3.1 Population Segmentation by Age: Adolescents, Baby Boomers, and the Elderly

Segmentation of the adolescent population is common when considering issues such as esteem building, safe sexual behaviors, avoidance of alcohol, and non-violent conflict resolution. Although topics such as these may be appropriate for many ages, program development is usually targeted for a younger, school-age population, and programs are often offered through school systems. Similarly, television campaigns designed to address these issues use time slots and program content known to be popular with adolescent viewers.

As another population segment, targeting the aging baby boomer generation is popular for both healthcare business development and communications. In fact, focusing on this population segment has led to interesting product and service innovations in response to the needs of this population. As an example, the development and promotion of assisted living facilities reflects responsiveness to baby boomer concerns such as fitness and lifestyle. New facilities showcase state-of-the art fitness centers complete with access to personal trainers and various lifestyle management classes. Similarly, new construction and renovation of healthcare facilities demonstrates the importance of keeping the customer (the patient) central, especially when structural innovations reflect a patient-centered philosophy of care. Use of light, color, and plants shows concern for spiritual and emotional well-being as well as clinical health. Furthermore, the incredible interest of baby boomers in the use and expansion of the Internet for learning about healthcare issues is creating customers who are more knowledgeable about their own conditions and more inclined to ask questions of their providers. Healthcare providers may respond to these interests by giving patients access to particular web sites, electronic mail addresses, or provider-sponsored chat rooms.

A focus on baby boomers and the elderly is also frequently reflected in the selection of healthcare topics presented by the news media. Health-related news stories focus on topics such as new medical technologies and approaches to medical care that would be of interest to the middle-aged and aging population. Television networks commonly list web sites associated with their news stories so that interested viewers can obtain more information via the Web. As examples, while media coverage of common diseases such as diabetes or high blood pressure may not be considered flashy enough to make the news, the use of herbal remedies to prevent the common cold or help relieve arthritis pain are topics that seem to generate considerable interest. Similarly, stories on treatment innovations in heart disease, advances in cancer therapies, and the development of new pharmaceutical interventions are often highlighted by the news networks.

3.2 Segmentation by Geography: Health Reform Initiatives

Health reform initiatives provide excellent examples of the importance of geography in segmenting populations. The state of Hawaii, for instance, developed and implemented a near-universal health insurance coverage program in response to demands for employers to provide health insurance to all employees who work 20 hours per week or more. Hawaii’s employer mandate program resulted in providing more than 95 percent of the state’s population with health insurance and was supplemented by a state-developed gap group-insurance program to cover additional citizens. With this system, primary care is provided and total healthcare costs are reportedly considerably below the national average, despite the fact that the actual cost of living in Hawaii is
much higher than the average (Lewin 1994). Health outcomes, consumer satisfaction and healthcare expenditures have all been monitored and been found to be good, although outreach for traditionally underserved populations by means of community-based prevention and primary care programs with family support services are still considered necessary (Baumgartner et al. 1993).

Another state-based health reform initiative was developed in Oregon in the late 1980s and early 1990s. Concerned that rising healthcare costs were leading to implicit rationing of medical care, the state decided to make the healthcare rationing process explicit. Using a combination of public debate and economic analysis, a coalition of legislators, policymakers and healthcare professionals developed a prioritization plan for healthcare services. Based on the results of the discussions and analyses, the program produced a basic list of healthcare services to which all covered individuals were entitled. By defining this list of covered services, the program hoped to allocate healthcare resources more rationally among the individuals it covered.

