



The Bravewell Collaborative

THE PHILANTHROPIC COLLABORATIVE FOR INTEGRATIVE MEDICINE

THE EFFECT OF CONSUMER-DIRECTED HEALTH PLANS ON ACCESS TO INTEGRATIVE MEDICINE

Phase 3 of a Continuing Study to
Map the Field of Integrative Medicine

Submitted by:

Mapping Committee
Bravewell Collaborative
The Philanthropic Collaborative for
Integrative Medicine

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INTRODUCTION

Overview:

One of the strategic goals of the Collaborative is to “identify, confirm, organize and document the existing landscape of the rapidly developing field of integrative medicine.” In pursuit of that goal, the Collaborative has undertaken three phases of a mapping project. This is the final report of the third of those phases, a study of the effects of consumer-directed health plans on access to integrative medicine.

The report of the first phase of the mapping project noted that the purpose of mapping is “to challenge and question past and future while also connecting some of the many pieces of the Integrative Medicine field—pieces that are visible but not yet linked—into a shared picture or navigable map . . . This attempt at mapping is intended to help understand how the future will be different from the recent past. It is intended to provide information and also to inform decision making.”

In Phase 1 of the mapping project, the Collaborative studied the opinions on integrative medicine of a number of thought leaders, considered alternative theories of change as they relate to the emergence of integrative medicine, and discussed optional scenarios for how its future might unfold. Phase 2 of the project described the emergence of integrative medicine in selected community hospitals, pediatric clinics, spas and hospice programs.

In Phase 3, the mapping project sought to understand the effect of consumer-directed health plans on access to integrative medicine. These plans, described more fully below, are rapidly emerging as a major response to the escalating cost of healthcare coverage. In general, they combine health savings accounts with insurance plans that have high deductible charges. In most conceptualizations, these plans shift much of the cost and responsibility for healthcare purchase decisions from payers to consumers. Phase 3 sought to answer the following questions:

- 1) To what extent does the design of benefits in these plans encourage or hinder access to integrative medicine?
- 2) How do web-based education programs treat integrative medicine services?
- 3) How do consumers with various characteristics value integrative medicine services?
- 4) How do providers of integrative medicine services structure marketing efforts to attract people who are able to pay for services through consumer-directed health plans?

The Mapping Committee:

The Mapping Committee of the Bravewell Collaborative includes the following members: Georgine Busch, Ann Lovell, Lu Lovell and Ruth Stricker Dayton.

This phase of the Mapping Study was conducted by Bill Henry, President of ForeSight Strategy Associates, and a consultant to the Bravewell Collaborative. In addition, Professor Stephen Parente of the University of Minnesota served as a technical consultant to the project.

WHAT ARE CONSUMER-DIRECTED HEALTH PLANS?

In an article in the New England Journal of Medicine (September 23, 2005), James Robinson addresses that question:

... the health savings account (HSA) ... reflects a philosophical shift in emphasis from collective to individual responsibility for the management and financing of care. HSAs form the core of the emerging "consumer-directed" insurance plans, imposing greater cost sharing on enrollees but permitting broader choices than the health maintenance organization (HMO) plans of the managed-care era.

The HSA is a financial vehicle, akin to an individual retirement account, to which contributions may be made with pretax dollars and from which balances may be withdrawn to pay medical claims, again without payment of tax. If not spent in the year they are made, contributions accumulate, are invested, and can be spent on health services in subsequent years. . . . Funds can be spent only on services considered by the Internal Revenue Service to be medically related, but the range of qualified services is broader than that often covered by insurance policies and may include dental, vision and complementary medicine services. . .

HSAs receive favorable tax treatment only when they are accompanied by an insurance policy with a high deductible, typically managed by a preferred-provider organization (PPO), to cover the expenses of catastrophic illness. By law, HSA-compatible deductibles must be at least \$1,000 for an individual and \$2,000 for a family, but substantially higher deductibles can be found in the insurance market. . . . When paying for medical services, the enrollee first uses funds from the HSA, until the balance is exhausted, and then uses personal, after-tax income (the so-called doughnut hole) until expenses reach the deductible threshold. The enrollee then continues paying part of the costs incurred, typically 20 to 30%, until an annual maximum for out-of-pocket payments is reached, after which the PPO pays all costs.

When combined in this fashion with a high-deductible insurance policy, the HSA is referred to as a consumer-directed health plan.

WHY ARE CONSUMER-DIRECTED HEALTH PLANS IMPORTANT?

