

Index To The Report

Getting Value From Compliance 52
University Of Michigan Program 53

Jewish Federation's Plan..... 53
Diabetes Ten City Challenge 54

Obtaining value for the dollars spent, rather than attempting to save money through cost and risk shifting and ultimately boosting illness and related-medical costs is an emerging health care plan strategy. Pitney Bowes pioneered “Value-Based Insurance Design” by waiving plan participant copayments for prescription drugs that are proven effective to manage costly illnesses such as diabetes. This report highlights this new strategy and groups adopting it. For information on Value-Based Insurance Design visit <http://www.vbidcenter.org> or to explore enrollment in the diabetes program, visit <http://www.aphafoundation.org> or <http://www.mbggh.org>.

ISSUED 6-8-07

In the past few years, employers have focused on increasing employee cost sharing to encourage their workers to become more cost-conscious health care “consumers.” However, costs can pose a barrier to patient compliance with their prescribed drug therapies, Larry Boress, president of the Midwest Business Group on Health (MBGH), noted at an MBGH’s February 2007 Learning Network symposium on Exploring the VALUE in Value-Based Benefits Design: Best Practices and Lessons Learned with a Focus on Diabetes Management.

A 2003 Pfizer study of 30 health plans with 11 million members ages 25 through 64 found high rates of failure of member compliance with prescribed drug treatments. These failures were primarily with patients (nearly half) not taking their medications appropriately (47% of those with medications for cholesterol and 46% each with high blood pressure and diabetes medications) and maintaining their drug regimens over time (34% for cholesterol, 38% for blood pressure, and 37% for diabetes at 12 months and 47%, 49%, and 51%, respectively, at 18 months).

Another survey in 2005 revealed that 35% of patients failed to take their medications because they wanted to save money and one-third failed to take their

medications for any reason. While lack of motivation or interest was a significant factor, employers can engage and motivate their members through education and benefit incentives for therapy compliance and healthy behaviors, Mr. Boress said. However, incentives must be aligned to encourage good behavior and discourage bad behavior, reward behavior improvement as well as the ongoing practices of healthy behavior, reduce barriers to good doctor-patient relationships, and consider the effect of incentives on ALL stakeholders, he added.

Approaches must be both personalized for individual employees/members and standardized for providers, according to a 2006 report issued jointly by PricewaterhouseCoopers, the California Healthcare Foundation, and the Pacific Business Group on Health (PBGH). Employees’ responses to benefit design incentives vary based on their income, health status, culture, and other factors. Providers are burdened with many diverse program requirements and contacts, the PBGH study concluded. Given these challenges, health benefits plans can improve results by standardizing program interfaces with providers and personalizing content and methods to foster collaboration among stakeholders.

Getting Value From Compliance

Although recent growth in health care costs has been lower than 10%, the amount does not include the ultimate costs of necessary medical services that are avoided, asserted A. Mark Fendrick, a physician and professor in the University of Michigan's Departments of Internal Medicine and Health Management and Policy, Center for Value-Based Insurance Design (VBID). Though price increases in pharmaceuticals have moderated, they are still substantially higher than inflation, and patient contributions, and the number of uninsured, continue to rise, Mr. Fendrick noted.

All these factors have been accompanied by substantial underutilization of "crucial" medical services, some say by 50% to 60%, and "tremendous treatment gaps," Mr. Fendrick added. "The impact on health outcomes must be measured before we can determine whether moderation of cost growth is considered a 'good thing.'" Health benefits plan sponsors must evaluate their motivation for offering the benefit and consider return on investment just as they would for their other purchases, he urged.

Access to new medical treatments and how to pay for them is a complex and "extremely political issue," Mr. Fendrick observed. However, the current strategies to control health care costs ultimately are not necessarily effective. Instead of denying coverage for medical services or requiring prior authorization, health benefit plans should determine what services specifically they should be buying for which they will get the best return on their investment. Disease management programs, however, offer opportunities to manage the most expensive patients to improve outcomes, and, while they likely will not reduce costs, they will provide value by encouraging patients to do the right thing, Mr. Fendrick said. However, to maximize the effectiveness of the plans' disease management programs, plans must "insist on reducing financial barriers to compliance."

