

# Value-Based Strategies

## Driving Down Costs by Improving Quality of Care

### Perspectives

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The U.S. spends more on health care — to the tune of \$2 trillion per year — than any other nation, yet ranks among the worst of industrialized countries for key health indicators, such as infant mortality and life expectancy. Employers have long known that, when it comes to health care, higher spending does not necessarily equal better quality care or improved outcomes.

To drive down costs and close the value gap, companies are assessing the varied needs of their employee populations and adopting value-based strategies. How? Through programs that provide the broadest access to and highest level of benefits for drugs and services that demonstrate the highest clinical value for the lowest cost. Key program elements range from plan design and provider purchasing strategies to innovative employee support tools and resources. The goal? To reduce costs and improve outcomes by motivating employee/provider behaviors that prevent or detect high-risk conditions early on, thereby reducing disease symptoms, improving well-being and eliminating redundancy and waste.

How can you bring these concepts to life in your own programs? This brief overview provides insights into:

- how to use population health data to build a value-based strategy
- how to address some of the most pressing health care challenges employers face today by closing the cost/value gap.

### Begin by Assessing Your Company's Population Health

Every marketer knows that different market segments have varied needs and preferences. In a similar vein, different employee groups have varied needs and health issues, based on demographics, geography, income, job type and so on. For example, a recent population health assessment conducted by a large pharmaceutical company revealed a higher prevalence of hypertension, coronary artery disease and depression

among certain demographic segments and low-wage workers than among moderate- to high-income workers. Another employer's population health data indicated a high incidence of certain cancers and coronary artery disease among employees in the upper peninsula of Michigan, where there is limited access to quality medical care.

"The fact that health issues are linked to different segments of a population, based on any number of variables, is common knowledge in the public health arena. Employers that evaluate health trend data in their employee populations can achieve a higher return on their health benefit investments by developing targeted strategies to address specific issues," says Jeffrey Dobro, M.D., F.A.C.R., Principal, Towers Watson.

Employers interested in value-based strategies can get started by assessing health trends in their employee population using questions such as the following:

1. What is the prevalence and cost of the most common health conditions in our member population?
2. Do our health care costs and disease prevalence vary by geography, demographics, income, job type or other factors?
3. What are the total costs of a condition, including costs for related conditions, also known as comorbidities? For example, if a diabetic incurs \$10,000 in annual health care costs, \$1,500 might be directly attributable to diabetes; the remaining \$8,500 could be due to related conditions, such as heart attack, amputation, dialysis or blindness.
4. What percentage of members complete a health risk assessment (HRA)?
5. What are the lifestyle-related health risks in our population?
6. Are our high-cost cases for the conditions we anticipated?
7. What is the future risk profile of our population?
8. What is the health profile of our employees versus their dependents?

9. What percentage of members are enrolled and engaged in disease management programs versus the percentage of eligible candidates (based on high-risk conditions, such as diabetes, high-risk maternity and coronary artery disease)?
10. What percentage of members take advantage of preventive care, such as periodic checkups, biometric screenings (cholesterol, blood sugar, etc.), mammograms, pap smears and colonoscopies?

Answers to questions like these will help employers determine what strategies to put in place to maximize value. These answers will also shed light on whether programs currently in place are delivering desired results.

## Closing the Cost/Value Gap

Hand in hand with assessing population health trends and targeting tactics to meet employee needs, programs that encourage preventive care and evidence-based medicine can go a long way toward closing the cost/value gap. As demonstrated by the following strategies, changing patient/provider behaviors to drive value in measurable ways can help employers address some of today's most pressing health care challenges.

## Encourage Preventive Health Care

**Issue:** It's well known that compliance with preventive screenings is highly variable in many populations. Yet people with undetected risk factors set themselves up for developing costly, chronic, potentially life-threatening conditions that could have been either avoided or better managed with earlier treatment. As just one example, more than 25% of the U.S. population overall has hypertension,\* a risk factor for cardiovascular disease, heart attacks and stroke. Yet close to one-third (30%) of hypertension is undiagnosed, and 10% of people with known hypertension are not being treated for this condition.

