Shifting the Focus From Cost to Value: An Employer Perspective

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ABSTRACT

OBJECTIVE: To review ways in which pharmacists can help health plans shift their focus from cost to value.

SUMMARY: Health care delivery is a continuum. Employers have moved along the continuum looking for value; they are now looking for integrated strategies to decrease cost and improve productivity within the workforce. The key to any integrated strategy is innovative service delivery and ground-breaking partnerships with vendors. Key areas that need to be addressed are medical care, pharmacy, behavioral health, disability, prevention, and presenteeism. Additionally, measuring program effectiveness is becoming more important, especially in terms of continuous improvement.

CONCLUSION: Updating data, fine-tuning plan design to improve effectiveness, and abandoning ineffective efforts is critical. The ultimate goal is to modify the target population’s risk.

KEYWORDS: Healthy workforce, Integrated health care, Value, Benchmarks, Disability, Prevention

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The World Health Organization (WHO) defines a healthy workforce using 4 adjectives: healthy, productive, ready, resilient. Healthy workforces have fewer health risks, and those workers who have medical conditions are actively engaged in managing their conditions. Productive workforces are composed of individuals who are fully functional at work and also at home, a point that engages employees by stressing that productivity is not restricted to the workplace. Ready workforces are prepared for change, and resilient workforces bounce back when change occurs and continue without devastating health or behavioral effects.

Fifteen experts under the auspices of The Institute of Medicine published a book concerning integrated employee health. Initially, this team’s task was to design an integrated health plan for the National Aeronautics and Space Administration, but they found that their efforts were transparent enough that they might constitute a white paper or a road map for many other employers. NASA, with its highly skilled workforce working in a high-pressure environment, serves as a prototype for many American businesses. The panel identified the prevalent current perspective and visualized what the desired perspective should be.

The current marketplace’s perspective is cost metrics: medical cost or pharmacy costs. The experts believed, however, that the marketplace should look at the economic outcomes of health on workforces. Similarly, they suggested that to improve the well-being of an employer’s workforce, the current focus on treatment and disease should shift to prevention, behavior change, and health. An integrated system for managing health within a population includes medical, pharmacy, disability, health risks, life-style risk management, disease management, and presenteeism (the effect of health on productivity or the problem of workers being on the job but, because of medical conditions, not fully functioning), and productivity. This approach breaks the established silo mold.

Often, employers fixate on price and avoid discussing value issues. Approaching health care from a value perspective is cutting-edge; only one fifth of the employer marketplace, and usually the largest of employers, is moving in this direction. A transition can only begin if metrics and measurements are available proving the effectiveness of medications on productivity. Pharmacists, when they discuss tiered formularies, should encourage employers to begin measuring productivity in addition to costs and medical outcomes. This will fill the existing gap between today’s reality and tomorrow’s necessity.

Value-Focused Health Activities

An American College of Occupational and Environmental Medicine (ACOEM) survey looked at value-focused health activities. This study queried 174 decision makers—medical directors and benefit directors who were embedded with employers—about how they focus on plan design issues,
purchasing, and value versus price. The study's intent was to determine how employers consider value when they make policy and benefit design decisions and the extent to which the concept of value had permeated the employer marketplace. This information could be used to drive the marketplace to look at value. Areas covered by the inquiry included disability, medical care, and pharmacy.

For pharmacy, the objective was to identify external influences on pharmacy benefits (Figure 1). The finding: employers look to benefits consultants and industry benchmarks to design their pharmacy programs. Employers had some interest in innovative benchmarks, so partnering with benefits consultants can help design innovative solutions. The decision makers did not generally consider pharmacy benefit managers (PBMs) to have a significant influence on pharmacy benefit design, however. This indicates that PBMs should be searching for ways to strengthen expertise in this area so they can provide valued consulting to their clients.

The question, “What do you feel your senior managers perceive as most important when you look at your health benefit design?” was revealing. The most frequent answer (85% of respondents rated this issue as moderately or highly important) was “managing health care costs.” More telling, “managing productivity” followed this answer in frequency. This implies that senior managers may be beginning to understand that health status affects productivity and good health is worthy of investment.

