Advisory Board

For health plans

Enhancing Member Communication to Drive Preventive Care Use

Four reasons members don't listen to recommendations for preventive care

Preventive care boosts plan revenue, retention, and growth

Yet members frequently skip preventive care tests and visits

Closing care gaps is vital for health plan revenue, membership growth, and retention.

Popular quality metrics rely on data from the Healthcare Effectiveness Data and Information Set (HEDIS) which tracks preventive screenings such as immunizations, cancer screenings, and flu shots completed by eligible beneficiaries. Employers, regulators, and members use these metrics to compare plans against each other.

In Medicare Advantage (MA), increasingly in Medicaid, and most recently in Individual market plans, members have access to quality ratings as they select and renew their plans. Increasing a plan's quality ratings is a key way to attract new enrollees and increase revenue. For example, a one-star higher rating is associated with as much as a 9.5 percent greater likelihood of member enrollment.

Additionally, some plans are eligible for financial rewards in the forms of bonus payments (e.g., Star ratings) or savings under value-based care contracts. In MA, plans that achieve a 4 or 5 star ratings are eligible for a 5% quality bonus payment.

Benefits of care gap closure to plans

Revenue

Medicare Advantage plans that score 4 stars or above can receive a 5% Quality Bonus Payment.

Growth and retention

A one-star higher rating has been associated with a 9.5 percent greater likelihood of member enrollment.

Satisfaction

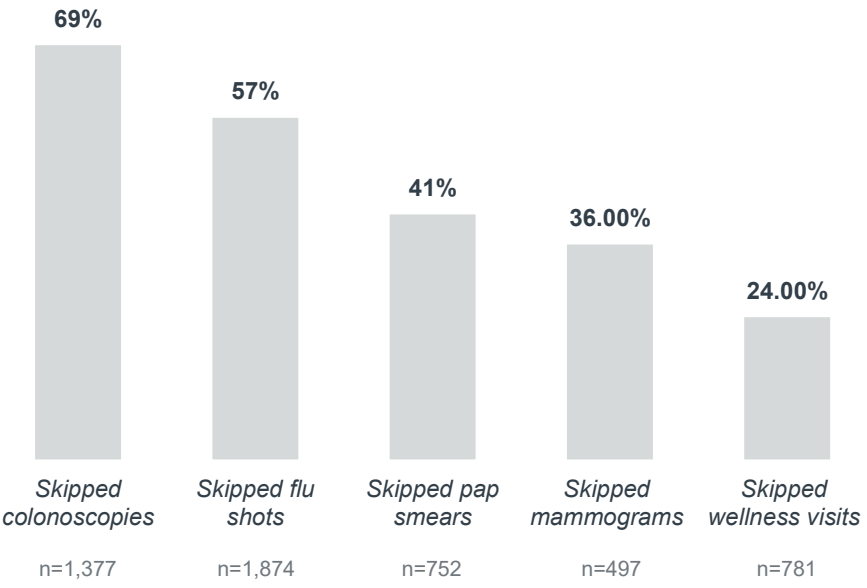
Members who receive and complete preventive screening score higher NPS.

Source: Navigant, "The Impact of Star Ratings on Rapidly Growing Medicare Advantage Market," February 27, 2018, https://www.navigant.com/insights/healthcare/2018/medicare-advantage-star-ratings-analysis; Advisory Board interviews and analysis.

Despite the demonstrated impact on revenue and loyalty, most care gaps are left unmet. Survey results from 3,255 respondents across different lines of business showed that most individuals don't seek out the preventive care their providers and plans recommend—69% of consumers skipped colonoscopies, 57% skipped flu shots, 41% skipped mammograms, and 24% skipped their annual wellness visits.

Majority of preventive visits skipped

Percent consumers with skipped preventive visits by visit type[1]



1. Did you have the following preventive care tests/visits.

Plans investing in multiple initiatives with no clear direction

Care experience frictions driving preventive care avoidance often unaddressed

Health plan marketers frequently tout the free preventive care services members have access to during enrollment, yet preventive care is often underutilized.

Members face a number of obstacles as they attempt to obtain the necessary preventive care services ranging from social determinants of health to inconvenient appointment times, and long wait times during office visits. Even the patients who have the resources and best intentions often forget to schedule their routine colonoscopies, mammograms, and wellness visits.

