



Academy of  
Managed Care  
Pharmacy®



EXECUTIVE  
SUMMARY

## *Employee Health Benefits Executive Forum*



SEPTEMBER 16, 2015 ■ MARRIOTT MARQUIS ■ WASHINGTON, DC

Hosted by the Academy of Managed Care Pharmacy and the Integrated Benefits Institute in partnership with

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**Medi**impact



### *To Business Leaders Addressing Workplace Health Care Costs*

Recently, a select group of business leaders from across the nation assembled in Washington, D.C., to address one of the most pressing challenges facing employers today: managing health care costs while improving worker productivity in the midst of a chronic disease epidemic.

This invitation only *Employee Health Benefits Executive Forum* addressed how designing effective benefits plans can boost employee health and business performance. It was conducted by the Academy of Managed Care Pharmacy (AMCP) and the Integrated Benefits Institute (IBI).

Today, more than ever, successful business performance requires maintaining a highly competitive, highly skilled and highly productive workforce. But as U.S. businesses pour billions into capital improvements and global infrastructure, are they doing enough to boost their human capital? Health benefit designs should not only pay for care, but actually improve employee health, which in turn boosts productivity and overall business performance.

This exclusive, private event featured Scott Gottlieb, MD, former FDA Deputy Commissioner for Medical and Scientific Affairs, as keynote speaker, as well as three panel discussions which explored in depth the following issues:

- *Workforce Health & Productivity: Are We on the Right Track?*
- *Managing Chronic Disease in the Workplace: What's the Employer's Role?*
- *Pharmaceuticals—An Investment in Your Workforce, Not a Cost*

As you consider your future health plan design and objectives, we hope you find the following summaries useful, as well as the insights noted in the key findings and takeaways of the forum.

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# EMPLOYEE HEALTH BENEFITS EXECUTIVE FORUM FACULTY



## ***Moderator***

**Thomas Parry, PhD**

President,  
Integrated Benefits Institute



## ***Keynote Speaker***

**Scott Gottlieb, MD**

Resident Fellow,  
American Enterprise Institute



## ***Luncheon Speaker***

**Nancy McGee, JD, DrPH**

Executive Vice President,  
Avalere Health

## ■ EMPLOYEE HEALTH BENEFITS EXECUTIVE FORUM PANELISTS ■

### **Jill A. Berger, MAS**

Vice President, Health and Welfare  
Marriott International

### **Julie Cameron**

Sr. Benefits Director  
Comcast, NBCUniversal, and Comcast-Spectacor

### **Richard A. Feifer, MD, MPH, FACP**

Chief Medical Officer  
Aetna National Accounts

### **A. Mark Fendrick, MD**

Director  
University of Michigan Center for Value-Based Insurance Design

### **Paul Fronstin, PhD**

Director, Health Research Program  
Employee Benefit Research Institute

### **Kevin Mead**

Director, Employer Channel  
Novo Nordisk, Inc.

### **Duane Putnam**

Director Consultant Relations  
Walgreens Co.

### **Kyu Rhee, MD, MPP**

Vice President and Chief Health Officer  
IBM Corporation

### **Bruce W. Sherman, MD, FCCP, FACOEM**

Consulting Medical Director  
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Senior Consultant, Strategic Initiatives  
Academy of Managed Care Pharmacy (AMCP)

## INTRODUCTION

The prevalence of chronic disease in the United States has influenced much of the health policy decision making in the 21<sup>st</sup> Century. The Affordable Care Act (ACA) included numerous provisions for patients with pre-existing conditions and sought to improve care coordination for individuals with multiple disorders. Not only has the epidemic of chronic disease in America had detrimental effects on health care expenditures, but it has had an important impact on the nation's employers. "The seriousness of the situation facing employers cannot be overstated," said Mary Jo Carden, Vice President of Government and Pharmacy Affairs for the Academy of Managed Care Pharmacy (AMCP). "Almost 80% of workers have at least one chronic condition—and more than half have two or more." The productivity cost is enormous: \$1,685 per employee per year or \$225.8 billion.

AMCP has been a leader in developing principles and practices that advance the Triple Aim of health reform. "These aims are directly in sync with the task before us today, such as, how to design effective benefits that improve health outcomes and increase productivity of today's modern workforce," Ms. Carden stated.

