of necessary medications.

“We believe in a CDHP/VBID hybrid—similar to some existing high-deductible plans—that could reduce or eliminate patient contributions for high-value medical

services and pharmaceuticals,” says Fendrick. Because most HSA-eligible HDHPs include first-dollar preventive services, it’s not a major shift, he says. But IRS rules regarding what constitutes preventive care present hurdles for HSA-based plans.

Domaszewicz has heard talk for years about loosening HSA restrictions, but he knows of nothing in the works—at least nothing with a high likelihood of adoption. He also says HRA-based plans don’t have the same restrictions, and those offerings can provide a broader, more effective list of medications for chronic illnesses.

It’s these chronic conditions Fendrick and his colleagues want to address. Medical evidence strongly supports the removal of barriers to high-value interventions. In fact, the evidence may be stronger for that than for first-dollar coverage of preventive care. The same logic that allows for preventive coverage should be applied to medicines that have “extraordinarily high value” for chronic conditions, Fendrick says.

But, Domaszewicz adds, there’s another issue that gets to the heart of CDH: How do you balance the need to promote behavioral change with the need to treat chronic conditions? Employers and insurers want to keep the “financial levers” in order to drive behavior change without

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Audioconference highlights VBIDs

Join HCPro for the live audioconference “Value-Based Insurance Design: Alternative to High-Deductible Plans” at 1 p.m. (EST) Thursday, March 13.

The hour-long audioconference will highlight why reducing the cost of copays for chronic illness treatments improves medication compliance and may significantly affect the long-term costs of treating such diseases.

Value-based insurance design (VBID) is gaining in popularity in the CDH and disease management industries, and the idea received a shot in the arm with January’s release of a major study led by a team of University of Michigan and Harvard University researchers. The study involved two major companies, one of which cut its employees’ copays in

half or altogether. Employee use of important preventive medicine increased significantly in the business that reduced its rate, whereas the employer whose rates remained stagnant did not experience a similar improvement. The speakers for the March 13 audioconference are leaders in the VBID movement: **A. Mark Fendrick, MD**, professor of internal medicine and health management and policy and codirector of the Center for Value-Based Insurance Design at the University of Michigan in Ann Arbor; and **Gregory B. Steinberg, MD**, chief medical officer at ActiveHealth Management in New York City.

To sign up for the audioconference, call 877/727-1728 or go to www.hcmarketplace.com.

VBID

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unfairly penalizing those with chronic conditions. “How do you make cost sharing appropriate?” he says. For example, if you remove financial responsibility for blood-pressure medication, do you reduce the incentive for diet and exercise changes? “There’s a fine line to be drawn there,” he says.

VBID is a great tool for targeting certain conditions and “doing the right thing,” Domaszewicz says, adding that the challenge is identifying which interventions are appropriate and coming up with a consistent approach.

A market for VBID products?

Value-based insurance design (VBID) has moved beyond pilot projects and the halls of academe. The following are three VBID-related offerings.

- 1. Hewitt introduces actuarial model.** Last year, Lincolnshire, IL-based Hewitt Associates launched a clinically oriented actuarial model to help employers quantify the cost effect of implementing a value-based design. The Value-Based Design Model lets companies analyze the compliance and financial effects of reducing employee cost sharing for specific healthcare services and increasing employee cost sharing for others.
- 2. Aetna targets self-funded companies.** In December 2007, Hartford, CT-based Aetna announced the launch of Aetna Healthy Actions Rx-Savings, which allows self-funded employers to offer a drug-class copay discount to employees based on a member’s clinical-risk profile and relevant evidence-based standards. Eligible members are identified through ActiveHealth Management’s CareEngine System technology.
- 3. Mercer launches Dx-Rx Pairing.** Earlier this year, New York City-based Mercer launched Dx-Rx Pairing, a pharmacy benefit design that encourages patients to follow pharmacy treatment plans proven most effective for certain high-cost chronic conditions by addressing common barriers to compliance. Dx-Rx Pairing targets those combinations of diagnoses and drug therapies that have been medically proven to improve health status while lowering overall healthcare costs.