For most plans, it's challenging to determine what most consumers value and which interventions will make the greatest impact.

Common member barriers to care gap closure

Care experience frictions such as, inconvenient appointment times, long wait times during office visits

Social determinants of health and competing priorities such as, lack of transportation

Low perceived value of preventive care

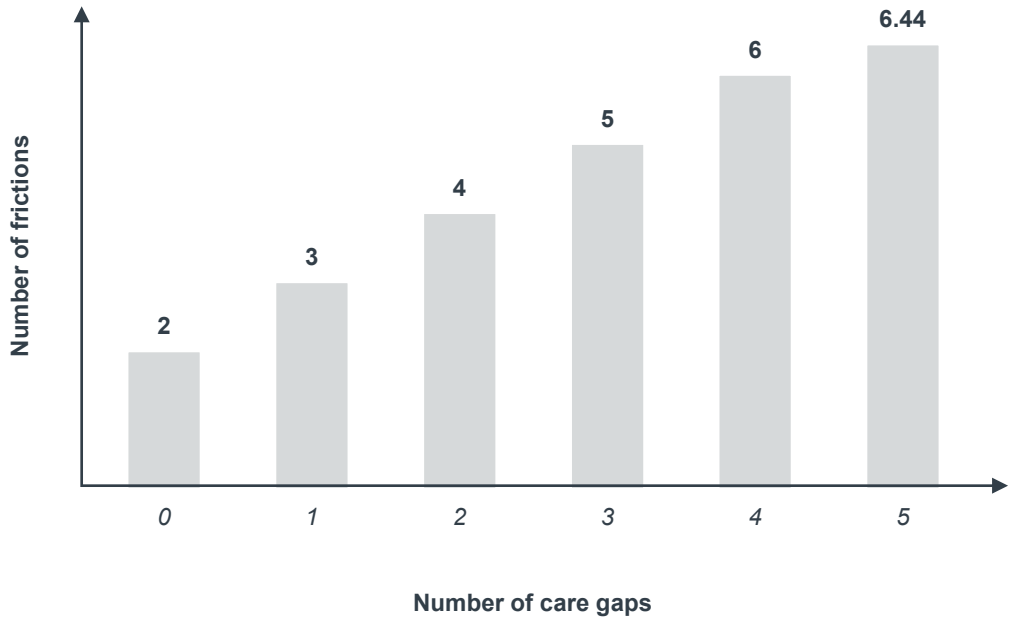
Insufficient incentives

As a result, plans invest in a number of care gap closure initiatives with no proven ROI, often too late in the year in a race to meet their annual HEDIS goals. This leaves care experience frictions that frequently deter members from seeking preventive care unaddressed.

Data shows that the more care experience frictions a member faces, the more preventive care recommendations they are likely to go against—members with 5 care gaps experienced an average of 6 frictions compared to 2 frictions for members without any care gaps. Investing in removing experience hurdles can make a tremendous impact on the uptake of preventive care services.

Majority of preventive visits skipped

Percent consumers with skipped preventive visits by visit type[1]



1. Did you have the following preventive care tests/visits.

Four communication enhancements that drive care gap closure

To help plans prioritize experience investments to effectively drive preventive care use, we surveyed more than 3,000 consumers on common frictions experienced while using care.

The following are four insights on how plans can enhance communication on preventive care to improve member experience and close care gaps.

1 Getting members to a provider or PCP is not enough, instead get the PCP to direct members to plan resources

ACTION STEP

Getting members to see a provider annually or select a PCP is not enough. Providers often don't have enough time to interpret, analyze, and disaggregate data that plans send them on care gaps. Yet, plans have made numerous investments in wellness and preventive care programs outside the PCP office. Plans should use the PCP to direct members to these plan resources instead of just relying on PCPs to close care gaps.

2 Members don't think preventive care is free; the biggest opportunity for plans in care gap closure is in price certainty

ACTION STEP

Members are often stuck with extra charges after providers order additional tests during their "free" preventive care visits, deterring them from future use. Members with a history of coverage and billing inconsistencies are also more likely to skip preventive care visits. Plans must therefore guarantee upfront costs to get members to use preventive care.