On the flip side of these startling statistics, using antihypertensive medication results in 4% to 9% fewer deaths from cardiovascular disease, a 38% reduction in hospitalizations for stroke, a 25% reduction in hospitalizations for heart attacks\*\* and a cost savings of \$4,000 to \$48,000 per 1,000 people (depending on the cost of detection and treatment).

“Programs that encourage preventive care and evidence-based medicine can go a long way toward closing the cost/value gap.”

This is just one of numerous reasons why employers should engage employees in HRAs, periodic biometric screening and other preventive measures recommended by the U.S. Preventive Task Force, an independent panel of prevention effectiveness experts.

### Employer Solutions

- Provide coverage and incentives — such as lower premiums, additional money in health savings accounts (HSAs), lotteries, personalized reward choices — for completing an HRA, taking advantage of preventive care or following through on recommendations, such as active participation in risk reduction programs, recommended tests, doctor/specialist visits and medication adherence, along with diet and exercise regimens.
- Provide additional high-touch follow-up using health coaches to support members with risk factors for chronic, complex conditions.
- Pay for performance — reward providers for improved blood pressure control, as well as other evidence-based preventive care.

## Eliminate Barriers to Medication Adherence for High-Risk Conditions

**Issue:** Studies have shown that people don't take their prescribed medications for any number of reasons. One such reason, cost, is a major barrier to adherence for a growing number of employees who are especially vulnerable to the financial bite of the current economic downturn, including low-wage workers who are more prone to high-risk chronic conditions, such as hypertension, heart disease and depression.

As just one example of the impact of non-adherence, heart attack patients typically show a rapid drop in medication adherence after the first 30 days following the event. As a result, these patients have a much higher likelihood of suffering another attack within the next six months than patients who take their medications as prescribed.

\* National Center for Health Statistics. *Health, United States*, 2004, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention

\*\* Cutler, D., “The Value of Antihypertensive Drugs: A Perspective on Medical Innovation,” *Health Affairs* 26, No. 1 (2007)

## Employer Solutions

- Structure benefit designs to ensure medications for specific conditions are affordable to employees sensitive to costs.
- Incent employees who have high-risk, chronic conditions to participate in disease management programs and comply with medical recommendations.
- Provide high-touch health coaches to support patient care and accountability.
- Identify gaps in care and reach out to appropriate providers.

## Encourage Informed Decision Making About Evidence-Based Care

**Issue:** The value of minimally invasive surgeries and treatments has been demonstrated for a variety of chronic, non-life-threatening conditions. Yet medical professionals sometimes opt to perform more invasive, higher-risk procedures that require longer hospital stays and back-to-work recovery time than less invasive alternatives. For example, cholecystectomy, the surgical removal of the gallbladder, can be performed as an open procedure (OC), considered major abdominal surgery, or laparoscopically (LC), which is minimally invasive.

“Plan designs must be structured to encourage employees to make informed decisions about preference-sensitive treatments.”

Multiple research studies suggest that LC, a newer procedure that became widely accepted in the 1990s, is a more cost-effective choice in comparison to OC due to lower complication rates, shorter hospital stays and faster return-to-work recovery. The number of cholecystectomies has increased since the LC procedure was introduced. But research indicates that the choice of LC over OC varies significantly by region and that variation has no clinical basis. Clearly, plan designs must be structured to encourage employees to make informed decisions about these types of preference-sensitive treatments.

## Employer Solutions

- Provide different coverage levels for different treatment options, with higher coverage levels for evidence-based treatment. For example, employers might consider higher coverage levels for minimally invasive surgeries for preference-sensitive treatments, such as gallbladder removal, hip and knee replacement, and knee surgery.