In developing an evidence-based, value-driven design, he says, it’s important to avoid creating an “incomprehensible tapestry of exceptions.”

Cost issues

Administrative ease is an important issue for employers, says Domaszewicz, and so is cost. Preliminary analyses suggest VBID ends up cost-neutral, with extra expenditures offset by savings and reduction in hospitalizations. The *Health Affairs* study wasn’t designed to assess costs. However, researchers didn’t ignore the issue.

The study states that “estimates based on crude assumptions about effectiveness of these medications on adverse events suggest that adherence results of the magnitude reported here could generate offsets equal to the costs of the additional prescriptions filled.”

A forthcoming paper from the same authors suggests that the crude estimates are on target. “It appears that cost impact is a wash,” Rosenberg says. The unpublished study found a very small, statistically insignificant cost savings. The cost for the drugs went up because more employees were using the medicine and paying a smaller copay. But the cost of other healthcare services, in aggregate, went down slightly more.

This suggests that employers don’t have to wait for long-term savings to see a return on their investment. And as the system becomes more sophisticated and efficient, Rosenberg says he expects additional savings would accrue in subsequent years.

Moreover, the study used a broad approach to reducing consumer cost: Anyone who was using one of the designated drugs when it was not contraindicated got the reduction; those taking beta-blockers for a heart condition and those taking it for stage fright got the price cut. An employer could take a more clinically targeted approach, focusing on those taking the specified meds for specific indications. It would be more cost-effective, but having employees on the same meds in the same plan paying different prices could create an HR headache. “We’d love to

find ways to balance the perception of fairness and try to have a better clinical focus," Rosenberg adds.

Health per dollar spent

Although preliminary studies find cost neutrality, Fendrick bristles at that being a requirement. "We need to look at the health achieved for dollar spent rather than striving for a bottom line number that does not incorporate the health outcomes," he says.

And that, Fendrick adds, VBID can accomplish. "We guarantee that no matter what the price point . . . a clinically sensitive benefit design will produce more health regardless of the amount of money spent," he says, adding that that happens by encouraging the use of high-value services in certain circumstances and increasing barriers to services of low or no proven value.

In most early VBID interventions, says Fendrick, relatively few services receive subsidies, so there'd be little effect on the employer's overall cost of coverage. He offers a proverb to make his point: "A cup of tea in the river is unlikely to change its color."

More than theory

It's still early, but VBID seems to be capturing the imagination of insurers, employers, and other stakeholders. (See "A market for VBID products?" on p. 4.) According to Lincolnshire, IL-based Hewitt Associates, 19% of large companies have implemented VBID, and

an additional 40% have indicated interest in learning more. A recent report about CDH from Chicago-based investment and equity research firm William Blair & Company identifies VBID as "another method aimed at increasing patient involvement in addressing personal healthcare needs and improving overall health." It predicts that employers will increasingly look to VBID programs as an alternative to existing plan options in response to the continued rise in healthcare costs.

Fendrick wants to fine-tune the approach to see even better clinical results for the same dollar spent. In fact, although the *Health Affairs* study is being hailed as a success, he says he is surprised and disappointed that—even with disease management support and financial incentives—about a quarter of the employees remained non-compliant. "While we did see a substantial increase, the study shows we have a long way to go," he adds.

Fendrick says he expects the various VBID experiments taking place around the country to provide insight about how to more successfully deploy the design; however, he wants more than a change in tactics or even in strategy. He's calling for a philosophical change too.

"Current healthcare benefit design does little to acknowledge that certain medical care services provide a high value, and others minimal or none," he says. The issue of clinical outcomes is being overlooked in the current discussion of healthcare cost. His plea is simple: "Return health to the healthcare-cost debate." ■

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Despite their differing perspectives, Celent and Blair analysts offer bullish predictions for future of CDH

Two recent reports—one from a banking analyst and one from an investment analyst—offer quite different perspectives on the success of CDHPs to date. However, both conclude that CDHPs are going to see significant growth and that customer satisfaction will play a crucial role.