3 Annual wellness checks and flu shots quickly drive satisfaction if given with a seamless experience and immediate access to care

ACTION STEP

Getting members to their annual wellness visit or flu shot results in a dramatic increase in satisfaction. Members who skip preventive care cite unavailable providers and inability to schedule conveniently online as the biggest reasons they avoid care. Additionally, members with prior negative provider experiences are more likely to skip their preventive care visits and tests. Plans must introduce convenient preventive care sites that offer immediate access to care without harming the member's experience.

4 Highlight the value of preventive care and streamline member communications when sending reminders

ACTION STEP

Members who skip preventive care rank low perceived value and not receiving reminders as top most common reasons for not getting the care they need. Plans bombard members with several preventive screening reminders, leaving them overwhelmed and not compelled to complete the visits. Instead, effective reminders for preventive care must identify high priority action steps for members to complete and highlight the value of that visit.

Getting members to a provider or PCP is not enough

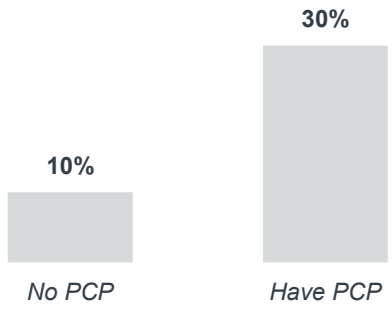
Care gaps are prevalent among members with PCPs and regular provider interactions

Most plans think that getting members to select a PCP or see their regular provider can boost member adherence to preventive care recommendations.

But our survey results show that otherwise. Getting members to sign up for a PCP or see their regular provider is not enough. The proportion of people with at least one care gap was roughly similar across groups with and without PCPs. And it's not because these members don't interact with the plan. In fact, members with care gaps have regular interactions with their providers and plans—29% of people with care gaps interacted with their plan through the plan website or mobiles apps, while 31% of members with care gaps called their plan directly using the phone in the past 12 months.

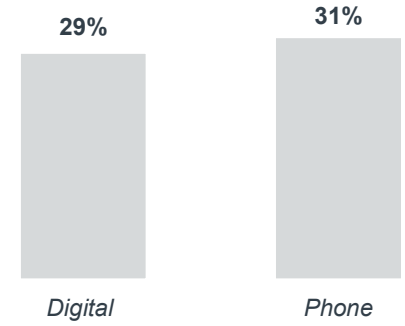
Having a PCP increases care gap identification but not closure

Proportion of people with at least one care gap among those with and without PCPs



Members with care gaps interact with their plans and providers regularly

Proportion of people with care gaps by mode of interaction with their plan



Despite plan efforts to financially reward providers for gaps closed or send data on which members to target, providers still fail to act. This means plan efforts fail to address the biggest reason provides don't use care gap data—resource limitations.

More than anyone else, members look to providers for health advice. However, providers are often too busy to sufficiently coach members and provide ongoing support. As a result, plans try to replace the provider as a source of health advice for the member, relying on impersonal and static demographic data to direct member actions, rather than using members' real-time clinical needs.

To influence member behavior, plans need to find ways to use the provider to make recommendations to members.

1. We defined a care gap as any discrepancy between recommended best practices for age and gender-based screening and tests for members (Including mammograms, colonoscopies, flu shots, an annual wellness visit, and a pap smear).

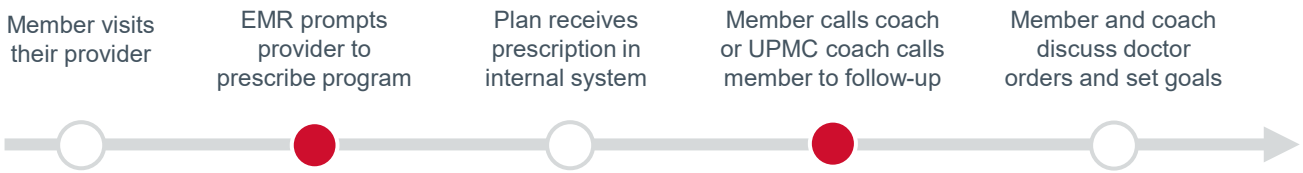
Use providers to prescribe plan wellness resources

UPMC integrates care gap information into EMR field reminders for providers

University of Pittsburgh Medical Center (UPMC) Health Plan realized that care management and wellness initiatives were most successful when providers introduced these resources to members, instead of the plan itself performing the initial outreach.