Among those surveyed, the most common value-focused activities (VFAs) were providing influenza vaccination, in-house clinics, and “Centers of Excellence” (hospitals that achieve the highest scores for cost-efficiency and cost-effectiveness in treating selected procedures/conditions, based on publicly available patient data). Other common VFAs were wellness programs, incentives for health-related activities, and rewards for perfect attendance. Least common were choosing a health plan to reduce absenteeism and improve productivity and waving medication copayments for good outcomes. (In the 2 years since this study was published, more employers seemed to be eliminating copayments for employees with chronic disease who demonstrate that they comply with taking medication and follow up on testing in order to improve outcomes.) Choosing a health plan for its flexible hours and allowing employees to cash out unused sick leave were also uncommon. The most common VFAs dealing with drug benefits were changing tiers to encourage medication adherence and placing certain medications on the formulary because of their safety profile.

There was some evidence that companies are planning to implement different activities in the future than those they most commonly performed. Decision makers most often were planning to add or considering adding incentives for health risk appraisals (25%), implementing a wellness program (24%), reducing premiums for health-promotion participants (21%), and choosing a more expensive disease management program because of demonstrated absence and productivity outcomes (21%). Since evidence that demonstrates what improves productivity is scarce, health care needs innovative partnerships to address future needs and direction.

Creating Successful Businesses

Managing health care costs within a corporation is a component of business success. Employee-centric data is the key. Managers must scrutinize employee metrics and measure the program’s effectiveness across what were traditional silos within a corporation. The ability to gather pharmacy, medical, and short- and long-term disability data must be enhanced with data covering work performance (including examining performance evaluations in addition to productivity). This quantifies value and represents integration. Ideally, examining employee-centric data can lead to several actions on the employer’s part:

- They may find a net value for their ideal health investment.
- They are likely to understand “total cost.”
- They will focus on truly integrated solutions.
- They will be able to define business outcomes.
- They might set best-practice benchmarks.

Ultimately, they can set realistic and achievable performance objectives.

Thus, value has many different components that contribute to total cost.

Case in Point: WorkWell

Hughes Electronics Corporation established a program in 1995...
Since Hughes did not want to give employees the perception that company expenditures were the sole concern, they used “improving your health and your wealth” as a metaphor. The objective was to demonstrate how better health improved participants’ medical conditions and decreased their premiums. Because Hughes passed on lower disability premiums to employees, and health care cost increases were mitigated over time, Hughes’ employees benefited financially. Hughes was able to demonstrate that program participants had fewer deleterious health conditions and better health (Table 1). In particular, they were able to tell employees that program participation led to fewer cardiac conditions and improved back health, both significant concerns for their workers.

Consumer education was also a focus, and it helped employees become more prudent health care consumers. Employees were taught to distinguish between conditions requiring primary care, emergency care, or self care. Using claims experience, Hughes found that WorkWell program participants responded positively to outreach communication and education. They had lower numbers of visits to emergency departments and were less likely to use primary care for conditions that were appropriate for self care.

Beginning in 1998, the program included a disease management (DM) program, and Hughes also measured its impact. Its DM program focused on major cardiovascular conditions, diabetes, asthma, back pain. The Hughes population was older than the general population (average age 45 years compared with an average U.S age of approximately 40 years) and predominantly male, so it had greater health risks. Almost 12% of WorkWell members participated in at least 1 program and over 3 years, and medical costs for participants decreased by 21%. Although total pharmacy costs for the 4 DM programs increased and the per-member-per-month (PMPM) pharmacy cost almost tripled, the overall result was noteworthy. Over 3 years, overall PMPM cost declined 15%, inclusive of pharmacy costs. Appropriate use of pharmaceuticals improved overall cost and condition management.

### The Boise Experience

Presenteeism in the workplace within the population was also monitored. Hughes examined work quality, work quantity (capacity or output), and added the increasingly important element, personal factors (mental, physical, social, emotional, functional status).

