EXECUTIVE SUMMARY

ANSWERING THE BIG QUESTIONS OF VALUE-BASED BENEFIT DESIGN

How does it work? Does it work? And how do you start?

APRIL 13, 2011

The goal of value-based benefit design (VBBD), value-based insurance design (VBID) and value-based design (VBD), is to help individuals make better decisions about health care by designing benefits that reward them for doing so. It has long seemed to be the solution to lowering health care costs, but there are still a lot of questions.

Employers and others came together to look at these questions at an Alliance Learning Circle event, *Answering the Big Questions of Value-Based Benefit Design — How does it work? Does it work? And how do you start?* on April 13, 2011.

The event included four sessions on the topic:

- **Value-Based Insurance Designs for Sustainable Health Improvement**, by John (Jack) Mahoney, MD
- **Getting the Most Out of Your Healthcare Investment: Essential Value-Based Insurance Design Considerations**, by Jan Berger, MD, MJ
- **Value-Based Benefit Designs for the Pharmacy Benefit**, by Wayne Salverda, R. Ph.
- **A Practical Approach to Value-Based Purchasing: A Local Employer's Perspective**, by Jeff Kluever

The Difference between a Financial and Value-Based Approach

The strategy between value-based solutions and those that are financially motivated is fundamental, according to Dr. Jack Mahoney, formerly the strategic health care director at Pitney Bowes, and so the tactics must be equally different. In value-based design, employers are looking at the total picture and are attempting to optimize the amount of benefit gained per dollar spent, as opposed to conserving resources by decreasing utilization. Other differences include:

- Value-based design puts a greater emphasis on the total picture, including direct costs, as opposed to management of each line item.
- Financial approaches often focus on cost sharing based on the acquisition cost of the service or product. Value-based design subsidizes effective services through lower out-of-pocket exposure and decreasing or eliminating subsidies for services that are deemed ineffective.
- Value-based design also varies based on individual's needs, but financial plan designs are applied uniformly to all members.

> "Value-based benefit design is not a panacea," Mahoney said. "Start with the basics – the direct and indirect costs of disease and design a plan and incentives that can be modified."

What Does the Research Show?

Research has showed that reducing costs for prescription medications and combining that with a disease management program can increase medication adherence, or the number of people taking medications as prescribed.

Mahoney described a study that looked at the effect of lowering out-of-pocket costs for diabetic medication at a large firm. Half of individuals were offered a VBBD plan that lowered coinsurance for all diabetes medications to 10 percent for generic medications and 35 percent for non-preferred diabetes medications. A comparison group was offered a traditional three-tier pharmacy plan with 10 percent copayments for generic drugs, 20 percent copayments for preferred brand-name drugs, and 35 percent copayments for non-preferred brand-name drugs.

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The program was offered to employees, spouses, and dependents covered under the medical plan. All had the opportunity to participate in a diabetes disease management program that offered targeted mailings, workbooks about the disease, telephone outreach and periodic monitoring. Individuals were allowed to opt out of the disease management program, which allowed for the researchers to see the difference between VBBD with and without disease management.

Results revealed that the VBBD and disease management program had medication adherence rates that were higher than those in the disease management-only group. The VBBD and disease management group had higher medical possession rates, defined as the percentage of days that an enrollee had the prescribed medication available (determined by when the prescription was filled and how many days were supplied).

For patients in the VBBD-plus-disease management group, the medication possession ratio for oral medications rose 3.7 percent above the ratio for those not in the value-based program in the first year after implementation. In the second year this increase was 4.8 percent, and in the third year it was 5.8 percent above the ratio for patients not in the value-based program. The group who had disease management alone increased medication possession as well, but at a lower level. This group began to see their rates lag sometime near the end of the second year of the study.

