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Motivational Strategies Having Mixed Results

Providers Focus on Co-Pays, Premium Cuts as DM Incentives

Arguably the toughest obstacles that disease management (DM) program administrators face in implementing and managing DM programs are getting people to enroll in the programs in the first place and then getting those same people to comply with the treatment regimens once they're enrolled.

To overcome those obstacles, many DM program managers have begun using a variety of incentives. Eliminating co-payments associated with the delivery of DM services has emerged as one of the most common carrots that DM program managers are dangling in front of DM program participants to lead them down the path to good health management.

But does this strategy work? The jury is still out on the effectiveness of dropping co-pays, according to DM professionals contacted by *DM News*, because the strategy has produced mixed results for the DM firms and health plans that have embraced it. Nonetheless, it's certainly a strategy worth considering, they add.

To use it, however, you first need an understanding of terms and how the strategy is being used in the marketplace, DM observers advise. Vince Kuraitis, a principal with Boise, Idaho-based Better Health Technologies, does the honors. There are diametrically opposed schools of thought about the issue of co-pays, according to Kuraitis. "In what I'll call a 'purist' consumer-driven health plan (CDHP) point of view, the thinking is to move away from co-pays and toward co-insurance." Both of those terms require definitions, Kuraitis says.

With co-pays, the patient pays a fixed amount for each encounter or prescription, he tells *DM News*. "For example, you pay $10 for a prescription, regardless of whether the drug actually costs $20 or $200," Kuraitis explains. "Relating to DM, the issue here is whether the $10 co-pay should actually be lower than $10 or even free, with the thinking being that any amount of co-pay 'disincentivizes' patients with chronic conditions from adhering to prescribed treatment."

With co-insurance, the patient pays a variable percentage based on the actual cost of the treatment, Kuraitis adds. "For example, the patient pays 10 percent, so if the drug actually costs $20, the patient pays $2; if the drug actually costs $200, he or she pays $20."

This type of benefit structure is being advocated in many CDHPs, according to Kuraitis. "The thinking goes they want consumers to have 'skin in the game' and to experience the full cost of care so that they will become more discriminating healthcare consumers," he explains.

Unlike co-pays, people with chronic conditions are far less sensitive about how co-insurance payments might affect them, Kuraitis adds. "CDHPs are so immature that it is not at all clear how this issue will play out. But all of us interested in providing better chronic care to patients need to pay attention here."

As for how the no co-pay strategy is being used in the marketplace and whether it's effective, Art Taft, a principal with Greensboro, N.C.-based MedWorks, offers this perspective. "Some of the big employers cover the employee portion of the insurance purchase, which can be as much as $500 annually for Johnson & Johnson, for being a good citizen, which includes participation in appropriate DM programs. This translates into a monthly $38 reminder to keep working on your health and seems to be getting a very supportive response."

Dan Johnson, president of CDJ Consulting in Spokane, Wash., sees the dark side of dropping co-pays. He says he is "pro co-pay and anti coinsurance" when it comes to managing chronic diseases and conditions. "The co-pay is designed to reduce frivolous consumption with a slight charge per visit with global rules applied," he explains. "A co-pay can be managed fairly easily, should be a small amount of money, and the doctor's office should have some say in whether they collect it or not without worrying about the light bill. Co-insurance and deductibles, on the other hand, are a large amount of money -- $200 to $20,000. Collecting deductibles is a huge pain for providers."

But Johnson qualifies his pro co-pay stance to a degree. "People with chronic diseases have enough financial concerns to deal with without having to worry about co-pays," he says. "Chronically ill people have a ton of other out-of-pocket expenses and have been found to be economically disadvantaged. The last thing you, as a plan manager, want are additional economic barriers. Just not being sure what you will be charged will keep people away from accessing appropriate care."

John Leary, senior health plan consultant with Free & Clear Inc., a national tobacco cessation firm, says his company has had bad experiences with co-pays. "In tobacco cessation, we have found both co-pays and co-insurances to have a large negative impact on participation," he explains. "With one health plan in the Northwest, a program that included at $17.50 co-pay resulted in a modest participation rate. As a trial, they removed the co-pay, and participation rose tenfold. Re-instituting the co-pay reduced participation to the level prior to the co-pay removal."

Leary says his firm's research has shown that a co-pay is "just another reason not to try to quit despite the logic of saving up to $100 per month in tobacco costs. The logic from the nicotine addict's perspective is, "You want me to go through hell to quit and have me pay for it? No thanks.'"

Whether it's dropping co-pays or some other incentive, research on the effectiveness of using incentives to gain participation in DM programs and generate compliance supports the use of incentives in DM programming, says Robin Foust, a healthcare consultant with Zoe Consulting in Catawba, S.C.. "Each group is different as to what type of incentive will work," she tells *DM News*. "I think it was Gordian Health Solutions and likely others who have shown that incentives tied to reductions in premiums for participation tends to be the preferred incentive. However, the interventions are critical to making sure that external incentives to get participation turn into internal motivation to change and sustain change."

Foust says her firm typically conducts so-called "nominal groups" as a part of its needs assessments with employer-based clients in designing their health and DM programs. Nominal groups make use of pooled judgments of a variety of people with varied talents, knowledge, and skills to offer creative solutions to problems. By doing this, the resulting ideas are likely to be better than those that might be obtained by other methods, say proponents of the nominal group technique.

Asking questions about incentives is part of the nominal group process that her firm employs, Foust says. "Although we assess other areas from the nominal group process, we have also found this to be a cost-effective approach to assess what motivates employees to participate in programs and make changes. Invariably, the data/employees indicate that the preferred incentive is reduction in premiums or eliminating deductibles."

Earning time off usually is ranked second or third, and general incentives defined as trips, gift cards or certificates also get frequent mentions in the top 10, Foust says. "And, believe it or not, we get 30-40 ideas that individuals rank for what will incent or motivate them to participate in programs and make healthy changes."

Taft shakes his head at these and other similar incentives. "I personally wonder about incentives that pay patients to take care of themselves," he explains. "This suggests that there was not a big enough reason without the cash. I guess a long and happy life are not enough of a reward."

But that's human nature, says Michael Hoffman, a healthcare executive with Signet Diagnostic Corp., a Riviera Beach, Fla.-based DM firm that specializes in managing people with irritable bowel syndrome and migraine headaches. "I know [Art is] being rhetorical, but it is a point so obvious we joke about it, yet it is an aspect of human nature that over the years I have seen elude so many otherwise incredibly intelligent caregivers. Just because something lengthens life or reduces risk or mortal consequences or reduces symptoms does not mean the patient has the same perception as us about the "happier life" aspect. Often the very pearls we offer as, to us, obviously leading to these benefits are assessed by the patient as leading to a much unhappier life since they require sacrifice of attachments to pleasure-giving things. The more instant and reliable and repeatable the "thing" is, the lower the value of sacrificing it as it will lead in their minds to a loss of pleasure and unhappiness."

Hoffman says the power of "attachments" is very strong, and everyone, not just patients in DM programs, assigns cost/benefit value to anything they are faced with changing when it involves an attachment. The more attached the patient is to money, the more powerful a relative cash incentive will be, he says.

"That is just an elementary 'Cliff's Notes' version of what I am sure everyone feels is self-evident when we put it down in black and white," Hoffman tells *DM News.* "But it never ceases to amaze me how few caregivers actually accept these as facts of human nature and adjust their paradigms accordingly."

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