Overall, the Oregon Health Plan was designed to increase insurance coverage for the working poor by expanding the use of Medicaid managed care plans. Legislation creating the plan was passed in 1989, and the program was officially launched in 1994. Within one year, the plan covered approximately 400,000 residents, including 130,000 working poor who would have no health insurance without this plan. However, the plan was not prepared for some of the results of its success. By expanding Medicaid coverage to individuals who would normally be uninsured, individual providers and hospitals were able to receive reimbursement for typically uncompensated care patients. However, some providers who now cared for patients who had previously been seen in public clinics were not prepared to deal with many of the social problems this population faced (Morrissey 1995). Health plans also faced unexpected difficulties covering their Medicaid managed care members and financial losses caused many HMOs to reduce or cease their business with the Oregon Health Plan. This has resulted in shifted coverage for many Medicaid recipients who had to struggle to find new providers willing to accept Medicaid reimbursement. Another problem has been the distribution of Oregon’s poorest residents. Managed care organizations have been able to successfully expand coverage to individuals living in densely populated areas or living near urban centers, but rural areas have been a problem. Instead, health plans have stopped providing service in rural areas because they are unable to make the business profitable. This has been true for both Medicaid and Medicare managed care programs. Regulatory solutions such as pay increases for health plans and physician groups are being considered, but the politics have not been resolved.


3.3 Segmentation by Geography: Regular Source of Care and a Medical Home

Geography is also somewhat related to the concepts of both a regular source of care and a medical home. The issue of a medical home is related to geography because, for the purposes of health management, geographic proximity becomes a key factor contributing to the selection of a site for receiving healthcare services. These concepts reflect the idea that individuals who have some place that they designate as their usual source of care, or their medical home, will tend to make better medical care utilization decisions than those who do not have a medical home. Instead, persons without a regular source of care often use medical care services less appropriately, such as using the emergency department (ED) for non-emergent cases or by delaying routine care, which may then result in the need for more intensive healthcare services later. One study of emergency department use found that persons who reported that they used the ED as their regular source of care were more likely to be of low income, to have been refused care by a healthcare provider in previous office or clinic visits, and to be those who misperceived that the ED was a lower cost site for care than a physician’s office (O’Brien et al. 1997). In general, persons who do not have a medical home tend to be the poor, uninsured, or homeless. Non-English speaking individuals also have difficulty naming a medical home because of problems accessing medical care related to language differences. Cultural factors may also be a problem, with some cultures supporting more personal responsibility for health rather than reliance on physicians for health monitoring and medical care.

The pediatric population is a group of special concern regarding a regular source of care. Despite attempts to expand insurance coverage to the nation’s children, 10.6 million children remained uninsured in 1996, or 14.8 percent of the population under age 18 (Census Bureau 1998). Lack of health insurance or a gap in health insurance coverage has been associated with lack of a regular source of care. A nationally representative study of children age three and under found that fewer than half of U.S. children had a single source of care during their first three years (Kogan et al. 1995). To address this issue, the American Academy of Pediatrics (AAP) specifically defined the concept of a medical home as a usual source of care for infants, children and adolescents. The goal of a medical home is to help make medical care “accessible, continuous, comprehensive, family-centered, coordinated, and compassionate” for the pediatric population. Further, such medical care should ideally “be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should develop a relationship of mutual responsibility and trust with them” (AAP 1992). This concept definition has been used to promote development of a medical home within the pediatric population, and has become the foundation of institutional and medical training programs designed to improve access to care for children. From a population health management perspective, supporting the promotion of a medical home can address healthcare utilization issues associated with lack of insurance and provide a reasonable avenue through which to promote health and healthcare management.


3.4 Segmentation by Communities: Idaho’s Healthwise Healthy Communities Project

Defining a population based on community is especially important in Idaho where whole communities have been using self-care handbooks and other population health management tools designed to reduce excess healthcare utilization. The Healthwise Communities Project was begun in 1995 to help educate and inform 280,000 Idahoan healthcare consumers. A special edition of the Healthwise Handbook (Healthwise 1995) was delivered to all households from four counties in southwestern Idaho that provided guidelines about home treatments and when to call a doctor. Residents were also provided with toll-free telephone access to nurse counselors, as well as access to a web site and self-care resource centers (Sasenick 1996). Workshops were also offered to teach skills to both consumers and doctors regarding self-care and shared care.