The study also looked at adherence to other good care guidelines for diabetes, such as visits to physicians, HbA1c, lipid tests, and urinalysis. Again, the group with the VBBD in addition to disease management had higher numbers here than the disease management-only group. Even though these were not mentioned in the design of the benefit, the researchers guess that as the group with the VBBD began improving their adherence to their prescription drugs, they became more involved in their care and saw a greater value from following these other recommendations. The disease management-only group did not see similar increases.

In analyzing costs, the researchers saw an increase in prescription spending throughout the study years for those in the VBBD plus disease management group, as expected due to higher adherence to medications. However, decreases in diabetes-related medical spending offset prescription increases to produce an overall decrease in diabetes-related costs which decreased in the first year and showed a further decrease in each subsequent year. They also saw a reduction in medical and prescription costs for all causes, specifically related to cardiovascular costs.

Both groups also saw a reduction in the cost of inpatient care, but only the group with the combined VBBD and disease management saw a reduction in outpatient costs.

Key Lessons Learned from the Research

- Results showed the combination of VBBD and disease management had a greater impact on prescription use and adherence to recommended medical guidelines than disease management alone.
- The effects were not only sustained, but grew over time
- The program showed modest cost savings over three years

Possible Improvements for New Programs based on the Study:

- Patient engagement and communication tools are important
- Focus should be on individuals gaining self-management skills, not just managing them
- Primary care providers play a critical role

Taking a Step Back: Basic Principals of VBBD and What Does it Take to be Successful?

"Chronically engaged," says Jan Berger, MD, MJ. Individuals don't just need to be engaged, they need to be chronically so. It's one of the conditions she says it takes for VBBD to work.

"We need to be thinking about health in our lives," she says. "Not health care." But the truth is that most individuals don't know much about health, much less VBBD. In a study where individuals were part of a one-year VBBD experiment, many not only had no opinion but also had no idea what it was.

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The Midwest Business Group on Health (MBGH) of Chicago did a study which looked closer at the perceptions around VBBD. They found that individuals have an interest in taking an active role in their health, but many don't have the money, time or know-how to do so.

Other findings showed:

- Individuals are skeptical that employers will steer them to the best choices for their life.
- Study participants wanted choice and control.
- Individuals found it counterintuitive that it is possible to pay less for higher quality or that there is even a significant difference in the quality of different providers.
- Patients trust their doctors.

To overcome an individual's bias and lack of understanding about VBBD, successful programs must have upper management buy-in. But because the members of the C-suite can change, it is important to not just have one member on board, but all members of the executive team. That way if one member leaves, there will still be support.

She also believes that expectations of return on investment (ROI) must be realistic. A good VBBD program can yield solid ROI, but there are other reasons to do it that can't always be measured. Competitive advantage and productivity improvements are also valid reasons.

"Employers need to practice stealth health. Individuals are given choices, but healthy choices are cheaper," says Jan Berger, MD, MJ.

Data is Key

The starting point of any good VBBD is data, according to Berger. It must drive all decisions. But that's not all. Data must be part of the plan along the way to see where re-calibration is necessary. This includes all forms of data; both claims-based such as demographics, medical and pharmacy, laboratory values, workers' compensation, productivity, behavioral health, and disability, but also self-reported patient data such as health risk assessments and quality of life.

Of course not all data is readily available. Access and collection issues, differing data element definitions, systems that don't communicate, and varying data integrity can all be a barrier. For this reason, it is important to make sure that individuals and vendors know that they will all be working together. Berger suggests holding a data summit where those with sometimes different interests come together to understand the need to work together. While data isn't perfect, it's still the best thing available to develop a plan that meets the needs of the employer and that has the best chance for success.

Incentives: What Works?

According to Berger, to work, incentives must be used smartly and continuously throughout a program. They must also be designed to match the culture of an organization. Often, they are used to get people to engage in behavior they may not do otherwise.

But not all incentives are as successful. A 2009 study by Buck Consultants showed that only 37 percent of incentives were moderately effective at influencing behavior change in employees. Another 25 percent were minimally or not effective at all. But according to Berger, the real problem is that many are not even measuring the success. In the survey, 21 percent didn't even know if their incentives were effective or not.