Celent: Bleak assessment, rosy forecast

Boston-based Celent predicts steady growth over the next five years, with 12.5 million accounts by 2012. The growth will be driven largely by a banking transformation marked by market concentration, customer churn, and—perhaps most significant—a more consumer-focused approach.

In *HSAs: Moving Beyond the Growing Pains*, the financial services consulting firm offers a less-than-glowing view of how HSAs/HDHPs have been deployed to date, but it nevertheless forecasts a rosy future.

Disappointing start?

Despite the dramatic overall expansion of HSAs, growth and revenues have been disappointing for most players, the report finds. Early-mover banks expected to have half a million or more accounts each by the end of 2007; only two have exceeded 250,000, and most have fewer than 25,000, the report notes.

One significant problem is that employers have failed to encourage adoption, often attracting less than 5% of their employees, Celent says.

Moreover, having an HSA-eligible CDHP doesn't mean you end up with an HSA. HDHPs may not be optional; HSAs are. "The conversion of an HDHP sale into an HSA sale, according to leading players, is typically below 50%. At midsize to large employers that offer three options, HDHP adoption tends to fall between 10% and 15% the first year," according to the report.

Jay Savan, principal at Towers Perrin in St. Louis, disputes the slow-growth premise. "Product evolution takes

time and behavior change, and to suggest that—four years after the genesis of HSAs, and one year after they were liberated from some of the more stringent requirements of the initial model by the Tax Relief and Health Care Act of 2006—the product market should be much further along is to deny the evolution of markets," he says.

Duplicate accounts and dissatisfaction

Alenka Grealish, author of Celent's report and managing director of its banking group, estimates that 10%–14% of HSAs are duplicate accounts. She interprets this as a sign of consumer dissatisfaction with the *de facto* HSA bank. Moreover, she adds, many accounts are dormant.

Dennis Triplett, president of UMB Healthcare Services in Kansas City, MO, isn't surprised at the figures for duplicate accounts. But he's not sure how it follows that the existence of either duplicate or dormant accounts suggests consumers are disenchanted with their HSAs. (Duplicate accounts aren't a problem as long as the total annual deposit doesn't exceed the federally mandated maximum.)

Duplicate accounts do suggest that individuals are shopping around, Triplett says. Someone who is a spender today may be an investor tomorrow—and may end up being a spender again in a few years. Consumers need to be able to migrate to HSAs that better fit their needs at a particular point in their lives, he says.

Daryl Richard, vice president of communications for Minneapolis-based UnitedHealthcare, doesn't see duplicate accounts as an indicator of dissatisfaction either. He notes that a number of consumers either keep their old accounts or open a new one with UnitedHealth Group's Exante bank, even if their employer is contributing to an HSA at a different bank.

Underestimating the challenge

The Celent report identifies several weaknesses in the HSA/HDHP model, including poor online functionality,

lack of preventive coverage, and failure on the part of employers to fund the HSA (see Figure 1 below).