Evaluation of the Idaho demonstration project was funded by the Robert Wood Johnson Foundation and accomplished by Blue Cross of Idaho and Oregon Health Sciences University. Results of one study showed that emergency department utilization dropped substantially as a result of the implementation of these programs. Claims analysis showed 18.1 percent fewer visits to the emergency department as a result of the program. Total program savings estimates ranged from $7.5 million to $21.5 million in avoided visits to physicians and emergency departments (Healthwise 2002).

Physicians championed the initiative, and reportedly valued both the Healthwise Handbook and the additional data available through the program. Consumers reported that their doctors encouraged them to use the self-care handbook, and study results showed that those patients encouraged to use the books were more likely to do so. The Healthwise Communities Project showed how a community-wide population-based education program can change health behaviors and self-care practices resulting in both improved health and reduced costs (Healthwise 2002).


3.5 Defining Community in Health Services Research

The importance of defining communities has also been very evident in health services research. A major research initiative called the Community Tracking Study, funded by the Robert Wood Johnson Foundation and organized through the Center for Studying Health System Change (2002), has targeted 60 U.S. cities for evaluation. National surveys are administered every other year to households, physicians, and employers who are members of these target communities. These surveys are designed to provide empirical information about the local markets and health system at a community level. Of the 60 cities followed, 12 cities have been selected for more in-depth study with site visits and larger survey samples to enable extensive analyses of the communities. These cities were selected to provide a nationally representative profile of health system change across the U.S. Aggregated data from the study are used to try to answer research questions about how the health system is changing; how hospitals, health plans, physicians, and other providers are changing; how such health system changes affect people; and how insurance coverage, access to care, utilization, healthcare costs, and perceived quality of care are changing over time.


3.6 Segmentation by Community for Health Reform Experimentation

Community is also a critical notion when considering local experimentation to improve health services. Experiments have been developed to help manage population health and contain healthcare costs in many U.S. communities. For example, in Rochester, New York, resident and employer collaboration resulted in savings of hundreds of millions of dollars over recent years. The one million area residents benefited from a 50-year-old healthcare experiment that included coverage by a single payer, community rating, a spending cap, promoting HMO use, and cooperation among employers, providers, insurers and residents. This program was reportedly successful at controlling healthcare costs while also providing widespread access to care for area residents. A study comparing the perceptions of Rochester residents and employers about their healthcare system found that they were more satisfied with the health system in Rochester, NY than were Americans in the rest of the U.S. system (Leitman et al 1993). Similar experiments in other communities and cities across the U.S. are designed to evaluate area circumstances and adapt health services delivery to best meet the needs of the local population.

3.7 Employer-based Cost Containment Strategies

Within organizations, various strategies can address healthcare cost issues associated with the employee population. A recent study of personnel and human resources managers at firms with over 200 employees found three common approaches to healthcare cost containment: 1) utilization management within traditional indemnity plans; 2) offering alternative health insurance options such as health maintenance organizations or preferred provider organizations; and 3) concentrating on employee development related to improving healthcare purchasing decisions (Blum et al 1996). Developing employee-based solutions such as providing employee education classes and offering demand management programs are discussed further in Chapter 6 of the book.


3.8 Segmentation by Employer: Mental and Behavioral Health Issues

Coverage for behavioral healthcare is a growing concern for employers. The Mental Health Parity Act, which passed in 1996 and took effect in January 1998, mandated that large employers provide parity in behavioral healthcare coverage. This legislation requires those employers to provide the same level of coverage for general medical care as for mental health care, alcohol, and drug care, preventing such employers from applying different dollar limits to mental health coverage from general medical coverage. Self-insured employers are exempt from this law under the federal Employee Retirement Income Security Act (ERISA) of 1974, so the impact of this legislation on all employers is somewhat limited (Burnam and Escarce 1999). Nonetheless, the expectation that employers provide, or attempt to provide, behavioral health coverage at the same level of medical care coverage creates another major financial obligation for the employer.