Value-based purchasing is a much more effective "cost control" strategy, as Pitney Bowes has demonstrated, Mr. Fendrick continued. Cost sharing with doctors and hospitals is another potentially useful intervention, he added. For example, a plan might pay medical providers less for less effective medical services. Also, set prescription drug copayments based on a drug's value rather than on price as is the current practice. Studies show that shifting costs to the patient reduces use in both essential and nonessential

care, he noted. This is reflected in significant lower use of cholesterol-lowering medications for each \$10 increase in drug copayment, with the lowest use when the copayment exceeds \$20.

The premise of so-called consumer driven health plans (CDHPs) is that charging consumers high out-of-pocket fees will encourage consumers to make informed purchases and thus reduce costs. However, while there is no evidence that CDHPs reduce cost growth, there is the likelihood that they will lead to worse clinical outcomes, Mr. Fendrick cautioned. As for the CDHP assumption that health care "consumers" are informed, "some day there will be adequate information to allow patients to make informed medical choices, but we're not there yet."

Instead, health benefits plans must offer incentives to encourage patients to obtain necessary services, he said. "If the patient is not the appropriate decision maker, the system should provide guidance and incentives to promote better decisions." Among patients who get essential care, those who demand it, those who can afford it, and those who "need" it, are not necessarily the same, Mr. Fendrick emphasized. For example, a cholesterol-lowering medication should be provided to individuals who already have had a heart attack and are at great risk of a second one, before it is offered to individuals with high cholesterol but low risk.

Mr. Fendrick recommends going from "one size fits all cost sharing" to "clinically sensitive" benefit design, or a "value-based insurance design" (VBID). This entails setting patient cost share based on value, not price, so that highly valued services require the lowest copayment, or a middle copayment for effective but expensive services, and the highest copayment for services of unproven or marginal benefit. Implementing a VBID requires changing cost sharing for highly valued services for all clinical indications and targeting specific patient groups with only certain clinical indications.

For example, Medicare first-dollar coverage, with copayments waived, of ACE inhibitors for beneficiaries with diabetes saved a net of \$7.4 billion over the affected group's lifetime. And eliminating copayments for cholesterol-lowering medications for individuals at medium or high risk of congestive heart disease avoided 110,000 hospitalizations or emergency room visits and saved \$1 million annually, according to a study published in a 2006 issue of the *American Journal of Managed Care*.

continued on next page

Other medical conditions and treatments that are candidates for VBID are asthma and congestive heart failure and cancer screening for patients with a family history of cancer or with tumor markers, Mr. Fendrick said.

University Of Michigan Program

Beginning July 1, 2006, the University of Michigan (UM), Mr. Fendrick's employer, implemented a diabetes medication pilot program for its employees and dependents. Under this program, diabetics are exempt from copayments for certain drugs necessary to control blood sugar, lower blood pressure, reduce the risk of heart and kidney problems that plague diabetics, and manage depression to improve compliance with drug regimens. The diabetes drug program works in conjunction with disease management and set guidelines. Some 2,500 UM employees have diabetes but too many diabetics did not use needed medications.

UM is measuring adherence to medication regimes, using pharmacy claims as well as outcomes related to spending for medications and for total health care, and to productivity (absenteeism, presenteeism, and disability). After it implemented this diabetes program, UM did not receive any employee complaints about special treatment for diabetes only, but received thanks from affected employees.

The university will not see any savings in the short term, Mr. Fendrick said. "Providing better health care will not save money except maybe in the long run," he told the Pharmacy Benefits Management Institute's 12th Annual Prescription Drug Utilization Management Conference in February 2007. Some PBMI conference participants suggested that drug utilization results may be improved by basing copayment levels on employee income.

A health care plan start can implement VBID with the following steps, as Mr. Fendrick suggested:

- identify partners and data to work with, such as care managers and claims administrators; the pharmacy benefit manager who will build a system allowing a formulary customized for the targeted program; and the disease management team,
- develop a custom formulary of targeted drugs,

- decide on the affected interventions,
- determine the level of clinical targeting, and,
- set copayment reductions based on a financial model.

