Disruptive Innovation: Value-Based Health Plans

F. Randy Vogenberg, RPh, PhD

Value and a Complex Healthcare Market

What Is Value to an Employer?
“Worth in usefulness or importance to the possessor; utility or merit.”
American Heritage Dictionary

“A principle, standard, or quality considered worthwhile or desirable.”
American Heritage Stedman’s Medical Dictionary

“A fair return or equivalent in goods, services, or money for something exchanged.”
Merriam-Webster’s Dictionary of Law

Like the everyday person, defining value for a payor of healthcare services varies depending on your perspective and application of the meaning. For a patient or employee, value means there is some worth in the usefulness of the subject or importance to possessing it. To a clinician, value relates to a standard of quality or a principle that is not only worthwhile, but also desirable. For an attorney, value is defined in contractual terms connoting an economic exchange or equivalence in goods or services. Thus, it is important for an employer, as a payor of healthcare services, to define value and its resulting business proposition to the organization’s mission or goals.

Healthcare has traditionally been a contracted services arrangement for employers who “purchase” it through health plans and/or pharmacy benefit managers (PBMs). Costs for these services, however, have grown over time along with continual double-digit increases in the cost associated for a healthcare plan that is purchased (fully insured) or funded through a self-insurance plan. Consequently, there is intense interest in the value associated with a health plan for the business enterprise and its associated value proposition.

Enter the Value-Based Health Plan

There are several so-called “early innovating” employers who began looking for alternative healthcare funding or contracting approaches that would address the cost trend and value question to their organization. Today, approximately 100 companies have begun or implemented various aspects of what is known as a value-based health plan, which may use a wide variety of tactical concepts under that umbrella.

The foundation for a value-based health plan starts with identifying the goals. Like any business plan, the employer, through their human resources (HR) team, must determine the organizational goals for their health plan. They should also identify goals that are in alignment with the mission and business goals of their organization.

Next come the objectives for the health plan. Based on the goals in the plan, clear, obtainable, and measur-
able objectives should be identified for implementation through the health plan. This can be done easier through a self-insured program, but can increasingly be accomplished with fully insured programs as part of a defined incremental strategy over time.

When the goals and objectives have been determined, the next step is to incorporate well-established patient behavior principles to design a health benefit program. This requires measuring and providing feedback, rewarding valuable or desired behaviors, assuring visible senior leadership and environmental supports throughout the organization, and engaging employees to promote their own accountability.

Although Pitney Bowes (PB) is among the most well-known innovative companies in this area, the strategy goes beyond PB value-based benefit design; Asheville, North Carolina, pharmacist interventions of counseling, collaborative care, and proactive medication monitoring; and Marriott or University of Michigan copay reduction and elimination tactics. There are health plans and PBMs who are talking value-based concepts from coast to coast.

There are several key messages from PB’s more than 10 years of experience in benefit design evolution (Table 1).

Messages 5 and 6 are perhaps the most important for an employer, because they relate to business strategy. For most employers who seek to implement a value-based health plan for their organization, they pursue it through some form of value-based benefit design. That may include some type of enhanced access to medical care or medications by tactics such as reducing the copay amount paid by the patient or pay-for-performance contracting with the provider network. It can also include some form of enhanced access to medications that have been shown to improve health outcomes for patients and that result in value to the employer, not necessarily the health plan, by lowering total healthcare claims cost.

### Table 1.

| 1. Most tools now give you a fine view through your rear window |
| 2. Identify key medical conditions using data |
| 3. Data are valuable even if you have little |
| 4. Benefits designs do drive consumer behavior |
| 5. Wellness/prevention should be redesigned to include care for chronic conditions and member engagement |
| 6. Prescription drugs, routine office visits, and screenings have value in managing chronic care |
| 7. Benefits planning can create a strategic advantage |
| 8. Benefits decision makers can make a difference |


Complexity and Technological Advances

Challenges to moving to a value-based approach relate back to human nature and the difficulty of dealing with complex issues or topics that may not be fully understood. In 1946, George Marshall had to deal with the enormous complexity of postwar Europe. The war and related events in those countries made it difficult for people to understand how they could rebuild their country or implement change. It kept people from acting on an issue, which was the postwar rebuilding effort, and made Marshall famous for his plan that provided a clear, understandable road map for people to follow.