Together with the Integrated Benefits Institute (IBI), AMCP organized and hosted the Employee Health Benefits Executive Forum to address how chronic diseases affect workforce health and productivity and how corporate employers can meet the challenge with actionable recommendations. "This is AMCP's second exclusive health care summit for senior executives from across business and the health care system," said Ms. Carden. "We're very proud to be able to convene some of the country's top thought leaders to address our most pressing health care challenges."

The Forum's moderator, Thomas Parry, PhD, President of the Integrated Benefits Institute, stated, "The ACA has changed a lot of things. One of these has been the shift in the conversation to the value of health. Employers have the option to walk away from health care and pay the financial penalty, and say 'I'm done with this.' Offering health benefits has to bring value to the organization," he said. "Not too long ago, employers considered health care a cost of doing business."

Dr. Parry believes this is an opportunity for health care professionals to demonstrate that health is more than a cost to business. "If CFOs don't believe [they] offer value to their business, employers will stop offering health benefit plans."

Held in Washington, DC, on September 16, 2015, the Forum was sponsored by Abbvie Inc.; MedImpact Healthcare Systems, Inc.; Novo Nordisk, Inc.; and Pfizer Inc. Nearly 50 corporate health executives participated in a full-day program that included panel discussions on how to design benefits that improve health outcomes and increase productivity of today's modern workforce and how to reset the corporate conversation around the value of health care benefits within their C-suite.





**Scott Gottlieb, MD**

Resident Fellow,  
American Enterprise  
Institute

Market and policy factors have greatly influenced the changing health care landscape, and the ACA is playing a huge role in the consolidation of the health care delivery industry, according to Scott Gottlieb, MD, Resident Fellow of the American Enterprise Institute. He believes that this will have enduring implications for health care finance and delivery.

In testimony before Congress, Dr. Gottlieb stated, “While we’ve seen other waves of consolidation sweep the health services sector (most recently in the late 1990s), the current series of mergers and acquisitions is different. It’s wider, and more sustained. It’s unfolding on an industry that was already heavily consolidated. As a result, the impact on patients is more profound and enduring.” At the Forum, Dr. Gottlieb explained that one reason this round of consolidation will be long-lasting is that rather than market factors driving it, the consolidation is much more driven by policy initiatives, the ACA in particular. Congress will not repeal the ACA, he indicated, because the so-called “doc fix,” the recent sustainable growth rate (SGR) recodification, is too significant a part of the ACA to make its repeal appealing to anyone—doctors, hospitals, or legislators.

The consolidation of health plans and hospitals has even more repercussions today, because of the very low number of new health plans or providers entering the marketplace.

Dr. Gottlieb noted that high regulatory barriers exist today for those willing to start a plan or hospital. “We’ve not seen any new *net* commercial plan increases since 2008. And about two-thirds of new plans are co-ops, which are subsidized and are largely under financial stress,” he said.

Dr. Gottlieb stated that provider consolidation is being propelled by several health policy initiatives, most notably by changes in reimbursement, the use of narrow provider networks, lower physician revenues and increased costs, greater payments for similar services in the hospital rather than the doctor’s office, and hospital and health plan consolidation.

**Bundling of Payments and Services.** The greater utilization of service bundling across therapeutic categories and treatments is one factor driving consolidation. “A couple of weeks ago,” said Dr. Gottlieb, “CMS surprised some by rolling out bundled payment arrangements for hip replacements. CMS will move a lot quicker toward these mandatory risk-based payments.”

**Narrow Networks.** Provider mergers and acquisitions are also occurring as defensive actions to payers’ recent emphasis on narrow networks, particularly for the exchange plans. “The ACA made narrow networks more politically accepted and protected,” noted Dr. Gottlieb, who does not believe that they will be subject to the consumer backlash seen with network cuts by payers in the 1990s. “Narrow networks are one of the remaining ways plans can control costs,” he said. “Other tools are either being regulated out or have been made relatively ineffective.” He expects that narrow networks will spread beyond exchange plans and into other areas of the commercial marketplace.