The plan integrated an extra field into providers' electronic medical record (EMR) that lets patient-centered medical home physicians, physician assistants, and nurses prescribe any "Prescription for Wellness" coaching program. These programs cover lifestyle improvement, chronic condition management, and shared decision-making for price-sensitive surgeries. UPMC offers these programs to members for free.

"Prescription for Wellness" Member Pathway



Condition(s):

- ❑ ADHD (attention deficit and hyperactivity disorder)
- ❑ Anxiety
- ❑ Asthma
- ❑ COPD (chronic obstructive pulmonary disease)
- ❑ Depression
- ❑ Diabetes
- ❑ Hyperlipidemia
- ❑ Hypertension

Sample scripting from coach

"Hi John,

My name is Jay Cochran and I am a lifestyle coach from UPMC. Dr. Stevens informed me after your visit yesterday that you needed support to reach your weight loss goals.

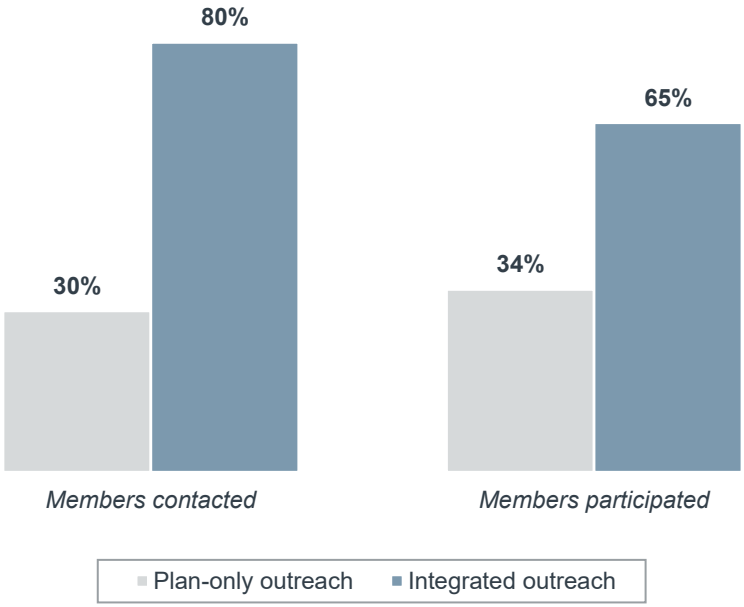
Can you share with me your concerns and what Dr. Stevens told you about health coaching so we can determine what is best for you?"

During the visit, providers instruct the member to call the UPMC health coach within 48 hours to "complete the prescription." If there is no inbound call from the member within 48 hours, the plan coach calls the member. The plan ultimately uses the provider visit as an opportunity to get the data it needs to deploy the right coaching to the member, and positions the provider as the main messenger to increase the likelihood members will follow through.

Within one year, the Prescription for Wellness program dramatically increased UMPC's wellness response rates, nearly tripling the percentage of contacted members, and almost doubling the percentage members who participate in the program. The prescriptions have also dramatically improved participants' health outcomes in tobacco cessation and weight loss.

UPMC prescription for wellness program member participation

Traditional outreach versus prescription for wellness



Costly confusion: Free preventive care

Members who skip preventive care tests have experienced cost surprises

Most health plans must cover the full cost of preventive care such as check-ups, vaccinations and screenings. But if the visit leads to services outside the scope of preventive care benefits, then the member will face either a co-pay or the full cost, depending on the insurance plan.

This is often a source of frustration for members who do not anticipate incurring any costs for these visits, and may have long lasting impacts on member decisions to renew their product or future care decisions. In addition, members now carry substantial deductibles that they must meet before coverage kicks in. This raises the stakes on what applies as a preventive service with no out-of-pocket cost versus a treatment for which the patient may end up paying in full.

Our results showed that members who skip preventive tests like mammograms, colonoscopies, and pap smears more likely experienced cost and coverage concerns such as higher than expected out-of-pocket costs, or providers not being able to give them estimates for the tests/services.