- Provide higher coverage levels when employees use tools and resources that improve decision making (e.g., structured second-opinion programs and access to unbiased expert advice on treatment options).
- Provide lower copays for using high-performance networks.
- Contract with regional centers of excellence (COEs) for specific procedures. These designated centers achieve better outcomes for a broad range of conditions — from cancer to infertility — at competitive costs.
- Offer free coverage for optional or required second opinions.
- Provide cash deposits in an HSA to cover the cost of a second opinion or actual treatment.

## Incent Coordinated Provider Care

**Issue:** Patients with chronic, complex health conditions are often treated by multiple providers. According to a Mayo Clinic Health Policy Center consumer survey, more than half of Americans who have a complex, chronic condition require care by more than one provider. Case in point: A liver transplant patient at the Mayo Clinic was cared for by 75 different people over five days and 11 shifts.

The lack of coordinated provider care can often drive up costs and add unnecessary complications. Dangerous drug interactions, redundant services, lack of coordinated diagnostic testing and treatment by doctors/specialists and misdiagnoses are just a few of the many costly problems that can result from disjointed medical care.

## Employer Solutions

- The Centers for Medicare and Medicaid Services (CMS) offer bonus incentives to providers for specific technology upgrades that support integrated care. Employers may want to further encourage these practices by providing higher payments to providers that upgrade their systems and technology (e.g., electronic health records and electronic medication adherence report cards) to identify and close gaps in care, reduce errors, improve outcomes and reduce costs.
- Encourage members to use on-site/near-site employer-sponsored health centers to effectively coordinate care.

## Reduce Hospital-Related Error and Waste

**Issue:** Hospital-related complications due to improper care account for 30% to 50% of health care spending. To address this issue, as of October 2008, CMS no longer pays hospital providers for eight “reasonably preventable” complications. What’s more, hospitals will not be able to pass on the costs of improper care to patients.

CMS’ list of preventable complications includes:

- air embolisms (gas bubbles in the bloodstream due to IV fluid and medication administration)
- blood incompatibility from transfusions
- catheter-related urinary tract infections
- falls and trauma
- foreign objects left in the body during surgery
- surgical-site infection following coronary artery bypass, and certain orthopedic and bariatric procedures
- bedsores
- infected IV sites.

(Effective 2009: Blood clots after total hip or knee replacement will also be considered a preventable complication.)

This Congressionally mandated CMS measure is projected to yield only \$21 million in savings, in comparison to the \$110 billion spent on inpatient care in 2007. But in the larger scheme of things, these steps are aimed at eliminating U.S. medical provider payment practices that systematically reward quantity of care over quality of care. In fact, a host of insurers and state Medicaid programs are following suit by adopting similar payment criteria.

## Employer solutions

- Provide higher payments to providers who meet specific quality standards.
- Provide more attractive benefit coverage for treatment at a COE.
- Provide travel benefits to encourage members to use best practice providers outside their local community.
- Provide member incentives for using a regional COE to confirm cancer diagnoses, and develop a treatment plan that can be delivered via a local facility.
- Incent employees to use a COE for discrete, targeted procedures, such as bypass surgery and joint replacement, which can be followed up by qualified local providers with limited risk.

## Looking Ahead

Even the best strategies and plan designs aimed at increasing value and driving down costs are all for naught unless they engage employees to take responsibility for managing their health and make informed decisions about their care. In brief, employers must understand the needs and receptivity of various employee groups, and deliver consumer-focused messages targeted to those groups through a broad range of communications, such as personal e-mails to e-health portals, letters, newsletters, phone calls and even posters in the cafeteria and other high-visibility workplace locations.

“Clearly, there is no single solution for closing the cost/value gap. Instead, employers must use a combination of strategies to proactively change employee and provider behavior,” says Dr. Dobro.

## About Towers Watson

Towers Watson is a leading global professional services company that helps organizations improve performance through effective people, risk and financial management. With 14,000 associates around the world, we offer solutions in the areas of employee benefits, talent management, rewards, and risk and capital management.