At Hughes's large call center employing 1,500 in Boise, Idaho, health care costs were considerably greater than at their other sites. Disability expense for Boise-based employees was 5 times greater, prompting closer examination of that particular population's health. A health risk assessment found that their risk factors were approximately 3 times that of the rest of the employee population. They had higher rates of diabetes, cardiovascular disease, hypertension, and hyperlipidemia. Boise-based employees were also more likely to smoke. The fact that the average age of Boise employees was much younger than the rest of the Hughes population reinforced the idea that this group had a collective

### Table 1: Outcome of Hughes’ WorkWell Program—Good Returns: Good Results

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and monitored its effectiveness for approximately 10 years. It built on a workers’ compensation program and then added an integrated disability management program. When Hughes began to correlate improving employee health and falling disability costs and overall health care costs, it developed a program called WorkWell. The Hughes Medical Plan offered a health risk appraisal with biometrics. Eligible employees were participants in Hughes’ preferred provider organization medical plan, and approximately 65% of their population participated. The early Hughes program attracted participants with a gift certificate, discounted pharmaceuticals improved overall cost and condition management. 

### Employee Engagement

Communicating this program’s effectiveness to employees was necessary. Since Hughes did not want to give employees the impression that company expenditures were the sole concern, they used “improving your health and your wealth” as a metaphor. The objective was to demonstrate how better health improved participants’ medical conditions and decreased their premiums. Because Hughes passed on lower disability premiums to employees, and health care cost increases were mitigated over time, Hughes’ employees benefited financially. Hughes was able to demonstrate that program participants had fewer deleterious health conditions and better health (Table 1). In particular, they were able to tell employees that program participation led to fewer cardiac conditions and improved back health, both significant concerns for their workers.

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poor health risk. This group, due to their relative youth, was ripe for intervention.

In Boise, Hughes administered the Health and Performance Questionnaire (HPQ), a brief self-reported instrument designed to assess the impact of health on 4 aspects of work functioning: time missed from work, performance while at work, injuries or illnesses at work, and job turnover. Absences related to allergies, obesity, depression, and pain disorders were common. Claims data and health risk assessment fail to collect this data, but the HPQ did; it helped Hughes create a focused program to eliminate drivers of absenteeism and lost productivity. They recognized that no one area drives health costs. In the first year, Hughes had a 7% savings on short-term disability costs and a small reduction in health care trend. More data will need to be collected as the program matures.

WorkWells message is that a variety of measurement tools, including presenteeism questionnaires and health risk assessments, are necessary to identify health risks and the opportunities for modifiable conditions.

Cisco Systems

Cisco Systems employs about 48,000 employees globally; most of them are shareholders in this company that generated revenue of $24.8 billion in 2005. The workforce is approximately equally divided among engineers, sales staff, and administrative employees, making it a white-collar workforce. It is also a young workforce—the average age is 39 years. It has a very low turnover rate for the high-tech sector—the average employee has 5 years of service. Cisco's chief executive officer values employee retention, so the company is planning as though current employees will stay until retirement. Their current health risks are known, and medical costs are low. Cisco's hope is to engage employees to mitigate health risks over time.

To accomplish this, Cisco assembled an integrated health strategy that has 4 components. To establish a baseline for risk factors in all areas, Cisco is using its 2005 metrics. As programs are implemented and time passes, the baseline will be used for comparison. Prevention programs are understandably a priority. A tailored architecture called HealthConnections is being used to integrate all health programs in the company under 1 umbrella. Communications that engage employees are also priorities to broadcast and promote the consumer-driven health plans being planned and developed. Cisco is crafting easy-to-use Web-based tools for its employees and partnering with companies that can help employees look at quality and value among its many health care options. Because Cisco Systems specializes in the seamless integration of data, voice, and video, connecting employees electronically with their health plans and physicians is also a key element of the strategy.