**Cuts to Physician Practice Profitability.** Further, physicians are seeing lower revenues and new costs imposed on them (e.g., health information technology requirements under the ACA). “Revenues have not kept pace with costs, even with substantial increases in productivity across specialties. It is thus causing more consolidation,” said Dr. Gottlieb. He suggested that the SGR fix will provide increases in reimbursement if physician groups can meet quality performance benchmarks. However, smaller medical groups do not have the IT system sophistication to meet the challenge; therefore, consolidation with larger groups or health systems may be the answer. He also noted a decrease in medical practices owned by physicians and an increase in doctors seeking employment in health systems and hospitals. He cited the case of oncology practices, where 46% of practices had six or fewer clinicians in 1997; this figure is estimated to be only 10% by 2020. The percentage of oncologists employed by hospitals is expected to grow, reaching 50% by 2020.

**Site-of-Service Reimbursement.** The differentials in payments for services provided in the doctor’s office versus in a hospital is another factor compelling consolidation. “For services that can be provided in the office, payments are much higher if they are shifted to the hospital setting,” Dr. Gottlieb said. This is especially true for oncology and cardiology. This large site-of-service differential will be difficult to address, he believes, because Congress has traditionally tried to protect hospital revenue: If a hospital experiences lower revenues, rather than unwinding consolidation, they would more likely shrink, with layoffs. Hospitals are often the largest regional employers in a Congressional district. Yet, he does believe site-of-service differentials “have to go away and rather quickly...there is so much scrutiny on a bipartisan basis of these site-of-service differentials today. If I were a hospital executive, I wouldn’t make a bet on provider buyouts if my profits were dependent on site-of-service differentials.”

**Hospital and Health Plan Consolidation.** The greater market leverage over clinicians by larger health systems has also contributed to provider consolidation. Mergers and acquisitions by health plans increased by 50% in 2014, noted Dr. Gottlieb. He predicted that this trend will continue as not-for-profit plans have difficulty maintaining or growing revenues in the face of several factors, including low margins associated with Exchange participation. Hospitals are also merging at unprecedented rates: 100 hospital merger deals were completed in 2014, a 14% increase from 2013. Additionally, more hospitals are part of larger health systems than ever before, he noted, spurring physician groups to join with others to avoid being locked out of networks in markets dominated by larger systems.

**A Move Toward Self-Insurance for Employers.** Large employers have often preferred to self-insure their health plans rather than fully insure them through managed care organizations. Employers are trying to manage risk, and self-insuring health benefit plans are becoming a more appealing option. The impending “Cadillac tax,” which is scheduled for implementation in 2018, will ensnare larger portions of the insured population than intended, according to Dr. Gottlieb, much like the alternative minimum tax did for the middle class. This may persuade more corporations, including some mid-size companies, to consider self-insurance. It will also further move employers toward a defined contribution rather than a defined benefit health policy.

Employers are also expressing a strong interest in directly contracting with providers. Contract discussions and negotiations with physician groups and hospital groups may be predicated on size of the provider network, further encouraging consolidation of practices. Dr. Gottlieb does not believe that smaller employers have the toolset to contract directly with providers, however. In response to an audience question, he said, “There are more self-insured options out there. Some payers are making it easier for smaller employers to self-insure. This doesn’t make it a good idea, though. For those employers concentrated in small geographic areas, it might make sense.” Dr. Gottlieb added that for those persons on the exchange, who earn low wages and are receiving a subsidy for health premiums, the financial benefit they get on the Exchange is far greater than if they received their health benefits through an employer-sponsored plan.

**Pitfalls of Provider Consolidation.** Although provider consolidation is a considerable force and is perhaps still gaining momentum, Dr. Gottlieb noted that the pitfalls of consolidation are significant. Foremost is the risk of less competition and thus higher prices. In addition, as more physicians are employed by hospitals on salaried bases, their productivity can be expected to decrease. Finally, as providers lose their autonomy, so too may they lose discretion in clinical decision making, as more direction is issued by the central health system.

A question from the audience pointed out recent instances of newly consolidated providers starting up their own insurance entities. Dr. Gottlieb replied, “The authors of the ACA always saw that, amidst all the consolidation, some would start their own insurance arms. But provider systems are not good at managing actuarial risk. The same thing did not work in the 1990s, and I don’t think they’ve gotten better at it. However, they have a better chance at success today than in the past,” he said, “because the data integration necessary to better manage the risk is now achievable. We also have better tools to analyze these comprehensive data,” said Dr. Gottlieb.