Members skipping preventive care have concerns about coverage and costs

"MY DOCTOR DIDN'T KNOW HOW MUCH CARE WOULD COST" is the

#5

Most common friction for members who **did not** receive a mammogram or colonoscopy

VS.

#8

Most common friction for members who **did** receive a mammogram or colonoscopy

Foregoing care because of high costs is a common occurrence—studies have shown that more than half of insured Americans skip care because it costs too much. However, results from our study highlight that when it comes to low-cost preventive care, members are concerned more about the uncertainty in costs.

Beyond tagging preventive visits as free, plans must provide estimates and guarantee upfront out-of-pocket costs to drive member uptake of preventive care regardless of provider care variation.

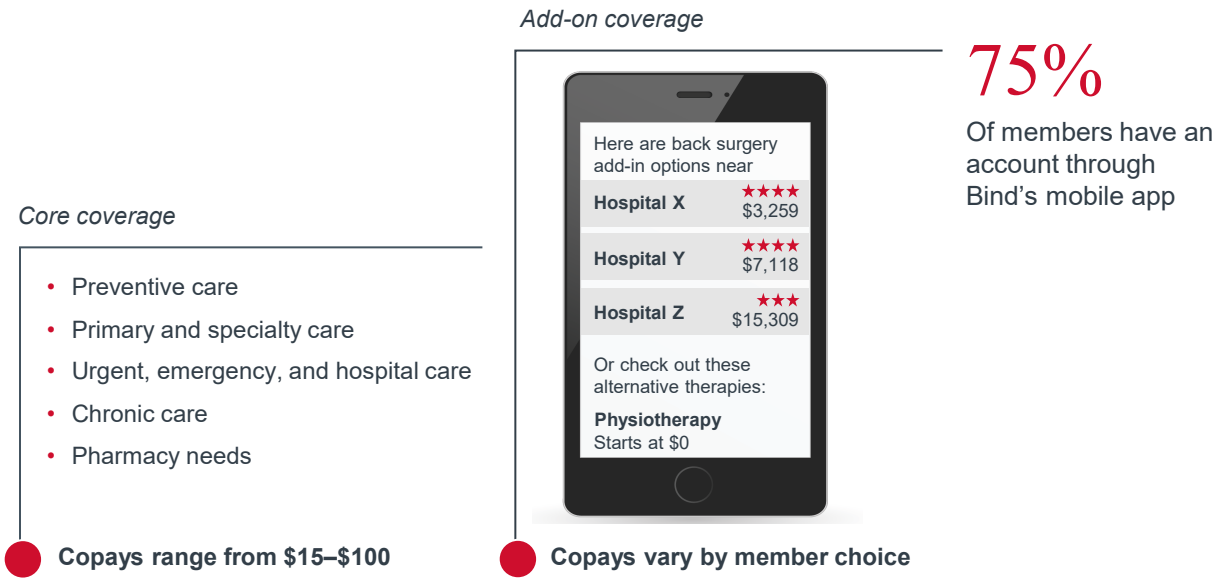
Practice extreme transparency

Predict procedure costs to guarantee prices for members up front

Bind Health has set out to eliminate the biggest plan vulnerability with members: unclear prices.

Bind is a new plan, currently operating only in the self-funded space, providing a new type of "on-demand insurance." Bind members pay low premiums for a core benefits package which covers most health care services, including preventive, emergency, and chronic care. When a member wants a planned service that isn't part of their basic coverage policy, such as back surgery, they must buy it as an add-on benefit.

Bind Health's simplified product design differentiates elective care



Bind adjusts the monthly premium when members purchase an add-on according to the service and specific provider—so when a member buys that coverage option, the member is also choosing the provider they'll use. Bind calculates these prices based on their historical data for that provider, including the range and variance of what that provider has charged for the service over the years.

Most importantly, Bind presents that price as the final, exact, subsidized price to the member, and it can be paid monthly, like a premium. Any deviation in the charges is absorbed by the health plan—fully eliminating surprise bills.

Right now this is possible only in the self-funded market, where coverage regulations are more flexible. But opportunities for this type of price transparency exist through demonstration waiver options with government programs, and changes to the individual market regulations might open up more flexibilities for this model.