Tools essential for VBID are information technology, clinical effectiveness research, disease management, and medical service provider pay-for-performance, Mr. Fendrick emphasized. Ultimately, VBID will raise the value of dollars spent for medical services by subsidizing only "valued" care and likely will slow the cost growth rate and improve the return on investment. He suggested that initial costs of lower or waived copayments for targeted medical therapies will be offset by avoided more costly services and by increasing copayments for nonessential or unproven therapies or services.

As described by Mr. Fendrick, the UM Center for Value Based Insurance Design, which he heads, "engages in the development, evaluation, and promotion of insurance products that encourage the efficient expenditures of health care dollars and optimizes the benefits of care." More information is available on the Center's Web site at <http://www.vbidcenter.org>. Mr. Fendrick told the PBMI group that he would like to see 116 interventions targeted.

Jewish Federation's Plan

The Jewish Federation of Metropolitan Chicago (Federation) has implemented a value-based benefit design that includes programs for asthma (JFHP Select) and diabetes (Taking Control of Your Health), explained Rabbi Louis Lazovsky, vice president of human resources. The Jewish United Fund/Federation is a philanthropic organization with 62 locations in the Chicago metropolitan area. Because the organization's fundraising costs represent only 7.5% of its annual budget, it "is as efficient as we are effective," Mr. Lazovsky said at the MBGH Learning Network.

The Federation and its affiliated agencies together employ 1,830 full-time workers, nearly three-fourths (72%) of whom are women with an average age of 43 years. As of mid-February 2007, all but 100 employees

were eligible for the Federation's medical plans, 40 were covered by their union's health plans, and the balance were in the 30-day waiting period. A large proportion of the covered population are in HMOs, Mr. Lazovsky said. Two different unions represent Federation employees. The Federation has a history of offering generous health coverage and multiple health plan options, he added.

To produce the best medical outcomes, benefit design can be based on systematic clinical research that supports the effectiveness of medical treatments (evidence-based medicine), Mr. Lazovsky noted. "Employers who are not looking at evidence-based benefit design are missing an opportunity to substantially improve employee health and quality of life and reduce medical premiums and claims costs."

To attain the greatest effect, an organization must identify its most costly medical conditions both in terms of health care spending and in lost productivity, Mr. Lazovsky advised. After that step, the plan must analyze which of the medical conditions can be affected through "strategic benefit design." A review of the Federation's medical claims and pharmacy costs confirmed that diabetes was one of the medical conditions that it needed to address. In response, the Federation on July 1, 2006, introduced a second self-funded health care plan (JFHP Select; the existing plan is the JFHP) that resembled a CDHP with a preferred provider organization and the following plan design:

- \$500 "first dollar coverage;"
- \$200 allowance and deductible waiver for wellness services;
- Deductible of \$1,000 for individual and \$2,000 for family;
- Plan coverage at 80% for in-network and 60% out-of-network;
- Low-enough premiums to eliminate employee contribution for single coverage and premiums for family coverage comparable to HMO premiums;
- Waived copayments for diabetes and asthma medications.

As of February 2007, the JFHP Select plan participants represented 6% of benefits eligible employees, with 63% of enrollees younger than age 45. Monthly drug costs per JFHP Select members averaged less than half the average cost for the regular

JFHP plan—\$89 compared with \$199, Mr. Lazovsky reported. And the total savings for the JFHP Select plan, including drug costs, was more than \$1 million below the 2006 plan costs for the JFHP alone.

Diabetes Ten City Challenge

The positive results have led the Federation to revise its overall wellness strategy by incorporating the MBGH's new pilot program, Taking Control of Your Health. This program replicates the design of the Asheville Project (Asheville, N.C.) in which plan participants with diabetes regularly meet with a specially-trained pharmacist who counsels the patients on managing their conditions as well as receiving free diabetes medications and supplies. The Asheville Project saved \$4 for each \$1 spent and reduced diabetic sick-leave use from 12.6 days prior to implementation to six days in the Project's sixth year. The Federation also is expanding this program to the regular JFHP plan participants.

The Asheville Project lowered total average annual health care costs per patient to \$2,000, saved over \$6 million in health care costs, and in the eight years of the program no diabetes patient has entered dialysis. Asheville has expanded the program to asthma and high blood pressure.