Just as technology in computing that has advanced through companies such as Microsoft, technological advances also confer benefits by improving health and increasing longevity. These advances coupled with the complexity of healthcare in the United States make it even more difficult for the individual to understand, let alone select, an approach for reforming the healthcare system.

These and other employers have begun to assess their own value proposition regarding medical and pharmaceutical health programs, and what they are willing to pay or share for the cost of those benefits to their employees. A common thread among most of these employers is recognizing in their employee population where there may be an opportunity to contain the cost of their benefit program while achieving the...
same or better health outcomes that ultimately keeps benefit costs under control.

For example, Marriott and the University of Michigan followed a similar strategy as PB in looking at disease conditions with their treatments in their population to determine where the best overall results for cost and clinical outcomes could occur. For diabetes, it was in the unstable or brittle diabetics where creative benefit designs to lower financial barriers could be established. Such benefit coverage is important to keep their condition managed on an outpatient basis. To do so includes enhanced coverage for testing equipment and supplies along with medications for the primary diabetes condition as well as secondary conditions involving vascular, cardiovascular, and vision that are established co-risk factors.

Value-Based Messages: Disruption, Eruption, or a Sustaining Market Trend?

In the past decade, there was an accumulation of experience and general direction toward value-based health plans. A partial list of employers (Table 2) and other key stakeholders (Table 3) in the marketplace provide an example of not only the number involved in these concepts, but also the diversity and significant players who are currently engaged.

Based on the marketplace experience, a logical question for pharmacy-related benefits then would be whether value-based plans have really changed how medications are utilized in plan design(s), and whether we have moved beyond identifying cost alone when speaking of “value” in healthcare.

A conventional health plan program follows the tenets of insurance underwriting that are based on a large enough population sufficient to cover the cost of those few needing health services versus the many who do not, while all are paying insurance premiums based on the general risks in the covered population pool. The excess dollars paid into premiums are invested for meeting future estimated payments that are based on actuarial tables of morbidity and mortality in populations. This is a reactive strategy to meet the cost demands driven by the healthcare delivery system and innovation with little ability to “manage” populations.

A value-based health plan takes the conventional approach into a proactive scenario to increase the ability to manage a population and engage the patient in both their own health status and use of healthcare services. It is built on a base of clearly established goals for the health plan; objectives determined for their ability to achieve the stated health plan goals; and a behavioral-based benefit design that incorporates incentives and disincentives designed to achieve the health plan goals. Information sharing and feedback to plan members is a critical component to a value-based health plan to achieve a successful behavioral-based benefit strategy.
Many would argue that the market view of value for pharmaceutical products remains focused on who controls the drug. By extension, who controls the drug relates not only to physical distribution but also to the means by which to pay for the product. Applying the principles of a value-based health plan addresses both views of value for pharmaceutical products. Such an approach would disrupt the current interrelationships and functioning of the healthcare system around pharmaceutical products.

In further considering the concept of healthcare disruption, it is useful to compare the potential for so-called hyperdisruption, similar to what has been experienced by the information technology (IT) market. A disruptive event occurs when a technological advance results in a breakthrough application, such as the recent Apple iPhone that disrupts the normal market pace or movement. The disruption accelerates further market changes in addition to competition, followed by evolution, until the next disruption.

In early 2007, IT market watchers provided insight into what should be anticipated by 2010. By comparison, anticipated changes in 2010 in healthcare are offered in the same 3 categories selected to illustrate this concept for healthcare decision makers. The relationships across similar burgeoning industries are noted in Table 4. IT and healthcare provide understandable examples of change as well as challenges being faced by those inside and out of these industry segments.