Source: Bind Health, Minneapolis, MN.

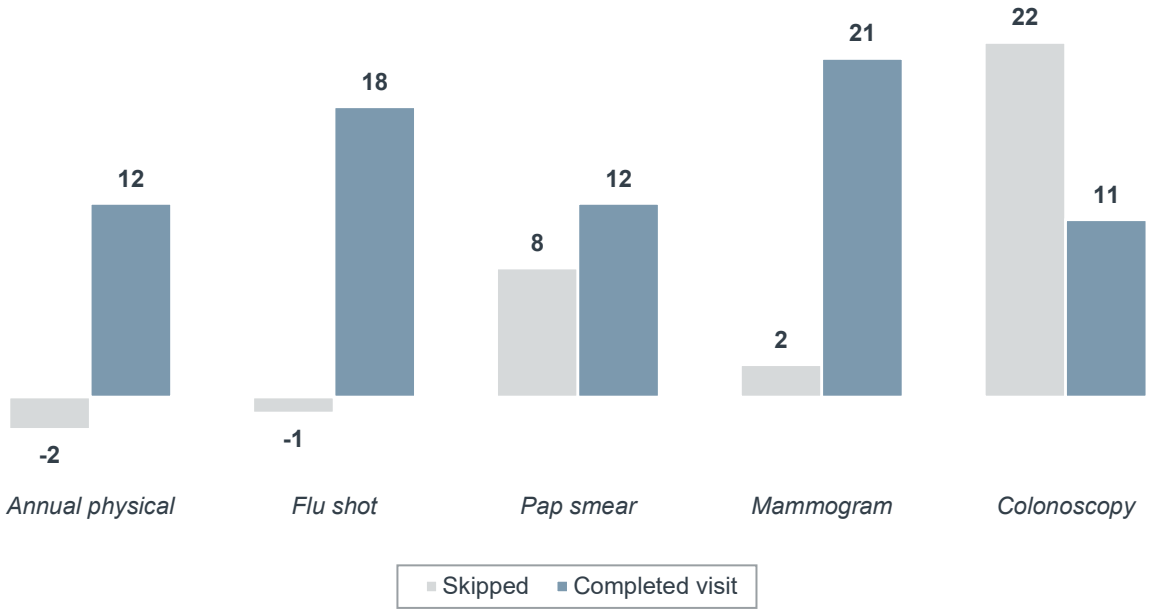
Annual wellness checks and flu shots quickly drive satisfaction

Inability to schedule appointments quickly is a persistent barrier

Completion of preventive care visits is linked to increased member satisfaction. Our data shows that member satisfaction is higher for members with completed preventive visits. Members who got flu shots experienced NPS gains of 19 points, while those who got their annual wellness test experienced NPS gains of 15 points.

Annual wellness check and flu shots quickly show value

NPS among members with completed visits vs. those who skipped



To avoid missing out on the satisfaction gains from preventive care, plans must address the experience frictions that deter members from getting preventive care.

Among those who skipped preventive care, the top cited reason was lack of access. Members indicated that they couldn't find appointments soon enough or schedule conveniently online. Additionally, members who skipped preventive visits more likely experienced negative provider experiences such as waiting too long on the phone to schedule appointments or waiting too long to receive care in the doctor's office.

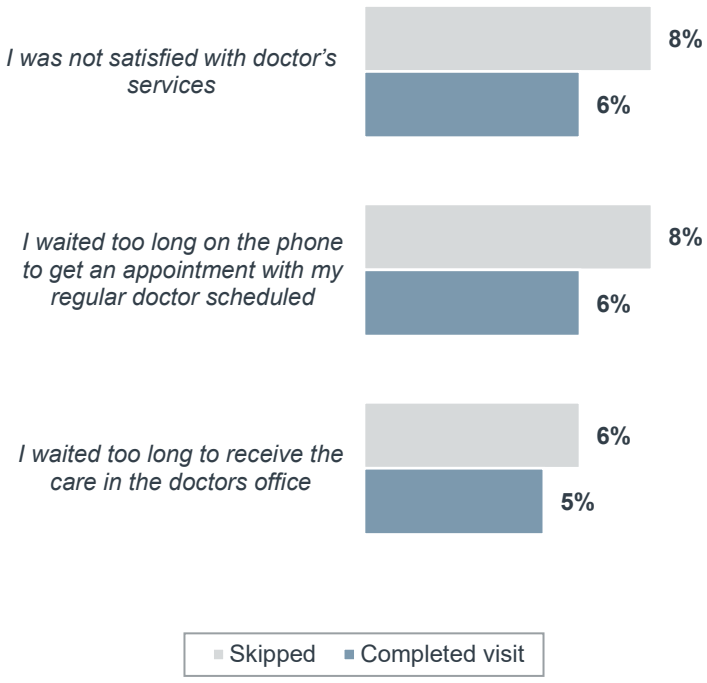
Top reported reasons for skipping preventive care