Robinson (above) identifies the most explicit reason why consumer-directed health plans are important to the future of integrative medicine: HSAs can be used to purchase at least some complementary medicine services. But there are other, more subtle and more substantial reasons why these plans will be important. First, consumer-directed health plans (CDHPs) promise significant reductions in employer health expenditures: in 2006, Deloitte & Touche reported that healthcare expenditures for employees covered by CDHPs rose less than half as much as those for employees in traditional health insurance plans. Second, CDHPs change health coverage from a defined benefit format to a defined contribution format. Just as in the change from defined benefit retirement plans (traditional “pension plans”) to defined contribution retirement plans (such as 401K plans), this change in health insurance limits the risk that employers face for future expenditures. Third, the design of CDHPs can conveniently incorporate other changes oriented to reducing healthcare expenditures and enhancing quality, such as pay for performance, preferred provider organizations, portability across employers or geographic locations, and focused management of high cost users of healthcare services.

Over time, CDHPs have the potential to dramatically change the landscape of the healthcare marketplace by shifting control, decision making and responsibility in healthcare to the consumer. Under CDHPs, healthcare becomes very much a retail good, marketed directly to consumers, rather than to payers or employers. This shift has important implications for how quality is assessed, for how services are priced, for how provider organizations compete and for how services are delivered, and it has the potential to elevate integrative medicine to a favored position in the new marketplace.

Of course, not all who study CDHPs find them to be entirely beneficial. Objections to these plans include the degree to which they expose the consumer to risk (the other side of the coin from limiting the employer’s risk), questions about whether consumers will be able to make informed decisions about healthcare, the absence of data on healthcare quality and price, the potential for reducing the quality of healthcare without the oversight now provided by payer organizations such as large insurers, and the potential for the use of CDHPs as tax-advantaged investment vehicles by wealthy people.

Many who criticize CDHPs suggest that placing the financial responsibility for healthcare purchase decisions in the hands of the consumer will lead to significant reductions in needed services. Many such critics cite the Rand Health Insurance Experiment of the 1970s as their primary evidence. In the RAND experiment, consumers randomly assigned to high deductible health plans were found to use fewer preventive care services. However, many of the current CDHP plan designs provide 100% coverage for preventive services, including physicals, well-child exams and diagnostic testing. In one new plan design by Aetna, generic pharmaceuticals viewed as useful for prevention or helpful for maintenance or improvement of the health status of the chronically ill, are covered at 100%.

THE INCREASING PREVALENCE OF CONSUMER-DIRECTED HEALTH PLANS

The last several months have seen a broad array of articles and editorials in both the popular and scientific literature on the “uptake” of consumer-directed health plans. However, deriving a conclusion from these writings about how many people are covered by consumer-directed health plans is not easy. A survey conducted in October 2005 estimated that “only 1% of the privately insured population ages 21-64 were enrolled in consumer-directed health plans.” A modeling effort by Steve Parente (a national expert on consumer-directed health plans who has served as a consultant to this project) and colleagues at the University of Minnesota published in November 2005, estimated that policy changes included in the 2003 Medicare legislation “could lead to approximately 3.2 million HSA contracts among Americans ages 19-64 who are not students, not enrolled in public health insurance plans, and not eligible for group coverage as a dependent.” Other sources report rapid increases in the number of people covered by these plans: a February editorial in the Wall Street Journal noted that “the insurance industry announced that enrollment in HSAs had tripled in 10 months to 3 million people,” and an article in the St. Paul Pioneer Press on June 9, 2006 reported that “UnitedHealth Group said the number of people signed up for its plans with health savings accounts or reimbursement accounts increased 75% over a year earlier, recently topping 1.75 million.”

The Wall Street Journal reported in February of 2006 that “8% of companies with 10,000-19,000 workers provided HSA benefits in 2005, compared with 1% in 2004.” A Mercer study reported in the Wall Street Journal in December 2005 “found that 5% of employers with over 500 employees and 22% of companies with over 20,000 employees were offering these consumer-driven plans in 2005. Next year, 11% of all employers will offer such plans.”

Most writers argue that the favorable employer response to these plans is a result of the limitation they place on employers' exposure for the healthcare costs of their employees: a 2006 survey by consultants at Deloitte shows that during 2004-05, costs in consumer-directed plans rose by less than half as much as in traditional plans. These cost savings result from changes in the use of healthcare under CDHPs, such as the following:

- Increase (from 20% to 45%) in the proportion of enrollees using less expensive medications (through expanded use of generic medications and of mail order pharmacy).
- Reduction in behavioral health visits, and a shift from psychiatry to less expensive providers such as psychologists and social workers.
- Reduction (typically 15%) in the number of physician office visits, accompanied by increased use of telephone consultations with nurses.

In addition to employer interest in consumer-directed plans, federal health policy has focused on stimulating these plans as a way to both increase the number of people with health insurance and a means of containing healthcare costs. Another Wall Street Journal editorial on February 3, 2006 reported that "The White House has said it intends its proposals to expand the number of Americans using HSAs to 21 million by the end of the decade. The McKinsey Quarterly estimates that "there could be 25 million HSAs by 2013."

HOW DO CDHPS WORK?

