Health care guidance for consumers

Providing support at critical decision points

Overview

The U.S. health care market is inherently complex, and it is becoming increasingly so as a result of various efforts to deliver increased affordability, quality and a better experience to consumers. Health care is a unique consumer market in how it is financed, the fragmentation of its various components, and the large amount of information available at varying levels of accessibility, all of which add to complexity for the consumer. Most people receive coverage through their employer or public payers, where coverage costs are subsidized and rates have been negotiated with providers, historically shielding them from the true cost of care. However, consumers are increasingly being exposed to those costs through rapid cost increases and high-deductible health plans. Health plans are responding by offering new products at varying price points to give consumers more options to find affordable coverage that meets their needs. However, this increase in choice coupled with an increasing amount of information – often conflicting or confusing – available to consumers and their providers has added to existing heath system complexity. As a result, consumers may not feel confident making health care decisions and may not choose the right care.

Consumers want simple, clear options so they can easily make the best decision for their care needs. In an individual's health care journey, there are several decision points that can significantly impact access and cost of care. At each point, health plans can use data insights and new technologies to offer them personalized support and guide them through system complexity. This support can help create a simple, seamless experience that allows consumers to access the right care, at the right time, in the right setting.

"As we continue to evolve how we support customers to improve their health, we must meet them where they already are and connect them with what they need, to provide an integrated, seamless care experience."

- Joan Harvey, Vice President, Consumer Health Engagement, Cigna

Market forces increasing complexity

The U.S. health care market is evolving to meet changing demographics, needs, and preferences. Market forces contributing to health system complexity include:

- **Changing demographics** – The U.S. population is becoming increasingly diverse, complicating care delivery by heightening the need to provide customized care and support to effectively meet consumers' unique social, cultural, and language needs. Additionally, the population is aging and increasingly ailing. These demographic changes, coupled with a rise in chronic conditions, can make it more difficult and confusing for individuals to access the appropriate provider in the right setting, follow treatment plans, and generally manage their health.[1]
- **Care fragmentation** – The various components of total health care – medical, behavioral, dental, and pharmacy – have traditionally existed in silos. This is at odds with best practices to achieve optimal health outcomes. Health conditions are interconnected, and co-occurring conditions must be addressed appropriately and simultaneously. The current fragmentation of the system decreases the likelihood that a consumer's health will be considered holistically.
- **Access to / availability of information** – Currently, there are many different sources of health information accessible to consumers. These include online materials, digital health apps, opinions of friends/family, as well as the advice of medical professionals, employers and health plans. It can be challenging and confusing for consumers to sort through the abundance of information to find relevant, accurate and actionable information.
- **New health plan solutions** – In an effort to improve affordability, health plans are offering new utilization management solutions and smaller, more local networks focused on providers who deliver quality, cost-effective results in addition to their traditional or larger networks. These more local solutions increasingly include features that help control costs and utilization, such as tiered networks, no out-of-network benefits (except in emergencies), and referral requirements. These product features make it particularly important that consumers can easily determine which providers are in-network, as they can face unexpected costs if they accidentally go to an out-of-network provider. Similarly, new pharmacy formularies tend to be tiered, to limit coverage for higher-cost or less effective drugs. These new products and networks also increase complexity for providers as they try to guide patients to services and care that are covered by a patient's benefit plan.

1. Wan He, et al. *United States Census Bureau*, "An Aging World: 2015, International Population Reports," Mar 2016.

- **Alternative ways to access care** – Consumers are increasingly turning to non-traditional models of care, such as retail clinics or telehealth, due to their generally lower costs and greater convenience.[2] While this can increase access to care, it is important that consumers understand when it is appropriate to seek care from these providers.
- **Value-based reimbursement** – Health care costs continue to rise rapidly, and nearly a third of these costs are considered waste.[3] Much of this can be attributed to components of a fee-for-service based provider payment system. There is an ongoing shift to a payment system that rewards providers for the value of care they deliver, however, the transition process has added complexity as providers and health plans adapt their products and services accordingly.

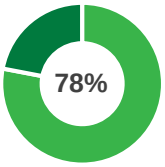
Changes to the health care system have been primarily focused around creating the affordability necessary to ensure continued access to care, and improving the quality of care. While essential, these efforts have often added to system complexity. Individuals have unique health care needs and preferences, and they could be overloaded with options without a clear view of which options can meet their needs. To make the most of their ongoing affordability efforts, health plans must examine what is creating complexity for consumers and employers and offer navigation guidance to simplify the health care experience. Health plans and new market entrants are making investments in health care technology platforms and applications to help guide consumers through the system.[4] This can help consumers focus on their overall health, rather than navigating the health care maze, and give them confidence that they are accessing the right care, at the right time, in the right setting.

Consumer decision points: navigating the health care system

Obtaining health care can be an overwhelming process for consumers as there are many factors to consider at each key decision point.