> "I couldn't get an appointment to see my regular doctor soon enough"

> "I couldn't figure out how to use my regular doctor's online scheduling tool "

Members with prior negative provider experiences skip wellness visits

Frictions experienced by members who completed an annual wellness visit vs. those that didn't



Link care, incentives, and rewards to convenient sites

Convenient shopping after diabetic eye exam increases compliance

Members expect convenience, quality, and transparency when choosing to complete their preventive care tests. Due to their extended opening hours and flexible scheduling options, retail clinics are an attractive option for members who are reluctant to wait for weeks before they get appointments with their regular providers or those who cannot access services during typical working hours.

For most insurers, these non-traditional sites of care open up opportunities for members to make health care decisions but if not well operationalized, such programs can harm a member's experience. Typically plans offer financial incentives to motivate members to receive preventive care but members often have to go through several steps to receive the reward. First, they have to set up the appointment, attend the visit, then wait for the gift card to be sent to them.

United Healthcare realized that linking the preventive visit, the member incentive, and the reward redemption could effectively encourage members to complete their diabetic eye exams.

"Coupons for Care" is a program for UnitedHealth care Medicare Advantage members in Tennessee. The plan provides transportation to and from Walmart, coupons for free eye exams for diabetic members, and a gift card to spend at Walmart. Members do not have to incur extra costs to attend their eye exam at convenient Walmart locations and are able to use the reward immediately after.

The company has since seen a greater adoption of eye exams by those members. Eye exam compliance increased by 50% after launching this program.

UnitedHealthcare's[1] "Coupons for Care" program

Member redeems coupon for a free eye exam at Walmart.

1

2

Member earns Walmart gift card, conveniently used for Walmart purchases at time of eye exam.

50%

Increase in eye exam compliance rate for diabetic members

1. Advisory Board is a subsidiary of UnitedHealth Group, the parent company of UnitedHealthcare. All Advisory Board research, expert perspectives, and recommendations remain independent.

Source: Kelly, Lauren, "MA Plans Can Utilize Community Partners, Providers to Reach High-Risk Members," Medicare Advantage News, July 2016, https://aishealth.com/sites/all/files/latest-issue-pdf/jul._21_2016/man072116.pdf.

Members don’t see the value of preventive care

Streamline reminders and highlight value to increase effectiveness

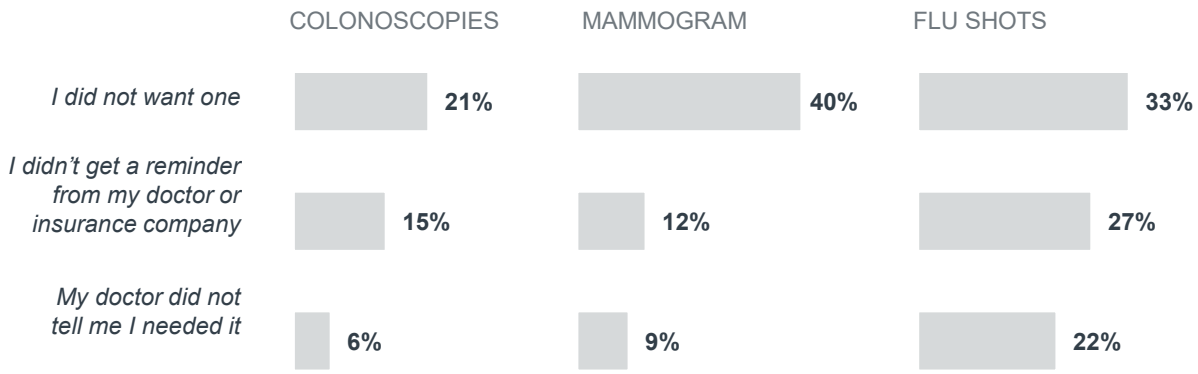
Reminders and notifications can help individuals manage their health and healthcare goals by alerting them to schedule preventive and screenings. Despite their potential utility, health plans bombard members with all of the different screenings, appointments, programs, and support that are available to them. This leaves members overwhelmed, unlikely to read any of the communication making it less likely they’ll do anything at all.