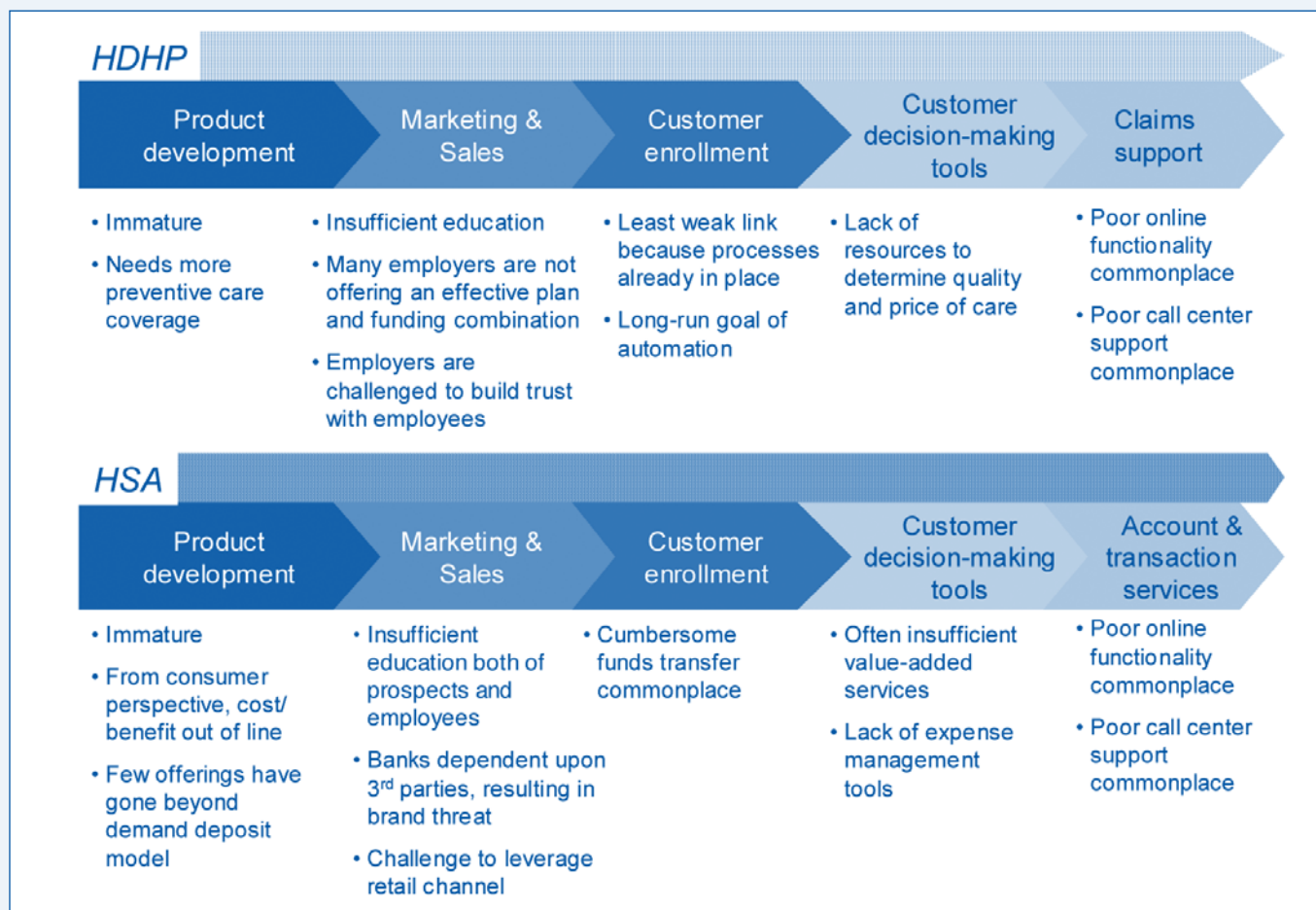
In general, employers, insurers, and other stakeholders underestimated what a “monumental transition” the HSA/HDHP model represents, according to Celent’s analysis. “As a result, there has been inadequate pre- and post-sale education, insufficient decision-making tools, and limited employer funding of accounts. Consumers are overwhelmed by the choices and are unable to conduct an adequate cost-benefit analysis.”

In effect, Celent levels the same criticism at the HSA/HDHP market that CDH proponents have leveled at providers—namely, that consumers lack the tools to make informed decisions.

Celent isn’t alone in raising concerns about inadequate education. *Listening to Consumers: Values-Focused Health Benefits and Education*, a recent report from the Employee Benefit Research Institute (EBRI), concludes that CDHPs may fail if employers don’t provide employees with proper education. “Should health education initiatives prove ineffective, the ‘consumer-driven health movement’ could well be doomed, especially if it relies upon fully educated health consumers taking self-initiated actions,” the report states. EBRI also argues that consumers are not getting the health education that takes into account both their psychosocial and income security.

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Figure 1



Source: Celent, Boston. Reprinted with permission.