### *Workforce Health and Productivity: Are We on the Right Track?*

**Panelists:** **Jill A. Berger, MAS**

Vice President, Health and Welfare  
Marriott International

**Kevin Mead**

Director, Employer Channel  
Novo Nordisk, Inc.

**Kyu Rhee, MD, MPP**

Vice President and Chief Health Officer  
IBM Corporation

The panelists agreed that the front-line workers are the ones most responsible for bringing in the business or helping companies retain it—and their health greatly influences their performance. Marriott International recognizes the need for “happy, healthy associates to take better care of our guests,” said Ms. Berger. Mr. Mead pointed out that back in 1776, Adam Smith, in *The Wealth of Nations*, made the connection between health and well-being of employees and the effectiveness of the labor force.

The session moderator, Dr. Parry, said that according to Towers Watson, one-fifth of employers have an incentives program to encourage employees to improve their health and wellness. These incentives average \$690 per individual involved in a health and wellness program. However, very few employers have the ability to measure the effectiveness of these programs or the effectiveness of general health benefits.

**Wellness and Health Promotion.** Mr. Mead stated that 98% of employers with 200 or more workers have health promotion programs in place. The level of engagement in these programs is a challenge, though. “This whole area of well-being and patient engagement started slowly, but when used in the right way, it is very effective,” he said. “Instilling a culture of well-being and patient engagement were rated the number 1 and 2 top priorities in a recent employer survey.”

At Marriott, the culture of well-being started with J. Willard Marriott, said Ms. Berger. It is based more on a philosophy of positive action rather than disincentives. “The only disincentive we use is against smoking,” she said. Some hotels have even gotten rid of the deep fryer and improved employee food choices, helping to earn them a “healthy hotel” certification. “Forty percent of our hotels were certified in the first year of the program,” remarked Ms. Berger.

Creating this culture of health is essential, agreed Dr. Rhee. “We do know that if you use disincentives for tobacco use, people smoke less,” he added, but for other programs, the outcomes are not always as clear, or not yet confirmed with evidence. He said that at IBM, its programs are not always evidence-based but *evidence-informed*: “IBM is a data-driven,



(L to R) Tom Parry, Kevin Mead,  
Jill Berger, Kyu Rhee



science-driven company.” In promoting this culture of health, “we need to make the healthy choice the easiest choice for our employees,” Dr. Rhee said.

IBM began offering health promotion incentives in 2002, according to Dr. Rhee. Today, employers use the same incentive for all of their workers, and he believes this will be personalized in the future. In addition, employee incentives will be according to risk, by analyzing data and producing employee-specific risk reports.

**Challenges to Employee Health.** Some industries are challenged with basic problems, such as diverse worker populations or limited health literacy. Ms. Berger commented that if Marriott’s workers have chronic conditions, “they are unlikely to change jobs because of our health benefits.” It is very important therefore to direct their associates to the most cost-efficient care with the right provider at the right time. A basic challenge to Marriott’s efforts, she pointed out, was that rather than owning the properties, they manage the majority, which limits the types of programs they can easily implement.

Another challenge is the actual effectiveness of employee incentives, admitted Ms. Berger. She stated that their incentives for participating in health-risk assessments (HRAs) did not work. Partly, this was an issue of trust. “When we told our associates that we would take money out of their paychecks if they didn’t complete HRAs,” she said, “they took the assessments, but there was widespread [employee] dissatisfaction. We’ve moved away from that now.”

Dr. Rhee emphasized that one of the challenges to employee health is that health providers spend only three to four hours per year with individual patients on health care issues. “We need to supplement that relationship with our employees on health,” he said, pointing out that retail pharmacies are a more common point of contact. He mentioned that IBM has promoted the use of “minute clinics” in network pharmacies.

An audience member pointed out that in the past, employees were given a finite number of sick days, and this has evolved to personal time-off (PTO) banks, which do not differentiate between sick days and personal days, and are not always set allowances. This raises challenges in terms of measuring disability and productivity. Dr. Rhee added that many behaviors cannot be reliably measured (e.g., asking workers whether they wear seatbelts and how often, or whether they wear helmets when riding bicycles or motorcycles). Dr. Parry commented that most employers have questions in their HRAs regarding workers’ personal behaviors and how many days they were sick last year. “The opportunity in engagement is to start getting pharmacists, physicians, and wellness coaches to ask these questions, and gather the data longitudinally.”