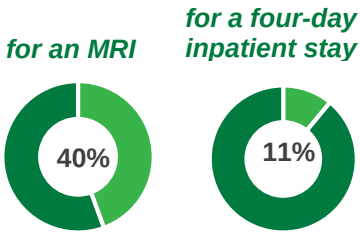
- **Choosing health coverage.** An individual needs to understand their plan options and be able to effectively compare and choose a plan that makes the most sense for their health situation, financial needs, and preferences based on cost, benefit features, and network design. If they are purchasing coverage through their employer, their options are based on which plans their employer has chosen to offer. In some cases, an individual may only have one plan available to them.[5]

Fig. 1. Physician practice managers and staff who reported patients or their families asking for recommendations on which health plan to consider.[3]



- **Understanding benefits.** After selecting a plan, individuals need help with onboarding. They need to understand all the benefit features and cost sharing responsibilities in order to fully use their coverage. Additionally, they should be made aware of whether their plan includes any programs, such as case management or health coaching, that can help support their health goals.
- **Navigating the network.** Once individuals have selected a plan and need to access care, they must choose a provider and determine what care setting is most appropriate (e.g., retail clinic, primary care physician office, or urgent care center). They may also want to understand which health care facilities and providers are in their network and accepting new patients, the estimated costs of care, which providers have been recognized for delivering quality care, if these providers have extended office hours, etc.
- **Obtaining care.** When meeting with their provider regarding a condition, consumers need information to enable an effective discussion about their treatment options and whether the options are covered by their health plan. Individuals often look to their health care providers to explain their benefits and financial obligations, yet providers often feel ill equipped or are hesitant to discuss costs. They expect health plans to educate consumers about benefit plans and financial responsibilities.

Fig. 2. Individuals that could identify how much they would have to pay...[7]



Repercussions of not being able to navigate the system

Consumers generally have low health literacy levels, with only about 12% of adults exhibiting proficient health literacy.[6] Health literacy is the ability "to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[7] Many people have a limited understanding about key aspects of health insurance or health plans, making it challenging to choose a plan, effectively utilize all their benefits, and access the best possible care.[8] One study found that, even with plan details right in front of them, most privately insured Americans did not understand plan features or costs.[9] **(See figure 2.)** Subjects were overconfident, stating

2. Kuhrt, Matt, *Fierce Healthcare*, "The rise of retail healthcare: What it means for traditional primary care practices," 28 Mar 2017.
3. Sahni, Nikhil, et al., *Harvard Business Review,* "How the U.S. Can Reduce Waste in Health Care Spending by $1 Trillion," 13 Oct 2015.
4. Milliard, Mike, "Venture capital funding for healthcare technology rebounds, investors log $1.6 billion in deals in Q3," 19 Oct 2015.
5. 2016 results from proprietary survey conducted by Cigna.
6. U.S. Department of Health and Human Services, "Quick Guide to Health Literacy: Fact Sheet," accessed 11 May 2017.
7. U.S. Department of Health and Human Services, "Quick Guide to Health Literacy: Fact Sheet," accessed 11 May 2017.
8. Taylor, Erin Audrey, et al., RAND Corporation, "Consumer Decisionmaking in the Health Care Marketplace," 2016.
9. Frakt, Austin, The New York Times, "Why Consumers Often Err in Choosing Health Plans," 1 Nov 2015.

they knew what various plan features were, but were unable to accurately answer questions about them. Additionally, when only price comparisons are available, individuals are more likely to associate price with quality; that is, the higher the cost of the plan, the higher the perceived quality.[10]

When an individual has a poor understanding of their plan options and benefits, how to navigate the network, and what their treatment options are, it can negatively impact their financial, physical, and mental well-being. They may:

- Choose a coverage option that is poorly suited to their individual needs
- Receive a surprise bill due to unintentionally using an out-of-network provider/facility or seeing a specialist without a necessary referral
- Miss out on beneficial features of their plan that they are not aware of (e.g., health coaching, discounted gym membership)
- Experience stress
- Avoid care or not adhere to treatment plans because of cost concerns, resulting in poorer health outcomes

Opportunities and barriers

Opportunities

Consumers are living increasingly technology-driven lives. They want information and support tools to be easily available at the point of decision making. At each stage of a consumer's health journey there are opportunities to support them with tools and services that can enhance and empower their decision-making process, powered by personal health data, insights, and next generation technology (e.g., artificial intelligence). As aggregators of large quantities of health care data, health plans are uniquely positioned to build and offer tools and services that can deliver this. These resources need to simplify the decision making process and be embedded in how consumers already make decisions.[11] They should be clear, intuitive, and incorporate features to guide consumers towards ideal choices – that is high-value coverage and care that meet their individual needs. Health plans can support consumers by providing:

- Simple, clear, comprehensive benefits descriptions, in multiple languages, avoiding industry jargon
- Cost and quality information to simplify side-by-side benefit, provider, and drug cost comparisons
- Messaging and digital apps that proactively communicate reminders about preventive care visits and incentives that consumers could earn for healthy behaviors (depending on their plan)
- Digital tools and telephonic support that guide consumers to appropriate providers and support care selection decisions
- A provider directory that is simple, accurate, and highlights high-value, in-network providers as well as other provider features, like extended hours, languages spoken, or expected costs
- Care options for common procedures and conditions to help inform conversations with providers (e.g., pain management options)
- Integrated experience within the health plan and coordination of services and tools with providers

By empowering and supporting consumer decision making, health plans can also alleviate some of the burden on providers. However, because providers are often a trusted source for advice and information, it is inevitable that many consumers will still turn to them. Therefore, it is important that health plans also offer tools and resources that simplify the process of finding these answers for providers, so they can focus on patient care. Moreover, adoption of value-based reimbursement will help alleviate the need for certain cost-control mechanisms that can complicate the process of accessing care.

Barriers

There are some barriers to simplifying health system navigation for consumers. These include:

- **Data exchange:** Data exchange between consumers, providers, and health plans allows health plans to provide consumers with personalized information to guide them to the providers and care that best meet their individual needs. However, the ability of providers, payers, and consumers to exchange and use data is limited today.[12] Health plans and providers are rapidly working to build or acquire technology that supports information-sharing capabilities.

10. The Advisory Board, "The Imperfect Consumer: Why Money Won't Inspire Rational Care Decisions," 2016.
11. The Advisory Board, "How to Influence Where Members Seek Care," 2016.
12. Shaw, Gienna, *Fierce Healthcare*, "Healthcare executives on overcoming the barriers to payer-provider data exchange," 17 July 2017.

- **Provider data accuracy:** Provider data accuracy has long been a challenge for health plans due to the significant complexity of data collection and management. Health plans and providers must actively work to implement processes and support initiatives to improve data accuracy. This will help ensure consumers can find care and providers get paid quickly and accurately for services they provide.
- **Consumer trust:** For health plans to effectively help consumers navigate the health care system, they must earn their trust. Consumers do not necessarily perceive health plans to be the best resource for health care guidance and information. By providing transparency in the tools and resources they provide, plans can promote trust and more effectively engage consumers.

Cigna's response

Cigna's goal is to more effectively connect care between our customers and their health care providers to help improve health, affordability, and customer and provider experience. To achieve this, we are focused on empowering our customers to engage in and make good decisions about their heath, and delivering a personalized, simpler experience. We have developed a suite of clear, intuitive health engagement tools and resources, powered by data and analytics that help our customers simply and seamlessly obtain health care and reduce the administrative burden on providers. These tools that help support informed decision-making include:

- **Cigna One Guide®:** A personalized health service comprised of digital tools and telephonic services to support customers' coverage, access, and health care decisions. It helps them choose plans and understand their benefits and guides them to quality, cost-effective providers. It also helps reduce surprise costs and helps them maximize their benefits by highlighting cost-savings opportunities, making them aware of health coaching or condition management programs available and any related incentives (depending on their plan), and providing them with recommendations for the "next best actions" for using their benefits and making care decisions.
- **Cigna Easy Choice Tool:** A self-service decision support tool that employers can offer to help guide employees in choosing a Cigna medical plan (may not be available with all medical plans) that best meets their personal needs, by comparing plan options side-by-side based on their indicated preferences, including identifying if their provider is in-network and highlighting cost-sharing responsibilities.
- **Brighter.com tools for dental customers:** Enhanced online dental transparency tools that allow dental customers to compare dentists based on patient reviews, price and actual cost based on their plan and to schedule online appointments (for dentists who offer the appointment scheduling service – actual features vary by plan and dental product type). This helps them find a quality, affordable dentist in their area.
- **Product / network / benefit design:** Working with employer clients and providers to build solutions that are designed to guide customers to the most appropriate site of care with providers in value-based arrangements with Cigna, and to help them effectively navigate care across the delivery system.
- **Drug cost tool:** Online tool to help customers compare the cost of prescriptions. This includes options such as lower-cost drug alternatives and 90 day supplies (if available under their pharmacy plan).
- **Integrated solutions:** Integrated medical, behavioral and pharmacy solutions allow Cigna to have a holistic view of the customer to guide them to the most appropriate care. For example, we can leverage the high volume of pharmacy interactions to guide customers to the most appropriate option (e.g., lower cost site of care for infusions or engaging customers with a health coach for whole health management).

As we build out our tools, resources and services, we continue to look for opportunities to improve engagement with our customers. We are doing this by meeting customers where they are, through their preferred communication channels; improving the quality of our provider data and data collection and exchange across the delivery system; and leveraging increasingly advanced predictive analytics and technology to proactively engage customers. Such efforts to help make the complex health care system simple and affordable are necessary to better connect customers with the right care, at the right time, in the right setting.

Together, all the way.®

Cigna®