Future of CDH

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Savan says some of these criticisms are off base. The problem isn't that employers failed to anticipate the scope of the change or are ignoring the need for education. Rather, the challenge comes from finding the right combination of incentives and tools to make it work. (He also points to the recent AHIP report that found that 84% of HSA-compatible plans cover preventive care at 100%.) However, Savan says that more—and different—education is crucial to success. But he sees it as an ongoing process. "Again, we're in a new environment which is typified by trial and error, and it will take a while before all the players get this right," he says, adding that to expect perfection at this stage is simply unrealistic.

Savan also notes that many of the problems with CDHPs are related to the plan side, not the account side. "The issue isn't HSAs per se; it's their conjoined twin, the HDHP, that presents the biggest hurdle to adoption," he says. HSAs themselves appeal to consumers and employers alike. The problem is that to have an HSA, one must enroll in an HDHP, and "the structural requirements imposed on HDHPs are significant deterrents to adoption."

Consumers driving change

For all the failings it cites, the Celent report does not consign CDH to the rubbish heap. Instead, it predicts dramatic changes and continued growth. The HSA market is ripe for a remodel—one that will spur growth, customer churn, and market concentration—and that remodel is already under way, the report states. The keystones of a remodel include:

- HDHP providers coming up with attractive (and profitable) products
- Employers willing to implement an effective plan (which includes contribution to the HSA)
- Account providers that charge reasonable fees (or offer value commensurate to the fees charged)
- Administrators that offer benefits to the healthcare providers, such as real-time adjudication

(See Figure 2 on p. 9 for more examples.)

Celent anticipates that during the next 24 months, the market will experience churn as consumers shop for a better offer—both in terms of price and service. Crucial to a successful remodel is pleasing the consumer and generating positive word of mouth. Banks that add value in this area will have a chance to gain higher ground, the report says. Others will grow stagnant.

Consumers are becoming more perceptive and informed, and the market will have to respond.

These informed shoppers are going to start looking for the best deal—and what that constitutes will vary, explains Grealish. Some want low cost, some want investments, some want higher interest, and many will want a combination of factors.

What they have in common is a "high nervousness level," she says. They have anxiety over their balances—more so than with traditional investment accounts. And that anxiety makes them savvy shoppers, she adds.

Although her focus is on banks, Grealish has a message for insurers and employers, too. Insurers must think of the CDHP as a consumer product—"no longer something you are selling to the employer," she says. Likewise, employers must build trust. That means investing in education—and in the accounts themselves. "Put your own money down."

Bifurcation in the market

Moreover, the Celent report predicts that the market will divide into manufacturers and distributors. "Because manufacturing has a relatively high fixed-cost component, it will be concentrated in the hands of around 20 providers, including HSA banks and HPAs [health plan administrators]," the report states.

The distributors will brand and distribute the manufacturers' HSA products.

Such segregation is already under way, says Savan. Canopy Financial, Fiserv, Metavante, and others occupy the manufacturing space, whereas more household-

name retail organizations (Wells Fargo, Bank of America, and Exante/Optum) and their HSA resellers (Aetna, the Blues, CIGNA, and UnitedHealthcare) occupy the distributor space.

