FELICIA S. WILHELM, RN

Value Based Plan Design . . . A promising innovation in group health benefits

When employers are looking for new ideas about how to save on their group health benefits (and, honestly, when is that not the case?) they invariably look to the same place first: plan design. "What can we change?" they ask themselves, and each other. "There must be a way to contain these costs." And that is where they may very well be making their first mistake. Employers must learn to stop thinking of their group health plan in terms of cost containment and instead think of it as asset management. That's the message in the latest, and most effective, concept of benefit management today: Value Based Plan Design.

What is Value Based Plan Design?

It's a new approach that emphasizes outcomes, individual by individual, and not just in terms of dollars spent. It is built on the concept of reducing costs by removing the barriers to effective care to increase the chances of those positive outcomes as guided by the employers' own data. In short, it's a fresh way of designing benefit plans that work.

Two of the proselytizers of Value Based Plan Design are Jack Mahoney, MD and David Hom, of Pitney Bowes. Dr. Mahoney, the corporate medical director, and Hom, Vice President of H.R. Initiatives at the company, have been spreading the word that health is an investment. And it's an investment in the most valuable asset any organization has: its human capital.

Recent years have seen the rise of consumer driven health care models, pushing additional responsibility for costs onto employees and their families. But is this growing trend doing any good? Higher deductibles and co-pays may in fact prove to be counter-productive if they create a barrier to effective care. Value Based Plan Design calls for a shift in the focus, demanding that the employees using the health plan be viewed as true human resources. That human capital requires proper investment and once overall group health is redefined as an investment, employers can go about managing that key asset and not just dollars.

Too often, employers view their health plan expenditures only in terms of the direct costs: what is spent on medical care and treatment, and pharmacy benefits. To get the big picture, they must also consider the indirect costs: absenteeism, presenteeism, disability and the serious costs associated with those. It's a real "tip-of-the iceberg" scenario, whereby the unseen health-related productivity costs represent up to 75 percent of the full cost of poor employee health.

The progressive benefits manager will recognize that it is therefore a matter of managing health for greater value. In other words, it does little good to shift the costs of care and pharmaceuticals to the employees if the higher costs keep the employees from getting the treatment they need. The cost of not getting that treatment is greater because that leads to those higher indirect costs.

What, then is the first step?

Health begins with the individual, and the individual must be engaged, and take responsibility for his own health. It is plainly clear that lifestyle choices such as whether to use tobacco and/or alcohol, and whether to maintain a healthy diet and exercise are much bigger factors than genetics. And early detection of disease is always critical in treatment for conditions such as colorectal cancer and diabetes. Individuals with chronic conditions and low medication compliance rates have high probability of moving to a higher cost tier within one year. Similarly, individuals with no exposure to the health care system are at a high risk of becoming

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Felicia S. Wilhelm is CEO of Prairie States Enterprises, Inc., (PSE) a Chicago-based health benefits administrator specializing in heath management. She can be contacted at 312-464-1888, or email fwilhelm@prairieontheweb.com. PSE is an IMA affinity partner.

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high cost claimants within three years. So individuals must become engaged in this process, and incentivized to take better care of themselves. It is up to the employer to create an environment where the individual is accountable.

Plans must be designed, then, with that engagement in mind. That means encouraging low cost (or no cost) health screenings and preventative care. It means providing first dollar coverage for routine medical care. It means encouraging compliance with treatment plans by making drugs more affordable. It means eliminating front-end deductibles. Removing these barriers to effective care is critical for the plan's success.

Think of the employee who is considering a screening, but who faces a high co-pay and must schedule time away from work in order to do it. Chances are he won't because of the costs, in time and money, to him. Value Based Plan Design recommends onsite screenings instead. Yes, there is the additional initial cost, but consider the value created in eliminating the need for more costly treatment later.

Consider the big cost-drivers: diabetes, asthma, and hypertension. The difficulty in treating such conditions is that in many cases, the patient does not "feel sick" most of the time. As a result, compliance to treatment plans becomes a real problem, especially when high deductibles and tiered pharmacy benefits mean that the patient does not comply with the course of treatment that will make him well. Because of this lack of compliance, the patient's condition worsens, leading to far costlier treatment.

What makes more sense: giving the employees better access to brand name prescriptions and checking constantly for compliance, or creating a barrier that will lead to the far greater expense of dialysis, in the case of the diabetic, or more emergency room visits for the asthmatic? There is much greater value in managing the condition than in managing the initial cost. Managing conditions means fewer ER visits, fewer hospitalizations, fewer hypo or hyper glycemic episodes, and a huge reduction in short term disability.

So what does it take to get the employees to share the new vision, and buy in? As Hom and Maloney say, "Carrots work better than sticks." Penalties are simply not a viable means of change. Instead, they say, people respond to incentives. Penalties often create an atmosphere of mutual suspicion, and cause employees to withdraw from the process. (Think of the smoker who would prefer to hide his smoking than to participate in smoking cessation programs out of a fear of being penalized.)

What kind of incentives work?

Value Based Plan Design says that employers should encourage their employees to maintain or acquire positive health habits by providing them with credits that accumulate over time, giving them additional flex dollars, for example, if they succeed over a period of time in their compliance. When the individual himself invests, it creates an atmosphere where all feel that they are paying their fair share.

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The idea therefore is to manage health, not disease. Making all the stakeholders share this vision is vital. Providers, employees and the employer all must be on the same page, with everyone aware of the goal. Transparency is also needed so that everyone involved see the true costs.

To achieve this goal, data is the key. After all, if the focus of Value Based Plan Design is to be on finding value based on outcomes, then those outcomes must be measured. The difficulty in addressing this issue, however, is the fragmentation in the system, disconnects between providers, employers, pharmacy benefit managers, payors. This lack of integration makes the big, complete picture more elusive.

This fragmentation makes the employers' choice of benefit administration partners crucial. Self-funded employers must choose their third party administrator not only for their accuracy and turnaround times, but also for their reporting capability, clinical focus, predictive modeling expertise, and IT superiority. And from a clinical perspective, the TPA must go well beyond the standards of case management, utilization management, disease management, and wellness. They must be able provide the support that makes greater compliance happen; they must be able to track those outcomes; they must be able to report the findings in a clear and integrated manner, and they must be able to do the analytics.

That's a tall order for any TPA, and one that can be filled only by those with the most robust combination of on-staff nurses and state of the art technology. Collecting as much data as possible is a first step. Employers must ask their administrators to establish a baseline profile and then begin the task of data integration: medical claims including physician and hospital visits, Rx, labs and diagnostics, absenteeism and disability with census data. From there they must look for patterns of utilization. They must construct a framework for the whole continuum of care, and not just work on the large claims as so many do. Only a TPA with the right combination of IT and clinical capabilities can adequately check for and report compliance with treatment plans and medications for chronic conditions. (Setting benchmarks is essential.) Measurement and adjustment over time must be ongoing.

A powerful data analysis tool such as NavigatorMD is a great asset for such analysis. With NavigatorMD, finding gaps in treatment, doing predictive modeling and health risk profiling, and measuring the program's effectiveness are easily integrated and reported.

Employers looking for cost savings have already been embracing Value Based Plan Design and its principles. It's a persuasive argument, as Mahoney and Hom have said: "Shift the perspective; create value by leveraging human capital. ■

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