Mr. Mead also stated, “The movement toward well-being is creating a different dynamic: Health care takes place on a daily basis, not just when you visit your doctor.” This emphasizes the importance of data collection beyond the physician’s office.

**Patient Engagement Is Key.** “We want to show our associates that they have a role in their health care,” said Ms. Berger. Most of the programs used by Marriott differ by hotel location. “We have 30 onsite health coaches at our largest properties whose goals are to work with

associates one-on-one, face-to-face, and develop trust. This program made a huge impact,” she explained, with Marriott finding decreased emergency room utilization associated with those properties employing the health coaching program. Ms. Berger also mentioned that health coaches can influence the usage of non-office visits, such as telephonic services.

Dr. Rhee urged that the mission of health benefits should be focused on “the Triple Aim plus patient engagement. We need to democratize the patient’s health care decisions,” he said. In other words, clinical decision making is not exclusively limited to physician discretion.

**Partnerships.** Marriott is seeking to work with organizations that can help identify workers at greatest risk for health issues. In an effort to increase employee access to care, Ms. Berger related that her organization has developed onsite and near-site clinics. This type of initiative is often affected by the location of the facility. For example, at the hotel’s Marquis property in Times Square, New York City, they have contracted with Montefiore Health System and Mount Sinai Health System to provide priority appointments for its workers.

**Telemedicine.** According to Mr. Mead, an estimated 16 million telemedicine encounters are expected this year. Although he does not care for the term “telemedicine” because he believes it sounds impersonal, he does acknowledge that “from what I’ve read, there’s a high degree of patient satisfaction with this model.”

**Data Analytics and Insight.** Only 10% of health outcomes are related directly to individual health care, stated Dr. Rhee. “The rest is related to genetics and environment.” He suggested that wearable electronics can be very important to contribute exogenous data on health care, which can be used for collection, analysis, and patient engagement.

An audience member asked how the panelists measure the value of interventions that they provide their workers. Ms. Berger stated that her company started by looking at claims data. “We saw an impact of some programs, but it was not huge,” she said. “But now we’re also looking at disability days as well, and you can see the impact grow. We also are tying that together with guest-satisfaction scores (and with healthy hotel certification scores).” Dr. Rhee responded that he analyzes the program against the established trend. “Under our health programs, we are typically about 50% of trend (overall, in all global locations). Of course, there’s also mammography and colonoscopy rates, and there’s adherence rates.” He mentioned that they collect health risk assessments on IBM’s five dimensions of health, and have started giving Fitbit monitoring devices to workers who are interested.

**Measures of Progress.** When asked whether corporate America was on the right track in terms of workforce health and productivity, the panelists’ responses were mixed. Mr. Mead explained that our success today “depends on what measures you’re looking at. Well-being indices seem to indicate that we’re moving in the right direction.” Ms. Berger believes, “We’re making inroads in employee happiness.” Dr. Rhee’s response was more ambivalent: “Some of us are on the right track, and some aren’t.” But he pointed out that time is running out—employees’ cost share will be untenable in the next 10 years. “We’re not moving as quickly as we need to.”



**Nancy McGee,  
JD, DrPH**

Executive Vice President,  
Avalere Health

According to consultant firm Castlight Health, annual health care spending in the United States exceeds \$3 trillion, 21% of which is shouldered by the nation's employers, reported Nancy McGee, JD, DrPH, Executive Vice President, Avalere Health. It is not surprising then that employers, looking for ways to reduce costs and improve the utilization of their benefits programs, are turning to the following:

- Tiered benefits and programs with market-based benefits (also called reference-based benefits)
- Incentive structures to encourage healthy choices
- Mechanisms to shift risk to employees (including high-deductible health plans)
- Experiments to transition employers to more meaningful benefit structures for their discrete employee populations

Dr. McGee commented that “employees are confused about the benefit, and are also subject to greater cost shares. You can understand their frustration.” From the employee's perspective, health care costs are a black box. Payers have tried to help members better understand their benefits by dramatically changing the information offered to them. “Employers must also help employees increase their health benefit literacy and better value the employer's investment in their benefit options,” she said. This can be accomplished by unifying all of the benefit options in one place so that employees can see how their choices impact cost (e.g., pharmacy vs. mail order, telehealth option vs. urgent care).