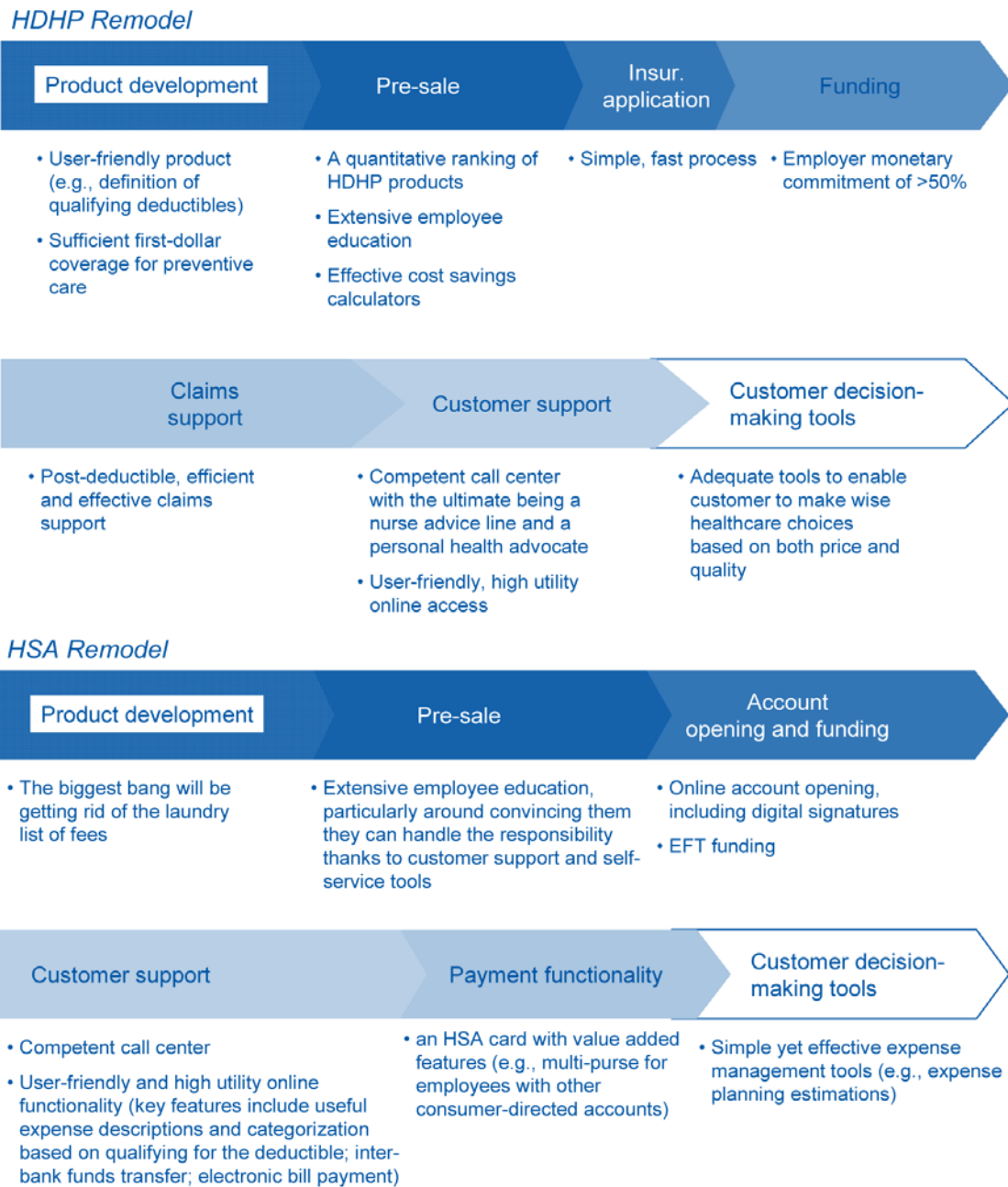
New partnerships will emerge as well. “Because the competencies of most players are limited to a select por-

tion of the HDHP-HSA value chain, partnerships are paramount to rounding out their offerings and remaining competitive,” the report says.

Savan thinks such partnerships are a more likely scenario than consolidation. “I anticipate a lot of Wintel

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Figure 2



Source: Celent, Boston. Reprinted with permission.

Future of CDH

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relationships as well, with partnerships and joint ventures forming among competitors or potential competitors," he says. (Wintel is a term used to describe Windows-based computers using Intel processors.)

According to Grealish, in the next 12–18 months, banks must decide "if they are in or out." Then they must decide whether they want to be manufacturers and build an HSA product in-house or be distributors and brand an existing one. Not every institution has to participate, but each has to decide. The opportunities presented by CDH are "too interesting to ignore," she says.

Blair: A more positive take

Another new report—this one from Chicago-based investment and equity research firm William Blair & Company—predicts that CDH, in its broadest sense, will transform the healthcare marketplace.