This strategy will transform the company into a culture of good health (Figure 2). Because of his interest in the health care marketplace, Cisco Systems' CEO, John Chambers, has embraced this concept. With about one third of Cisco's employees located outside the United States, innovative solutions that can be applied across an international spectrum are necessary. In 2006, Cisco hopes to establish the program in the United States. After that, expansion will follow.

Baseline numbers were determined using a health risk assessment (HRA) created by WebMD, with the HPQ embedded in it to assess presenteeism. Approximately 40% of Cisco employees took the HRA in 2005, and the expectation is that a larger proportion of employees will take it in 2006. The baseline assessment determined that about 70% of Cisco employees have 2 or fewer health risks, and only 2.6% of employees have 5 or more risk factors. Cisco's challenge is 2-fold: (1) help employees who are in the low-risk area remain low risk as they age, and (2) help the 30% of employees who are in the moderate-to-high-risk area lower their risk. High-risk individuals are substantially more expensive (incurring health costs of approximately $12,000 annually at age 39 years) than low-risk individuals (who incur costs slightly greater than $1,000 annually). Changing risk levels requires behavior modification and disease management. If Cisco's program simply maintains all employees at their current risk level, they will save considerable sums on health, disability, and sick leave in the future.

The information from the HPQ is still being tabulated to gather presenteeism data for Cisco, a step that is important for the business case. To build the Health Connections program, Cisco gathered all of its health partners—25 different companies and their representatives—to discuss the collaboration necessary to improve the health of all Cisco employees. PBM s and a number of pharmaceutical firms that have been helpful in sponsoring

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**FIGURE 2** Transforming to a Culture of Health

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<thead>
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<th>Global Health Improvement Strategy</th>
<th>U.S. Health Care Strategy</th>
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<tr>
<td>• Global health information and HRA</td>
<td>• Lifestyle risk management</td>
</tr>
<tr>
<td>• Global health enhancement program</td>
<td>• Innovative Web-based educational offerings</td>
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**2006 Initiatives**

- Integrated medical, behavioral health, and pharmacy-measuring outcomes
- Onsite pharmacy, possible onsite clinic
- Lifestyle risk-management programs with HRA
- Health care technology, e-visits, e-prescribing
- Enhance Health Connections
- Streamlined disability-management process

programs within the company were included. The goal: leveraging everything offered from all health partners to create the best benefit design and employee program going forward.

A major priority is establishing a behavioral health carve-in to measure outcomes. Each of Cisco’s health plans has a PBM. Cisco would like to determine if having primary care physicians, behavioral health specialists, and pharmacists work together ensures that employees who access behavioral health or chronic DM programs are referred appropriately and are adherent with medications. The continuum should often include appropriate medication and counseling, as in the case of comorbid chronic disease and depression.

Cisco is also involved in several connected health programs. The Silicon Valley Health Information Technology Program rewards physicians for adopting health information technology. This pay-for-performance program is examining E-prescribing, electronic health records, and physician/patient messaging. This is a partnership venture with Intel and Oracle, and it involves 10 medical groups in the Silicon Valley area. Each employer has contributed additional funds as incentives for medical groups to adopt this technology. It is Cisco’s belief that employees will have better physician access, and they expect that medication adherence will improve and medication error decline. Record keeping should be more comprehensive and accurate, leading to better outcomes.

In the summer of 2006, Cisco plans to begin a pilot program that will reimburse physicians in 1 geographic region for electronic office visits to promote employee access. This should stimulate adoption of secure technology and advance secure and structured physician/patient messaging and electronic prescribing. Employees will probably have fewer absences and enjoy more timely information exchange with their physicians.

## Conclusion

Enhancing program integration with employee education will promote employee engagement. Groups targeted for interventions will be more likely to become involved in appropriate programs. Establishing baseline metrics will allow employers to see what programs work and allow for recrafting of programs that are not achieving results. Constant reassessment, looking for opportunities to improve, will be essential, as will working with external partners and innovative designs. This integrated effort will ultimately improve the health of the population over time.