Employers may attempt to address some behavioral and social issues through an Employee Assistance Program (EAP). EAPs focus on providing support for employee mental and behavioral health and provide confidential access to resources that can help employees prevent or solve problems. Typical EAPs offer services such as individual employee evaluation and referral, including referrals to consultation services, workshops and training sessions, and support groups. Targeted programs may include initiatives such as stress management, caregiving, or dealing with problems such as addiction, depression, domestic violence, or children’s stress. These initiatives are designed to help employees cope with issues that may seem unsolvable and seep into their work lives. EAPs may be included in a disability management strategy, as discussed in Chapter 9 of the text.

3.9 Employer Cost Containment Strategies: Purchasing Coalitions

Many options have emerged for employers concerned about reducing healthcare expenditures for their defined population of employees. In some areas, employers have banded together into group purchasing coalitions such as the Pacific Business Group on Health, the Washington Business Group on Health, and other organizations. By combining the purchasing power of both small and large employers, such coalitions strive to leverage buying power and improve administrative efficiency, while accumulating comparable performance information for health plans, physician groups, and hospitals. The Washington Business Group on Health (WBGH) was established in 1974 as a nonprofit health policy and membership organization and now represents 160 large national and multinational employers. Combined, WBGH employer members purchase healthcare for more than 39 million individuals. The organization’s goal is to promote performance-driven healthcare systems and competitive markets that help improve the health and productivity of both companies and communities (WBGH.org). The Pacific Business Group on Health (PBGH) has a similar focus on large employers with over 2,000 employees eligible for benefits, but also includes small employers with between 2 and 50 employees. Through employer-focused initiatives, PBGH strives to improve the quality of medical care while moderating healthcare costs. They helped pioneer employee health plan satisfaction surveys, and use analysis and collective purchasing power to try to improve the ability of employers to purchase health insurance based on value (PBGH.org).

Other market-based coalitions have also been developed to help employers contain healthcare costs. In Minneapolis, Minnesota, employer groups banded together to form what is now called the Buyers Health Care Action Group (BHCAG). Originally formed as the Minneapolis Buyers Health Care Action Group, the employer-owned and governed healthcare purchasing coalition offers a benefit program to consumers that strives to preserve and promote consumer choice. The stated purpose of the group is to improve healthcare quality, increase provider competition, increase consumer knowledge and responsibility for healthcare decisions, and enhance the efficiency of healthcare delivery (www.bhcag.com).

3.10 Insurance-based Criteria: PPOs

Another form of managed care is the Preferred Provider Organization (PPO) arrangement. Similar to HMOs, PPOs are also organized with panels of providers, and enrollees who sign up for PPO options have the ability to select providers who are not on the PPO panel with limited financial penalties. Financially, enrollees have an incentive to select panel providers, but the costs of receiving services from non-panel providers are also partially covered under this insurance option. While HMO members who choose to receive care from non-panel providers may be responsible for 100 percent of the cost of any non-panel care, PPO members will typically be responsible for their copayments and a limited percentage of the costs.
3.11 Health Plan Performance and NCQA

The National Committee for Quality Assurance (NCQA) provides key leadership in the area of health plan performance measurement, in addition to accrediting managed care organizations, managed behavioral health organizations, and other health organizations requiring oversight. The principal performance measurement tool utilized by managed care organizations is called the Health Employer Data and Information Set (HEDIS) and is a set of standardized measures used to compare and contrast performance among health plans. NCQA manages the evolution of HEDIS, helping to develop and refine its measures. The latest version, HEDIS 2000, includes more than 50 performance measures, including those related to heart disease, diabetes, cancer, asthma, smoking cessation, and counseling for menopause. HEDIS also now includes a consumer survey and a survey that examines parents’ experiences with the care of their children (www.ncqa.org). For individuals who are members of an MCO population, this oversight and attention helps ensure good quality of care as well as appropriate service and care options.