How are services paid for? CDHPs include three types of payment for medical services. The first expenditures come from the health savings accounts – these typically amount to \$1,000 to \$2,650 for individuals and up to \$5,250 for families. When the funds available from the HSA are exhausted, the consumer makes payments out of pocket until the deductible of the accompanying indemnity insurance plan is reached – this second level of payment is referred to as the "doughnut hole." The third form of payment occurs once that insurance takes effect: usually the insurance plan pays 80% of approved expenditures and the consumer pays 20%. The services available for coverage under the high deductible insurance plan more closely resemble those provided under managed care plans, and are not as broad as those covered by the HSA.

How much money can be contributed to an HSA? In any calendar year, a person or family may add to their HSA an amount equal to the amount of the deductible applied to the related insurance policy, but not more than \$2,650/year for an individual or \$5,250/year for a family. The Bush administration is proposing that these limits be increased to \$5,250/year for individuals and \$10,500/year for families. The balances in these accounts can be invested, as in 401(k) plans. Unused funds roll over at the end of each year.

What can be purchased with funds from an HSA? These funds can be used for “qualified medical expenses” as identified in Internal Revenue Service regulations. Such expenses include those for acupuncture, chiropractic, and dietary supplements “recommended by a medical practitioner . . . for a specific condition diagnosed by a physician.” These expenses exclude non-prescription medications and general dietary supplements.

The key element in CDHPs is not so much what can be purchased with HSA funds, but that both the HSA expenditures and those in the “doughnut hole” are real out of pocket expenses for the consumer. As such they compete with other purchases that the consumer wishes to make.

What is the role of web-based education in CDHPs? CDHP members can access proprietary websites that provide increasingly sophisticated information on a very broad array of health conditions and treatments, including some information on cost and quality of specific health services. A 2005 University of Minnesota study of the members of one CDHP found that less than half of the members used the plan’s website. Only 1/4 of the members used the website to research information on healthcare resources. At the same time, a 2005 study of Blue Cross CDHPs found that CDHP members are more likely than those in traditional health plans to research their healthcare.

There appear to be concerns about the quality of information available to CDHP members. In a 2006 Pricewaterhouse Coopers study, only 1/4 of top executives at 135 large US companies stated the belief that they are providing good information on healthcare quality to their employees.

FINDINGS

This phase of the mapping study focused on four questions. Each of these is discussed below.

To what extent does the design of benefits in these CDHPs encourage or hinder access to integrative medicine? At this point, only qualitative answers to this question are possible. In particular, there are two aspects to the design of consumer-directed health plans that appear to have important positive implications for access to integrative medicine. First, by establishing health savings accounts which consumers can use to pay some of their medical expenses, CDHPs provide a broader array of choice to consumers. Funds in HSAs can be used for “out of pocket” purchase of medical services that are not as constrained as those typically available to enrollees in HMOs or other managed care plans. These purchases are also made without review by gatekeepers or other intermediaries common in managed care plans. While expenditures from HSAs are limited to some extent, many complementary services that are part of integrative medicine can be covered.

Second, to provide the consumer education that is a central tenet of consumer-directed health plans, each plan includes access to web-based education systems. As is discussed more fully below, these systems typically include discussion of various integrative approaches to health problems, especially when there are data supporting the cost-effectiveness of those approaches.

But while some aspects of CDHPs may encourage the use of integrative medicine, other aspects of the design of these plans may hinder access to those services. It is thought that consumers may resist making expenditures from their HSAs because they seek to avoid the out of pocket expenditures of the doughnut hole. As a consequence, CDHPs may serve to restrict access to all forms of care. As a Wall Street Journal article (February 2, 2006) notes, “The hope is that people [covered by HSAs] will make wiser, price-conscious choices. Critics contend that HSAs will lead consumers to forego necessary medical care, because they are paired with high-deductible insurance that requires people to pay more for care out of pocket.”

A related issue is the use of HSAs as investment vehicles as well as health insurance plans. The Wall Street Journal article noted above also says, “HSAs are more comparable with 401(k) plans or other retirement accounts. The money can be invested, typically in mutual funds, and grows tax-free, with unused funds rolling over each year. . . . Once you’re 65, you can also spend the money on non-medical expenses without paying a penalty – but you’ll owe income taxes on those funds.” Indeed, the tax-advantaged investment aspect of HSAs has drawn the attention of

a number of financial services firms, as discussed in an article in the McKinsey Quarterly in June 2005: “A range of financial-services companies . . . already provide savings, investment, credit and payments products as well as financial advice. Now, greater consumer participation in paying for healthcare presents these companies with an opportunity, and many have introduced savings accounts and investment products to attract HSA assets.

A new study by Parente and colleagues will examine the relationship between HSA investment decisions and portfolio choice decisions for at least two large national employers offering both 401K plans and HSAs. The researchers will examine whether consumers will make decisions between health and wealth as part of the ownership society hypothesis stated by proponents of market-based solutions to medical care and retirement savings.