In 2007, the American Pharmacists Association and drugmaker GlaxoSmithKline joined to implement the Diabetes Ten City Challenge, for which the MBGH is coordinating the Chicago site program, Taking Control of Your Health, funded by drugmakers Novo Nordisk and Novartis and allied with the Illinois Pharmacists Association. All three drugmakers providing funding for the project produce drugs for diabetes control, but, according to participating organizations, will have no influence on study results.

As of April 2007, Chicago-area participating companies in addition to the Federation were the City of Naperville, Hospira (maker of specialty drugs and drug delivery systems such as I.V. sets), and Pactiv Corporation (maker of Hefty (R) storage garbage bags, and other consumer products). Other cities participating in the Diabetes Ten City Challenge are Charleston, Colorado Springs, Honolulu, Los Angeles, Milwaukee, Pittsburgh, and Tampa.

Lake Forest, Ill.-based Pactiv has 8,000 employees nationwide with 80% of employees enrolled in the company's plans, explained Judy Hearn, manager of

continued on next page

Health and Welfare benefits. In 2007, Pactiv reduced the number of health care plan options to six, including an HDHP and a “Build Your Own PPO” option, but nearly half (49%) of employees are enrolled in HMOs. Although cardiovascular disease is the most costly health condition for Pactiv, 166 employees in Illinois have diabetes, she said. The company initially is implementing the Taking Control program only for PPO-participants in Illinois. Pactiv implemented a disease management plan in 2005 and waives deductibles or copayments for health plan participants using preventive drugs, Ms. Hearn continued. To implement the Taking Care program, the company will disseminate a mailing that includes an enrollment packet targeted to PPO participants with diabetes.

Once enrolled in the diabetes management program, a patient is assigned to a specially-trained pharmacist who will be the patient’s “coach” and meet with him/her initially every month. The first visit with the pharmacists is set to be one hour long, while subsequent visits will be about 15 minutes. The participating patient qualifies for the waived diabetes drugs copayments only if he or she meets with the assigned pharmacist at least quarterly. Pharmacists will work with the patient in private consultation areas or at the patient’s worksite to train him/her to manage his/her disease as well to have scheduled tests and procedures. After each patient visit, pharmacists also will provide results to the patient’s doctor and give information on medical and cost trends and outcomes to a research unit.

The stated objective of the Taking Control and the Diabetes Ten City Challenge’s participant periodic meetings with the specially-trained pharmacist is “to help people understand how to track their condition and encourage adherence to their medication, fitness, and treatment regimens,” an MBGH release explained. “As participants learn how to better manage diabetes, their health improves making it possible to minimize unnecessary and costly physician and emergency room visits and surgeries.”

Employer sponsors must promote the program, orient, and enroll patients. The organizations also

must be able to provide either directly or through a pharmacy benefit management firm (PBM) reduced or waived copayment prescription cards. In addition, they must provide the program’s research unit access to data on total health care costs from the past two years, and pay pharmacists for their counseling and screening services. Ultimately, the physician remains responsible for the patient’s overall care.

The Hawaii Business Health Council implemented the Asheville VBID model in 2006, Gary Allen, the Council’s executive director told the MBGH group. As of February 2007, eight Hawaii employers were enrolled in the program and by September 2007, the Council expected to have 12 employers enrolled, including the State of Hawaii. The new program shifts care from the current “illness rescue” and managing supply health care system to a “new relationship to support the employee in his lifestyle choices,” and prevention of disease by changing participant behavior and promoting health, Mr. Allen said. The new VBID project shifts the focus to the individual by educating and supporting individuals to improve and maintain their health. This personal health improvement model promotes proper nutrition, exercise, and a caring-for-self attitude, Mr. Allen continued. It’s about letting individuals make decisions and removing barriers (including financial ones) to regimen compliance.

Currently, cost-savings of VBID have not been demonstrated scientifically, Mr. Fendrick concluded. “Let’s just say that it’s cost neutral,” he advised. Companies implementing the VBID philosophy for their health care plans must be patient to see results, as results probably won’t be evident for several years after implementation, he added. “You don’t need to save money; you just need to spend it well.”

The MBGH during 2007 expanded the program to all interested employers and in the future may add it to other medical conditions such as asthma, cardiovascular conditions, and depression, Mr. Boress concluded. ■