Clearly we have seen marketplace “eruption” trends through “early innovating” employers and health plans along with local communities and state governments who are now exploring a value-based approach for employees who are plan members. In the past 10 years, at least a 10-fold increase in known marketplace value-based benefit coverage strategies has been reported. At national conferences today, many of the presentations cover various applications of a value-based strategy in the implementation of a particular benefit design or health program for employees.

Recent surveys, however, conducted in several cities have indicated a more conservative and incremental strategy that involves a more traditional approach than that represented by a value-based health plan. Survey results from one business group in the Southwestern states noted that familiarity and senior management interest in value-based benefit was high. Upper management interest in a value-based approach linked with how it can track to their organizations’ strategic objectives. HR and user understanding and access to medical and pharmacy claim data was low. How benefit change affected medical and pharmacy utilization was not clear. Finally, the 2007-2008 trend was thought to reveal “little to no change” for planned benefit design changes.

These results indicate the extent and type of disconnects that currently exist in health benefit plans and decision-making within an organization. HR-managed benefits are not in sync with corporate goals or objectives that may result in lost productivity, job turnover, or recruitment delays. Lack of accessible data and its interpretation limit the ability of HR decision makers to determine if a program is successful, a failure, or needs limited modification to improve on success.

### Table 4.

**The Information Explosion**
- Information technology will see a 100-fold increase in data
- Consumerism in healthcare and knowledge derived from the human genome project will result in a significantly increased number of applications

**Explosion of Devices**
- Mobile devices available and used in the market will double
- Biotechnology product availability and subsequent utilization grows 4-fold

**Transaction Explosion**
- Information technology has moved from concerns around platform stability for connection to concerns around interaction or interactive capabilities for users in multiple applications
- Healthcare claims adjudication or simple financial transactions transforming to more real-time, interactive transactions, incorporating components for a value-based health plan

Translating Plan Performance Evidence for the CFO

Private sector companies have moved toward a value-based health plan because it offers a more effective way to better manage healthcare costs as well as the health status of their working employees. The private sector is not alone in this debate, and with the intro-
duction of Medicare Part D, the prescription drug program for seniors, the Centers for Medicare & Medicaid Services (CMS) is on its own search for value. CMS has already moved toward creating a better value proposition with an integrated benefit program administered by the Medicare Advantage and Prescription Drug Programs (MA-PDPs) evolving over PDP stand-alones that represent an old paradigm, a silo cost-management tactic that is not cost-effective for the “ultimate” payor of all healthcare benefits. Value includes the cost of care (purchasing or payment) as well as management of care over time that produces both predictable cost with known outcomes. This view of costs associated with higher level care can have far-reaching implications for the commercial market as CMS continues moving toward a more value-based strategy.

Employers must begin moving beyond PBM/MCO population initiatives to control prescription utilization and cost initiatives that primarily benefit the third-party payor.

This strategy can be further demonstrated by the various payor population-based initiatives by third-party payors that are aimed solely at controlling medication utilization and costs from their perspective and not that of the employer payor. Initiatives are driven through plan design administered by third-party payors (health plans, insurers, and PBMs). Some are linked to a health risk appraisal instrument that could be useful in overall healthcare cost trend management; however, what is generally seen are efforts to maximize generic medication usage, especially through mail order, which benefits PBM stakeholders, and step therapy for the approval of medication usage that incorporates easy edits online during claim adjudication or what is known as a soft prior approval (i.e., a paper submission barrier to getting the medication).

Employers must begin moving beyond PBM/MCO population initiatives to control prescription utilization and cost initiatives that primarily benefit the third-party payor. Following a value-based approach, the strategy must acknowledge that healthcare costs are largely driven by a small group of patients with chronic illness, representing 5% of patients and 50% of health plan costs. From a management strategy perspective, the prudent path is to follow the dollar. One trend that will be uncovered is the rising cost share of the severely ill within a covered health plan population.