In sum, in comparison to traditional health plans, CDHPs provide more money for out of pocket healthcare expenditures by members, make more choices available to those members, impose fewer constraints on those members buying decisions, and encourage more active consumer behavior on the part of members.

How do web-based education programs treat integrative medicine services? As noted, the web-based education programs that are integral to consumer-directed plans generally include many references to the use of integrative medicine services. To assess the degree to which these programs addressed integrative medicine, three websites were reviewed as part of this study: Blueprint for Health (used by Blue Cross of Minnesota), My Medica (used by Medica Health Plan) and Definity Health (a division of UnitedHealth Group). In preparation for assessing the websites, five integrative medicine physicians practicing in the Bravewell Clinical Network were asked to respond to two questions:

- For what five diagnoses, conditions or symptoms should these websites be most likely to identify one or more CAM or integrative approach?
- For what five CAM or integrative modalities should these websites provide at least some background information for consumers?

Responses to these questions yielded the following conditions and modalities:

<i>Conditions:</i>	Arthritis	Headaches
	Anxiety	Insomnia
	Back Pain	Irritable Bowel Disease
	Chronic Fatigue Syndrome	Osteoporosis
	Depression	
<i>Modalities:</i>	Acupuncture	Ayurveda
	Traditional Chinese Medicine	Yoga
	Massage	Relaxation Techniques
	Mindfulness-based Stress Reduction	Nutrition Supplements

While a detailed analysis of the content of the websites relative to these elements is beyond the scope of this study, the following statements characterize their approach to integrative medicine:

- Each website provides extensive information on CAM modalities and approaches to treatment of various conditions.
- However, much of this information is included on segmented areas of the website labeled “complementary medicine” and is not integrated in larger discussions of treatment.
- Evidence on efficacy (or the lack thereof) is frequently included in discussions on the websites, including citation of scientific studies published in the medical literature.
- In general, the websites are very supportive of consumer choice, especially if the consumer pursues information contained in the “complementary” section of the website.

As an example, consider the topic “tension headache” discussed on the My Medica website. That discussion includes references to 64 articles, including information on acupuncture, massage, 5-HTP, peppermint, menthol, hypnotherapy, biofeedback, homeopathy and spinal manipulation.

How do consumers with various characteristics value integrative medicine services?

There do not appear to be data on how people who are covered by consumer-directed health plans value integrative medicine. Importantly, the design of these plans makes it very difficult for providers of care to discern just which patients are and are not covered by CDHPs, especially in integrative medicine settings. For the most part, people who pay for medical services from HSAs will appear to providers as paying out of pocket, often by credit card. Especially in integrative medicine settings where the lack of insurance coverage often leads to billing consumers directly rather than billing insurance companies, it will be difficult to identify people who are covered by consumer-directed health plans.

How do providers of integrative medicine services structure marketing efforts to attract people who are able to pay for services through consumer-directed health plans?

Answering this question is perhaps the most important aspect of this phase of the mapping study. Because the movement toward coverage by consumer-directed plans is not yet on the radar of most providers, especially in integrative medicine, efforts to attract those consumers have not yet been mounted. However, there are critically important aspects of consumer-directed plans that have significant advantage for integrative medicine. As noted, CDHPs include more out of pocket expenditures, encourage unencumbered buying decisions by the consumer, and provide information on CAM and other aspects of integrative medicine.

CONCLUSIONS

There is every indication that CDHPs could be “the next big thing” in healthcare. Key factors in expanding CDHPs include their advantages in reducing employers’ healthcare costs, the studies noted above showing the growth of these plans, and the efforts underway to convert coverage of many employer and government plans to CDHPs. One example of the rapid rise of CDHPs comes from an address presented in April 2006 by a top executive of a major provider organization in the Twin Cities. He emphasized the growth of these plans and the changes they would require in providers. After citing several indices of the prevalence of CDHPs, he asked the CEO of large health insurer in the audience if his estimate of their growth was overstated. She responded that the growth was far greater even than he had noted.

Importantly, CDHPs convert healthcare to more of a retail commodity. A 2003 presentation to the Society for Health System Market Development by Kaufmann, Guptill and Pew identified five key components of retail medicine:

- It is demand driven, rather than driven by provider decisions, as is the case in traditional medicine. Because CDHPs put purchasing power in the hands of individual consumers, it is their buying decisions, rather than those of large insurers, that will drive the market.
- It is consumer-focused, rather than focused on the interests of either providers or payers as is the case in traditional health plans.
- It encourages a partnership model of care, in which the patient, family and providers share decision-making.
- It is cash-based, rather than reimbursement-based.
- It must compete with other purchase options—in healthcare and in other areas of the consumer’s life.