Now that's an Incentive

One organization rewarded individuals to take a colonoscopy. The incentive? A free day off. After all, who wants to use their own time for this test? It made this avoidable test easier and rates increased.

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When it comes to incentives for their coworkers, individuals think it is okay as long as their peers are receiving the benefit for achieving a behavior change, such as quitting smoking. On the other hand, when their coworkers were provided incentives for things like chronic conditions, such as diabetes, their peers didn't feel it was fair. They wondered why they weren't being rewarded when they already were maintaining a healthy lifestyle. In the MBGH survey, 48 percent of respondents wanted the same chance as their coworker to reduce their costs.

A Case Study

As a case study, Berger offered Polk County, an employer that covers more than 8,000 individuals. The employer offered a new program to individuals on the plan with diabetes or high blood pressure in which they signed a Contract for Care where they agreed to meet face-to-face with a nurse and a pharmacist to discuss their condition. They also received time off for follow-up visits with the nurse and pharmacist where the individual received education and information on how they could improve their health.

If the individual enrolled in the program and completed the initial and follow-up visits they received a $0 copay for diabetes and/or hypertension medications and supplies. For some patients this could be worth more than $100 per month if there were two patients per family. This was equal to 10 – 20 percent of some patients' monthly net income. If the individual was non-compliant with their Contract for Care, they were taken out of the program.

The results generated improvement in health status across the board for all participants. Individuals showed health improvement and drug adherence increased slightly. In addition, hospitalizations decreased and emergency room usage decreased for a total savings of $369,735, about 1.6 percent of the organization's total annual spend. The employer also saw improvements in productivity, in the form of reduced presenteeism and absenteeism.

Communication Brings it All Together

When communicating to employees about a VBBD plan, more is better, but what you say is also important. According to Berger it's important to ensure individuals understand that their information will be kept private and that it will not be used against them or affect their job. Other important messages include:

- High cost does not equal high quality.
- The plan is a benefit to all because it will create more money for all (if you are only focusing on one target group).
- Communicate what's in it for the individual.
- Make it easy, explain the why and how.
- Target communications to the individual's life stage and gender.
- Use employer champions to send message as individuals trust their peers.
- Prioritize face-to-face communication and use print communications as a secondary medium.
- Educate physicians on what you are doing as many participants will go to their physician for an opinion.
- Use plain language and repeat the message a number of times.
- People learn in different ways so your communications should be geared to those needs.

What's Next?

Berger says we're only beginning to scratch the surface of what VBBD can do. She expects to see it move into other areas such as maternity, mental health, oncology, and end-of-life care. But no matter where VBBD is applied next, employers must have reasonable expectations. It will not cut costs by 50 percent, but it can do well if you keep your population in mind, set reasonable expectations, utilize behavior modification tools, and communicate effectively.

What about Prescription Benefits?

The third speaker at the event, Wayne Salverda, R.Ph., senior clinical services director at WisconsinRx/National CooperativeRx looked at the considerations of VBBD connected to the pharmacy benefit.

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Features of a Sound Plan Design

A sound plan design is core to any VBBD plan. According to Salverda, sound value-based prescription plan designs focus on encouraging generic use by offering low copays for them, creating brand copays that are 5 to 7 times the cost of the generic copay, and offering a more favorable cost share for generics.

He also stressed the importance of supporting the formulary by creating a differential of at least $15 between tiers, with some suggesting as much as $25. He also suggested a 1.5 times difference in coinsurance between tiers. For example, 20 percent for tier 2 and 30 percent for tier 3.

Finally, the benefits should be aligned with desired outcomes. For example, the plan should offer smoking cessation solutions if that is a goal for the population.

Developing the Rx Component of a VBBD

An employer's prescription benefit management (PBM) partner should be able to supply the data needed to create the plan design. If employers are not receiving a quarterly report from their PBM, they should ask to receive one. This report will show adherence measures and top drugs by gross cost and day's supply. One important component to look at is the availability of generics versus utilization of those generics. This report can be supplemented with other program information, such as wellness and disease management information.