Results from our survey showed that the top two reasons members skip preventive tests is because they don’t think those tests are valuable to them and they don’t get reminders from their provider or insurer.

This means that plan messaging on preventive care is not enticing enough for members to read and does not address key member reasons for preventive care avoidance.

Members skipping preventive don’t get reminders and see no value

Reasons why members skip preventive care by visit type



This presents a significant opportunity for plans to better leverage patient reminders.

Rather than sending a slew of messages on preventive care sporadically to members, plans must deliver messaging when they have the members attention, highlight a few recommended tests, and outline the importance of the preventive test to the member.

Target reminders to members during care interactions

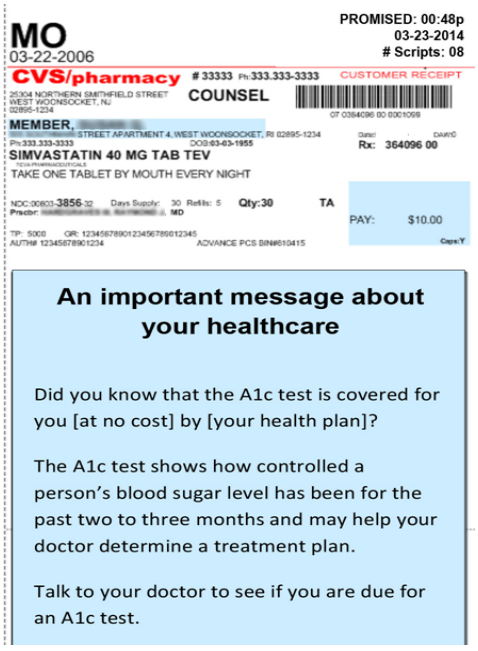
CVS prescription labels include preventive care reminders

CVS Health and Cigna realized that getting preventive care messaging to members in the right format at the right time can drive up preventive care use.

To help members get the most out of their benefits while shopping at their local CVS Pharmacy, they launched HealthTag® Messages on prescription bags. These messages serve as reminders for needed health actions by the pharmacist or clinician, and provide information on available Cigna Health and Wellness Coaching services included in the members' Cigna plan at no additional cost.

When a member goes to fill a prescription, they get a personalized "Health Tag" which highlights the highest priority preventive visit, it's value, and associated costs so members can receive it right there and then if possible. Health tags can be used to deliver reminders for immunizations and other screening tests.

Sample HealthTag®



Opportunities for cost savings

Increased access to primary care

Increased access to pre-diabetes screening

CVS HealthTag® program results[1]

45% Of Cigna customers' Urgent Care facility visits that could have been conducted at retail health care clinics

81% Potential reduction in health care costs per visit

This messaging captures the member at the moment when they're focused on their health and in a setting where they can do something about it. Cigna estimated that about 45% of urgent care visits can be conducted at a retail clinic, correlating to an 81% potential reduction in care costs per visit if they get members to use the retail clinic as a preferred site of care instead of traditional care sites.

Source: "Cigna And CVS Health Launch Cigna Health Works, A New Model For Customer-enabled Design For Affordable, Convenient Access To Pharmacy And Health Care," Cigna Press Release, June 2017, https://www.cigna.com/newsroom/news-releases/2017/cigna-and-cvs-health-launch-cigna-health-works-a-new-model-for-customer-enabled-design-for-affordable-convenient-access-to-pharmacy-and-health-care#rel.

1. Cigna Next Gen Access Opportunity Analysis Report, Greater South Florida, 1/2015–12/2015.

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