Consumer-Driven Health Care: 2008 Update—Three Years Later: The Tip of the Iceberg predicts that healthcare consumers "empowered with more information and financial responsibility will dramatically alter their health care purchasing patterns over the coming years, which, in turn, will have a monumental, and in our view beneficial, impact on the future of health care delivery in the United States."

But unlike the Celent report, the Blair report portrays CDH as a success. "I think the major thing that surprised me, and continues to surprise me, is the speed at which consumer-centric healthcare continues to evolve," says coauthor **Ryan S. Daniels**, a Blair analyst.

Blair published its first CDH analysis in January 2005. Daniels marvels at the ensuing change. "When we first wrote our piece three years ago, I would have never assumed that the insurance companies, payers, and—increasingly—consumers and employers would be attracted to the market." Unlike the Celent report, which primarily considers banking (and secondarily, HDHPs), Blair is looking at the broader notion of healthcare consumerism.

"CDHC to me is about more information on quality and price paired with more financial responsibility. Often, people I speak with hear 'CDHC' and think immediately about insurance plans. However, there are many ways outside of HSAs and HRAs to increase consumer responsibility and modify behavior," Daniels says.

Despite its broader scope, the Blair piece identifies the following five factors that will drive CDHP adoption in the coming years:

- ▶ Healthcare costs continue to escalate and a crisis is looming for Medicare
- ▶ The marketplace provides greater price and quality transparency

Employers and cost cutting: Cause or effect

The Celent and Blair reports maintain that employers primarily see CDH as a means to control costs.

The Blair report notes that employers are likely to embrace CDH as a means to control costs when they should be approaching it as a way to help employees "gain more control of their care and hopefully . . . lead healthier and more productive lives." Celent's report takes it a step further, contending that employers have been driven to CDHPs by cost savings alone. What's needed is a "dramatic shift . . . away from a cost-cutting mentality to a defined contribution mind-set," the report states.

Not everyone agrees that employers view CDHPs merely as a way to cut costs. "That's inconsistent with our research and experience," says **Jay Savan**, principal at Towers Perrin in St. Louis. His firm's research indicates that cost savings are a byproduct, not the primary objective.

Research also suggests that encouraging better use of health services, achieving measurable behavior improvement, and encouraging shared responsibility with employees are the key drivers of adoption, he says, adding that these objectives, when achieved, result in sustainable cost savings for employers and plan participants.

- ▶ There is increased financial responsibility for consumers coupled with greater consumer acceptance of CDH
- ▶ Health insurers and employers increasingly embrace consumerism
- ▶ Recent studies offer a positive view of CDH

Daniels elaborated on two of them: transparency and consumer acceptance.

Transparency and comfortable customers

Healthcare services providers must change to accommodate newly empowered consumers.

“We believe these changes are appearing in the form of benefits such as more convenience for patients, more information regarding providers and services, and increased pricing transparency. In our opinion, companies that understand the need to offer these types of benefits to patients will win in the CDHC revolution,” the report states.

However, Daniels emphasizes that although providers are moving in the right direction, they’re still far from where they need to be. “There are myriad factors driving this—state legislation requiring transparency, posting infection rates, hospital [comparison] data, value-based purchasing, etc., will all drive the need for providers . . . to change,” he says. “I would not say everyone is doing it today,” but the momentum of CDH will eventually force providers to embrace transparency and to compete on price and quality.

And that’s a key theme of the report: Providers that offer more consumer-centric healthcare will thrive by attracting more patients. As a result, “low-cost, high-quality—including convenience for patients—will win out,” says Daniels.

Insurers, too, need to provide tools and information to members and give them incentives to make proper healthcare choices.

Consumers “are the solution to this problem, not the insurers as gatekeepers,” he adds.