Healthcare spending falls into a few key buckets (hospital, medical/physician, pharmacy, and other). For pharmacy, the cross-bucket effects of more or less spending on medications can be dramatic. Using new biotechnology therapy as one example, the U.S. healthcare dollar can be broken down to show pharmacy representing approximately $0.12, of which $0.10 or less goes for traditional medications and approximately $0.02 for biotechnology products. Typically, the biotechnology category is aggressively managed, resulting in higher out-of-pocket costs and possibly requiring more approvals before or during their use. At the same time, these new technology-driven applications of genome knowledge represent what medical treatment has become. Many times a $0.01 to $0.02 slice of the healthcare cost pie is denied, requiring employers to pay almost another dollar of healthcare—a cost that could be avoided.

Another example lies in the impact resulting from plan design or human behavior barriers to taking medication that had been prescribed for a chronic medical condition. Many studies have documented the nearly $1-trillion impact on the U.S. economy resulting from the cost of lost productivity alone. For a company CEO, improved medication-taking behavior can result in some of the following quantifiable benefits:

- Improvement in employee health status and productivity
- Reduction in total cost of health
- Improved return on health investment for workforce
- Reduction in hospital and emergency room use
- Reduced short-term disabilities/workers compensation
- Employee accountability achievement (the employee no longer feels entitled to dependence on employer/health plan support) and employee self-management behaviors

A Call to Action

Many questions remain unanswered:

- Is it possible to rearrange the rocks currently arrayed in our health-related benefits, or are these boulders unmovable?
- Do employee wellness programs and retiree health go together for an employer anymore? If so, what is the value proposition?
• What is the impact of benefits tactics on human capital assets and what is the value proposition?
• Do acute versus chronic episodes of care require different strategies and how are they linked to recruitment/retention?
• What will the role of the employee benefit manager/HR department be in the future? Will that position be considered in or out of healthcare management?

Technological advancements challenge employers in many ways; however, consider that medication and medical technology is advancing patient treatment as well as escalating diagnostic costs today. Cost-sharing burdens from medication formulary management strategies are not always advantageous to an employer and lack a value-based behavioral plan component beneficial for the employer.

Examples discussed in this article on value-based health plans demonstrate that achievement of value is or should be a major part of your business strategy. Data alone are not sufficient. It is important also to know how to aggregate data and interpret them. The goal is to change value proposition by truly tying benefit designs for enhanced outcomes performance to behavioral-based health plan goals.

Costs continue to increase while the issues remain the same. There is an employer opportunity to be proactive and “disrupt” the marketplace to its advantage. An employer or health plan sponsor must (1) understand the total cost. This is important for a value determination and represents the shift from traditional silo cost management to a total cost of care model; (2) understand plan members’ behaviors using their own data to create a value proposition that can work; and (3) finally, determine if their healthcare advisor(s) provide innovative strategies and solutions. There must be a positive alignment and direction for the health plan program to your business goals and objectives.

For inquiries or comments, please e-mail editorial@AHDBonline.com.

AHDB Stakeholder Perspective

Value-Based Drug Benefit: Implications for Manufacturers

The impact of value-based drug benefit designs on manufacturers will depend on how quickly individual firms adapt their business thinking and communication strategies.

Until recently, the path to success for a drug manufacturer was based largely on product novelty, physician-centric marketing, and pricing strategies, balancing the unit prices and concessions against formulary position. To maximize market share and margins in the world of value-based drug benefit designs, manufacturers will need to (1) demonstrate the clinical and economic case for each product and therapeutic class; (2) build absolute and comparative evidence on a continuous basis; (3) develop new value-based pricing models and market partnerships; and (4) communicate far more effectively with public and private payors.

For many firms, this will require a significant, even scary change in thinking and tactics, payor-centric communications, comfort with a massive increase in transparency, and a greater willingness to partner. Therefore, while the financial risks of moving to a value-based world are daunting, ultimately the greatest challenges are intellectual.

Value-based drug benefit designs will pose the greatest challenges to manufacturers with product lines (or pipelines) dominated by “me too” drugs; rigid, risk-averse organizational silos; and outdated, prescriber-centric communications.

Kip Piper, MA, CHE

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