In developing a plan, employers can choose a selective or broad approach. In the selective approach, specific conditions, such as asthma, high cholesterol, diabetes, or hypertension are selected as targets for prevention. In a broad approach, preventive drug lists are used to drive consumer-driven health components such as high-deductible health plans or health savings accounts.

An Employer's Perspective

Like many employers, Journal Communications, Inc. once struggled with the question of how to provide affordable coverage, manage the impact of medical inflation on their budgets, and improve the health status of their employees. To achieve it, they introduced a value-based prescription program for their medical plan participants.

The program started in 2008 with a focus on diabetes. Jeff Kluever, Journal Communications risk manager, described the program. Designed after the Asheville Project model, the program trains participants to manage their condition and learn about their condition through face-to-face education, assessment, monitoring and follow-up with pharmacists.

Participants received 100 percent coverage for diabetes prescriptions and supplies. Subsequent variations on the program focused on cardiovascular issues, asthma and depression. In these cases, participants received a 50 percent reduction in copays for cardiovascular, asthma and depression prescriptions.

Patients met with a pharmacist about four to six times a year for 30 minutes to an hour. Appointment location was flexible and could be held at a confidential work location, the pharmacist's practice site, a private location or via Skype for those in a remote location.

Patients agreed to be open to learning more about their condition and its treatment and schedule and complete all clinical measurements and laboratory tests. They were also required to give 24-hour notice if they were unable to keep an appointment.

Communication is Key

Kluever said communications focused on four key areas:

- The prospect for improved health status
- The opportunity to save money
- The likelihood of fewer complications and associated out-of-pocket expenses
- Improved knowledge and more control of their disease

Patient sign-up involved the following steps:

- Invitation to a meeting or webinar
- Application available online or mailed to the participant
- Patient returns application to eligibility manager
- Benefits for reduced copays activated shortly after first visit

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Administration of the Plan
Journal Communications used three partners to help manage the program: Humana, their TPA; Piedmont, their pharmacy network; and Wage Works, their eligibility vendor. All three partners worked together, ensuring that data was shared and the efforts were coordinated.

Humana identified which program would make the biggest impact and provided prescription and medical reports to Piedmont. They also built the plan design, administered the medical and prescription benefit, and reported on progress.

Piedmont provided the network of clinical pharmacists who worked directly with individuals to manage their condition. Much of the communication was focused on ensuring the patient knew how to take the drugs correctly, for example the correct dosage, at the right time, and in the right way, such as with or without food. They were also able to connect the efforts of the patient's physician, health educators and others in the community to help the individual.

Finally, Wage Works was the point of contact for communications to participants. One of the biggest things they were able to do was ensure that individuals in the program understood that their information was being kept confidential. They also served as the service center for all questions.

Results of the Plan
Overall the plan resulted in reduced costs to Journal Communications and better health outcomes for those who participated. There was a 44 percent reduction in total paid for those in the program compared to a 22 percent increase in spend for those diabetics who didn't participate. Overall, there were fewer hospital admissions, reduced length of hospital stays, and fewer emergency room visits.

Results are still being compiled, but early results show that patients gained better control of blood sugar, blood pressure, blood lipids and had consistent peak flow readings. They also showed positive PHQ9 results, a survey used to determine depression levels. Care of feet, eyes and kidneys also improved, but there was no improvement in body-mass index.

The Next Iteration
A member of the Business Health Care Group of Milwaukee, Journal Communications is part of a larger group working toward the implementation of VBBD. As this group shares information with each other, they are learning what works and how they might structure programs in the future.

According to Kluever, he sees a greater interest in disincentives in the future, such as implementing an opt-out model, where everyone will be in the plan unless they actively decide not to be. Doing so could result in consequences such as making an individual ineligible for plans other than high-deductible plans.

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