Meanwhile, consumers are warming to CDH, says Daniels. He cites the following factors:

- ▶ Consumers are becoming aware of the research demonstrating that CDHPs don’t negatively affect outcomes or limit access to care.
- ▶ As more individuals participate in CDHPs, it increases interest and comfort levels with their peers. “For example, if you have a friend in such a plan and she loves it, you are much more likely [to enroll in one],” says Daniels.
- ▶ Some employees, such as those working for small businesses, have no other realistic option.
- ▶ The support infrastructure is improving. Daniels points to financial tracking services and integrated insurance cards linked to HSAs and HRAs that make the experience more pleasant.
- ▶ Healthcare consumerism—in particular, retail clinics—is becoming more common and accepted.

Momentum

Like the Celent report, the Blair analysis forecasts dramatic expansion. “Overall, we continue to believe the consumer-driven healthcare revolution is approaching rapidly,” the report states.

Daniels doesn’t expect the election or any other external factor to slow this momentum.

“I view CDH as more data, more responsibility, more transparency, more empowerment. There is no way, in my view, that this will slow,” he says, adding that CDHPs will be the fastest-growing insurance offering in the next decade.

The Blair report offers a similarly upbeat conclusion, predicting that consumer-centric healthcare organizations—many of which are identified in its last half—will provide superior long-term results to investors. “We believe the progress thus far is merely the tip of the iceberg and expect there are many more significant changes afoot that will continue to surface—and help reshape the U.S. healthcare market—over the coming years.” ■

Editor’s note: For information about obtaining the Celent report, visit www.celent.com. For information about obtaining the Blair report, visit www.williamblair.com.

Computerized calls inspire exercise in sedentary adults

Computer-generated telephone calls provide an effective, low-cost way to encourage sedentary adults to exercise, according to a recent study. The findings could have applications for employee health.

Results of the yearlong study found that regular telephone calls, delivered from either live health educators or by an automated computer system, successfully encouraged adults to take part in a regular 150-minute-per-week exercise program.

The study by researchers at the Stanford University School of Medicine, which looked at 218 San Francisco Bay area adults aged 55 or older, was published in the November 2007 *Health Psychology*.

The automated calls were nearly as effective as the human ones, the study found. That has a very practical effect: Calls can be made anywhere, any time, and at a reasonable cost.

Get moving

The goal was to get participants to take a brisk 30-minute walk—or do some other medium-intensity physical activity—most days of the week. (The target was 150 minutes per week.) Participants were divided into a control group that didn't get calls, a group called by trained health educators, and a group called by a computer delivering an interactive, individualized program similar to that being delivered by the humans.

After one year, both of the "called" groups averaged above the 150-minute-per-week goal: Participants who received computer calls averaged 157 minutes per week of exercise, compared with 178 minutes for the group that received live calls and 118 minutes for the control group, which was not called.

The conclusion? Automated telephone calls represented an effective alternative for delivering physical activity advice.

Sometimes, you get what you need

Lead author **Abby King, PhD**, professor of health research and policy and a senior investigator at the Stanford

Prevention Research Center, noted that at the outset of the study, about 80%–85% of participants said they preferred—or even needed—a real human caller.

But in fact, some participants did even better overall when they didn't have to talk to a human. The lesson here is that people tend to prefer what they know, but that preference doesn't necessarily mean it's the best program for them.

"We have found in several of our research studies that an individual's initial preference concerning what type of program they believe they could do best with or need is often based on what they are most familiar with," King tells **CDH**.

New approaches to health promotion may initially be less attractive to many individuals, she says. But these new programs could be as good or better for them than the more comfortable, familiar ones.

Bringing it to the workplace

Similar approaches are already in place. For instance, Louisville, KY-based Humana uses computer-generated calls to work with members with chronic conditions. It also uses the calls to remind members about preventive health services and prescriptions refills.

The response has been positive, reports Humana Wellness Strategy Leader **Phil Smeltzer**. Older consumers and women tend to respond the most favorably. "Computer-generated calls have their place in many health-management programs. They are not practical or an intervention that works for all of our members, but for many individuals, the calls can be a help to improve adherence to various programs," he says.

King's telephone study looked at an older population, but she believes the findings have employee-health applications. Such interventions "could be an excellent and potentially lower-cost alternative for delivering individualized physical activity advice and support for those individuals seeking to become more regularly active," she says. ■