A conceptual model that is especially helpful in understanding how this shift might affect integrative medicine providers is discussed at length in The Future of Competition by Prahalad and Ramaswamy (Harvard Business School Press, 2004). They first characterize an older model in which a company invests in a product or service, and exchanges it in the marketplace for money from the consumer, who then uses the product or service. In its place, they suggest a newer model prompted by the shift in the role of the consumer: “from isolated to connected, from unaware to informed, from passive to active.” In this new model, the company and the consumer come together to co-create value, the individual consumer’s unique experience with the product or service is the primary determinant of that value, and what has been a market becomes more of a forum organized around active consumers and their co-creation experiences. Examples of consumers co-creating value with companies include:

- *Netflix* versus video rental stores.
- *Amazon.com* versus corner book store.
- *itunes* versus local music store.
- *Onstar* versus roadmaps.
- Blogs versus newspapers
- Birthing centers versus labor and delivery departments.

Especially for purposes of this report, it must be argued that the ascendancy of integrative medicine is also an example of value co-creation by consumers.

When Prahalad and Ramaswamy apply this perspective to healthcare, the result has important implications for both integrative medicine and CDHPs:

Consider the evolution of the healthcare industry. Innovations in pharmaceuticals, biotechnology, nutrition, cosmetics, and alternative therapies are creating various treatment modalities and transforming our concepts of health. As both consumers and technologies advance, traditional medicine (“curing sickness”), preventive medicine, and improvements in the quality of life are rapidly merging into a “wellness space.” Let us examine the changing dynamics of interaction between a consumer and the firms that participate in the wellness space.

Twenty years ago, when I was feeling ill and visited my doctor, I might have undergone a battery of tests that would have informed my doctor’s diagnosis, which he would explain to me only if he had to. He would then choose a treatment modality, prescribe some medications, and schedule a follow-up examination. Healthcare back then was generally doctor-centric, just as commerce was company-centric. Doctors thought that they knew how to treat me, and since I wasn’t a physician myself, I probably agreed. Similarly, most businesses figured that they knew how to create customer value – and most customers agreed.

Now, the healthcare process is far more complex. As soon as I feel ill, I can tap into the expertise and experience of other patients and healthcare professionals. I can access an abundance of information, some of it reliable, some of it not. I can learn what I want about breast cancer or high cholesterol or liposuction. I can investigate alternative treatments for any condition and develop an opinion about what might and might not work for me.

Ultimately, I can cut my own path through the wellness space, thereby constructing a personal wellness portfolio. If I’m grappling with cholesterol, then I can include pharmaceuticals for blood pressure and cholesterol approved by the FDA, health supplements not approved by the FDA, a fitness regimen developed with an instructor, and genetic screening for hereditary heart disease.

Notice that my wellness portfolio does not fit neatly into any traditional industry classification. Yet, I visit my doctor. I get tests and medications and submit the bills to my medical insurance, provided through my employer. But other services in my wellness portfolio fall outside insurance industries. My wellness space springs from *my* view of wellness, *my* biases, values, expertise, preferences, expectations, experiences, and financial wherewithal. . . .

Rather than rely solely on my doctor's expertise, I can seek experts among my peers—other healthcare consumers—organized into thematic communities, such as a high-cholesterol group. This networked knowledge encompasses not just the medical aspects pertinent to my condition but its sociology, psychology, and likely impact on me, my family and the community at large.

Thus, my next visit to the doctor can differ dramatically from the conventional checkup. I can ask, Why did you prescribe this treatment? Why not the alternative that I found through exploration with other consumers and the Web? My doctor probably won't enjoy my challenging his expertise and authority. After all, I'm asking him to explain and defend his approach, which takes time and energy. What's more, I'm testing the depth, breadth, and currency of his knowledge. What if I'm experimenting with alternatives—herbs, dietary supplements, and so on—that he may not understand? Will he know of any complex interactions between these treatment modalities? Should he?

Of course, healthcare consumers have always shaped their own treatment to a certain extent. Remember Grandma prescribing a remedy such as chicken soup for a cold? But with today's access to information, consumer war stories, and advice from an experienced peer group, consumers are far more likely to network and experiment than ever before. As a healthcare consumer, I can more actively determine the "value bundle" that is appropriate for *me*, cutting across customary industry boundaries.

The opportunities for creating that individually-determined "value bundle" are greatly expanded by both integrative medicine and CDHPs. Indeed, the intersection of those two innovations fits almost exactly the thesis expounded by Prahalad and Ramaswamy.

Prahalad and Ramaswamy identify four "building blocks of co-creation" that also have important implications for integrative medicine: dialogue, access, risk assessment and transparency. The relationship of each of these to integrative medicine is discussed below.

Dialogue.

Dialogue means interactivity, deep engagement, and a propensity to act—on both sides. Dialogue is more than listening to customers: it entails empathic understanding built around experiencing what consumers experience, and recognizing the emotional, social, and cultural context of experiences. It implies shared learning and communication between two *equal* problem solvers." Dialogue is also a "building block" of integrative medicine, and one of the key factors that distinguish it from traditional

medical practice. It is only through dialogue that the provider and consumer can arrive at the mutual understandings necessary to decisions about diagnosis, treatment and prognosis. Clearly, because dialogue is central to integrative medicine, it also positions integrative medicine to compete effectively in the “wellness space” described by Prahalad and Ramaswamy.

Access.

Prahalad and Ramaswamy note that “Increasingly the goal of consumers is access to desirable experiences. . . .Access begins with information and tools.” Integrative medicine seeks to provide access for consumers to desirable experiences in various treatment, prevention and wellness modalities and strategies, all in the context of informed decision making that results from dialogue.

Risk Assessment.

Risk here refers to the probability of harm to the consumer. Managers have traditionally assumed that firms can better assess and manage risk than consumers can. Therefore, when communicating with consumers, marketers have focused almost entirely on articulating benefits, largely ignoring risks.” It takes little imagination to translate these comments by Prahalad and Ramaswamy to the communication between traditional medical providers and their patients. The perspective of “doctor knows best” has characterized this sort of communication, and kept patients from full knowledge of treatment options and the accountability that comes from that knowledge. As consumers take more ownership of their health and healthcare in integrative medicine, they will also come to bear a greater share of responsibility, deriving in large part from better risk assessment: “if consumers are active co-creators, should they shoulder responsibility for risks as well?”

Transparency.

If we are to enhance access through dialogue and encourage responsibility through more complete risk assessment, then transparency must characterize both providers and consumers. Current efforts to improve the information available to consumers on healthcare quality and prices are important steps toward this transparency, and reflect the comments of Prahalad and Ramaswamy: “Companies have traditionally benefited from information asymmetry between the consumer and the firm. That asymmetry is rapidly disappearing. Firms can no longer assume opaqueness of prices, costs, and profit margins. And as information about products, technologies and business systems becomes more accessible, creating new levels of transparency becomes increasingly desirable.”

GENERAL RECOMMENDATIONS

As has been noted, it is entirely possible that CDHPs are “the next big thing” in healthcare, but there is little evidence to support that assertion at present. Further, while the points expounded by Prahalad and Ramaswamy appear to hold critical importance for integrative medicine, especially if CDHPs take hold, their writings at present are little more than a theory. Taken together, these two streams of thought present exciting, if highly speculative, opportunities for integrative medicine. The recommendations presented below are offered with full awareness of the germinal nature of the situation to which they are directed, but with equal awareness of the opportunities that could emerge.

Providing Integrative Medicine

As has been discussed, integrative medicine seems to be uniquely positioned to succeed in the experience environment described by Prahalad and Ramaswamy, especially if CDHPs expand sufficiently to make out of pocket healthcare purchases an important component of the market. Recommendations oriented to organizing integrative medicine for success of integrative medicine in this environment include the following:

- *Design*: Integrative medicine must continue to expand opportunities for consumers to co-construct their own health experiences on demand. Unlike traditional medical care, integrative medicine has been consumer-centric, rather than provider-centric. It must continue this orientation in the face of what could be rapidly expanding demand and pressures for increased efficiency.
- *Growth*: Because knowledge and experience differ across people, and over time within each person, integrative medicine must accommodate a broad array of sophistication in consumers. Especially as integrative medicine moves out of academic health centers and into mainstream clinical settings, its success will depend on its ability to engage people with widely differing characteristics in co-creation experiences.
- *Acuity*: integrative medicine must recognize that some patients will want to consume passively rather than co-create value, especially those experiencing acute illness or trauma. While extensive dialogue, consideration of myriad treatment options and discussion of various criteria of effectiveness are essential to managing health in integrative medicine, the application of that medicine to emergency or acute conditions will require more direct and unilateral decision-making on the part of the provider.

- *Continuous quality improvement*: advances in knowledge and technology will continue to provide opportunities to improve the quality of integrative medicine provided to consumers. However, current processes for improving the quality of healthcare present something of a paradox: while process improvement generally seeks uniform quality and homogeneity of experience, both integrative medicine and the experience environment described by Prahalad and Ramaswamy require heterogeneity of experience, tailored specifically to the needs, strengths and interests of individual consumers. New forms of quality improvement must be developed for integrative medicine.
- *Whole person*: a key tenet of integrative medicine is its focus on the consumer as a whole person. Addressing only a symptom or pathology is not sufficient – the consumer must be engaged physically, emotionally and intellectually if real co-creation is to occur. Individuation of treatment, careful selection from an array of therapeutic possibilities, and assessment of results against outcomes specific to individuals and families are essential components of this approach.
- *Relationship*: because it is impossible for a provider to participate in a co-creation experience unless that provider has a relationship with the consumer, integrative medicine must explicitly recognize both the social and the technical aspects of the healthcare experience. Unless a provider is able to quickly develop empathic relationships in which dialogue and trust can emerge, it will make little difference how technically skilled she/he may be.
- *Communities of consumers*: it will be increasingly unusual for a consumer with any continuing or chronic condition to engage a provider without first having some contact with a group of consumers dealing with similar conditions. Not only does this mean that interactions will be informed by the experience of many other consumers, but because word of mouth communication among consumers is so important, what transpires in the relationship between providers and consumers will be easily and rapidly disseminated among these communities.
- The billing function in integrative medicine providers will have to become more sophisticated as CDHPs become more prominent. Among other things, whether consumers are paying for services out of pocket or through an HSA will usually not be known. Clinics should develop capabilities of talking with consumers about their CDHP coverage and counseling them on how to best use resources, independent of expenditures for the clinic's services.

- Because it is essential for providers to understand the services they provide from the perspective of consumers, they should use mystery shoppers, customer surveys, focus groups and other means of gathering information directly from their own customers.
- Throughout, providers should build on the significant strengths that integrative medicine affords in the co-creation environment:
 - Relationships between providers and consumers.
 - The integrating role of the empowered consumer.
 - Continuous dialogue with consumers.
 - Broad diversity of approaches.
 - Tailoring approaches to the needs, wants and interests of individual consumers.
 - Focus on the whole person.
 - Clarity on the risks and potential rewards of various approaches.
 - Transparency and openness.
 - The healing environment as the arena in which this all occurs.

Marketing Integrative Medicine

- In the co-creation environment, healthcare consumers are far more likely to network and experiment than ever before, especially because, under CDHPs, their buying decisions will often involve expenditures from their pockets or their HSAs. In this new environment, word of mouth is the critical form of marketing: what other people or groups that are important to a consumer have to say about a provider will have significant bearing on buying decisions. Much of a provider's marketing budget must be dedicated to informing, supporting and influencing word of mouth among consumers. Conversely, unless word of mouth communication about a provider is positive, other marketing efforts will lack credibility.
- Success in this environment will require getting as close to the customer as possible. Extensive use of local market data and regular customer surveys will be essential. Prahalad and Ramaswamy suggest that when firms in the co-creation environment identify core competencies, they must include those of their customers.
- Because healthcare becomes a retail commodity under CDHPs, studying the lessons learned in retail marketing will be important. Many of these lessons address concepts that are largely foreign to marketing today's medical services: the importance of location, ease of access and parking, promotion, building traffic, add-on sales, cross-selling, branding, and others.

- Buying decisions in this environment are likely to be far more price sensitive than is the case when at least a portion of the price for a service will be paid by an insurer. While providing services that are paid for out of pocket is nothing new for most integrative medicine providers, successful marketing under CDHPs calls for marketing that includes very sophisticated pricing strategies. Among other things, these strategies should include the following:
 - Services at several price points, so that consumers can decide how much they want to pay.
 - Clear explanations for why services are priced as they are and demonstrable relationships between quality and price, so that consumers can compare services across providers.
 - Recognition that other providers will offer competing services, and that customer loyalty may not extend from one episode of service to another.
 - Positioning of providers among competitors along price and quality continua.
 - Recognition that providers compete not only with other providers of medical services, but with other options consumers have for the use of money.
- One of the ways to be successful in this new environment is to become a “nodal firm”—to serve as the central link between a network of consumers and a network of resources. Nodal firms provide intellectual leadership, build coalitions and forge pathways for products, expertise and information. However, because the networks of providers and consumers these firms deal with are extremely fluid, they must develop extraordinary capabilities in identifying value, marketing, understanding consumers, and balancing interests.
- Similarly, because there can be no co-creation without relationships, it is essential that integrative medical practices build effective relationships between individual consumers and key providers. It is likely that many of the more technically skilled providers in any medical practice are not people who are very skilled at relationship-building. In those practices, using people who are good at relationship building as an intermediary between providers and consumers may be helpful. For example, health coaches attuned to gender, age and ethnic differences may be able to bridge the gap between various populations of consumers and key providers.
- The value of communities of consumers in building business for an integrative medicine practice has been noted. It will likely be important for such practices to develop and support such communities as adjuncts to other marketing efforts. Input from groups of consumers with particular conditions will also be essential to the continuing design and improvement of services.

BIBLIOGRAPHY

Barrett, Amy and Michael Arndt, "Health Costs: Good News at Last," *BusinessWeek Online*, May 20, 2005.

Benko, Laura, "Consumer-Driven Plans Find Support From Employers," *ModernHealthCare's Daily Dose*, November 16, 2005.

Benko, Laura, "Most Employers to Offer Consumer-Driven Plans: Survey" *Modern HealthCare's Daily Dose*, October 10, 2005.

Brewer, Benjamin, "A Family Doctor Adapts to Health Savings Accounts," *Wall Street Journal* editorial January 24, 2006.

Cogan, John F., R. Glenn Hubbard and Daniel P. Kessler, "Not a Panacea . . ." *Wall Street Journal*, February 9, 2006, p. A12.

Costello, Daniel, "Hospital Bills – But with Interest," *Los Angeles Times*, December 12, 2005.

Dash, Eric, "Savings Accounts for Health Costs Attract Wall Street," *New York Times*, January 27, 2006.

The Economist.com, "Desperate Measures," January 26 2006.

Feldman, Roger, Stephen T. Parente, Jean Abraham, Jon B. Christianson and Ruth Taylor, "Health Savings Accounts: Early Estimates of National Take-Up," *Health Affairs*, November/December 2005.

Fonstin, Paul and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Healthcare Survey," *Commonwealth Fund Issue Brief #288*, December 2005.

Francis, Theo and Ellen E. Schultz, "Health Accounts Have Benefits for Employers," *Wall Street Journal* February 3, 2006, p. B1.

Goldstein, Amy, "Uncertain Cure: Early Reaction to Health Savings Accounts is Two-Sided," *Washington Post* March 12, 2006, p. F01.

Government Accountability Office, *Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan*, report to the Ranking Minority Member, Committee on Finance, U.S. Senate, November 2005.

Gratzer, David, "Congress Got Something Right!" *Wall Street Journal*, December 7, 2006, p. A18.

Hanessian, Brain G., Celia P. Huber and Shubham Singhai, "The Future Convergence of US Healthcare and Financial Services," *McKinsey Quarterly*, June 2005.

Health Savings Account Blog, "Study Shows Health Savings Accounts Can Help the Uninsured," <http://www.health-savings-accounts.com/hsa-weblog-arch/2006/01/study-shows-hea.html> January 3, 2006.

Herzlinger, Regina H. (Ed.) *Consumer-Driven Healthcare: Implications for Providers, Payers, and Policymakers*, Jossey-Bass 2004.

Inside Consumer-Directed Care, "Consumer-Directed Health Plans Could Fuel Growth of Flat-Fee Clinics," October 21, 2005.

Kaisernetwork.org, "Daily Health Policy Report: Coverage and Access," December 13, 2005.

Kaufmann, Geoff, Janet Guptill and Steve Pew, *Retail Medicine Models: Lessons Learned*. Powerpoint presentation to the Society for Health System Market Development September 2004. Provided by the senior author.

Krugman, Paul, "Medicine – Who Decides?" *New York Times* editorial, December 26, 2005.

Lee, Thomas H. and Kinga Zapert, "Do High-Deductible Health Plans Threaten Quality of Care?" *New England Journal of Medicine*, September 22, 2005.

Lueck, Sarah, "Bush to Seek Bigger Health-Savings Tax Break," *Wall Street Journal*, January 21, 2006, p. A3.

Lyke, Bob, Chris Peterson and Neela Ranade, "Health Savings Accounts," *Congressional Research Service Report for Congress*, March 23, 2005.

New York Times, "The Lopsided Bush Health Plan," editorial, February 3, 2006.

Parente, Stephen T. and Roger Feldman, "A Call for National Health Savings Accounts," submitted for publication February 2006.

Parente, Stephen T., Roger Feldman, Regina Levin and Jon B. Christianson, *What is the Impact of the Internet on Medical Care Use and Cost? New Findings from a Consumer Driven Health Plan*. Powerpoint presentation reporting the findings of a University of Minnesota project funded by the Robert Wood Johnson Foundation, June 2005. Provided by the senior author.

Prahalad, C.K. and Venkat Ramaswamy, "Co-Creation Experiences: The Next Practice in Value Creation," *Journal of Interactive Marketing*, Summer 2004.

Prahalad, C.K. and Venkat Ramaswamy, *The Future of Competition: Co-Creating Unique Value with Customers*, Harvard Business School Press 2004.

Rauber, Chris, "Most Health Savings Accounts are Staying Empty," *San Francisco Business Times*, June 12, 2006.

Robinson, James C., "Consumer Directed Health Insurance: The Next Generation," *Health Affairs* web exclusive, 13 December 2005.

Robinson, James C., "Health Savings Accounts – The Ownership Society in Healthcare," *New England Journal of Medicine*, September 22, 2005.

Robinson, James C., "Managed Consumerism in Healthcare," *Health Affairs*, November/December 2005.

Rosenthal, Meredith B., "Doughnut-Hole Economics," *Health Affairs* November-December 2004.

Rubenstein, Sarah, "Is an HSA Right For You?" *Wall Street Journal*, February 2, 2006, p. D1.

St. Paul Pioneer Press, "Most Execs Say Health Data Falls Short," Business Section April 11, 2006.

Wall Street Journal Online, "Review and outlook: The Healthcare Opportunity," February 1, 2006, p. A14.