Dr. McGee looks toward disruptive innovations in health care, which may be able to suddenly change the landscape, much like Uber did in the ride services industry. Disruptive innovation in this field is emerging from third-party vendors to:

- Increase adoption of cost-efficient benefit designs that empower employees to make informed choices while increasing the impact of other health and wellness programs,
- Reduce absenteeism and enhance workforce performance by improving presenteeism,
- Establish a recruiting competitive advantage by increasing employee satisfaction with benefit programs, and
- Boost workforce engagement in health care programs by adopting savings opportunities and rewards/incentives for choices.

“We're scratching the surface in using technology to help our employees make their own choices,” according to Dr. McGee. For example, an analysis revealed that women and men search the Web differently for health care information. Topics most commonly searched for by women reflect frequent conditions or complaints, with medical search terms such as endometrial ablation, fibromyalgia, bariatric medicine, and hip replacement. Furthermore, Dr. McGee said, women tend to be more specific in their search terms than men, who will search more often by body parts (i.e., shoulder, hernia, wisdom tooth, tennis elbow) than by disease state. “In addition, search terms and times are differentiated by geography,” she

## LUNCHEON ADDRESS CONT'D

explained. Searches by individuals living on the West Coast identified patient interest in alternative medicine such as acupuncture, massage therapy, and naturopathic doctors, whereas in southern states, searches were three times more likely to relate to bariatric surgery and obesity-related health issues. "This helps us to refine and understand employee engagement by understanding what is important to them," said Dr. McGee.

She cautioned that data are only useful if they can be distilled into insights that drive goals and objectives for both the employer and employee. Dr. McGee offered a case study from a third-party vendor whose client, a chicken-processing company, experienced greater emergency department (ED) visits than the national average. The data were analyzed by the consultant, finding that one specific manufacturing plant was driving the trend, and the ED overutilization was limited to night-shift workers at the one plant. The consultant helped to improve night-shift workers access to non-ED care by promoting telehealth benefits. The result, Dr. McGee reported, was a 21% reduction in ED visits at the specific site and a 9% reduction in ED visits overall.

She concluded that we are only just beginning to use disruptive technology tools to help employers structure meaningful benefits for their employee populations. "It's about unifying all their benefits, helping them understand their benefits, and helping them feel good about it. It also makes employees more productive at work," Dr. McGee said.

## Managing Chronic Disease in the Workplace

**Panelists:** **Richard A. Feifer, MD, MPH, FACP**  
 Chief Medical Officer  
 Aetna National Accounts

**Paul Fronstin, PhD**  
 Director, Health Research Program  
 Employee Benefit Research Institute (EBRI)

**Bruce W. Sherman, MD, FCCP, FACOEM**  
 Consulting Medical Director  
 Employers Health Coalition Inc.



(L to R) Tom Parry, Richard Feifer,  
 Paul Fronstin, Bruce Sherman

**ROI and Value.** When considering the management of chronic disease in the corporate environment, Dr. Feifer raised the issue of return-on-investment (ROI). “Demonstrating the effectiveness of narrowly focused disease management programs remains a challenge,” he said, and showing ROI has been the key concern. “What defines a successful initiative, beyond ROI?” he asked. “We are seeing a significant trend away from the narrow view of ROI to the broader view of success or effectiveness.” He added that a perfect measure of effectiveness does not exist, and in accepting this concept, Aetna now employs several measures, displayed as a dashboard for their patient support and care management efforts.

“It’s important to remember why employers are offering health benefits,” counseled Dr. Fronstin. “They think it’s important to their business. Here we are, post-ACA, and employers are still offering the benefit, despite the small penalty (\$2,000) versus what it would cost to provide the benefit.” He did worry, however, about what might occur when the next recession hits. “What will employers do then?” he wondered.

Dr. Fronstin said that employers spend more than \$600 billion directly on health care expenditures, but productivity losses account for an additional \$300 billion. Chronic conditions are responsible for the majority of these costs. He believes that CFOs are still looking at ROI for these programs, asking, “When are these DM [disease management] benefits going to save us money?”

**Provider Accountability and Population Health.** Although population health has been a focus of payers, academicians, professional associations, and even the government for a number of years, providers are a little late to the game. Dr. Feifer noted that the major transition toward provider accountability (e.g., formation and participation in accountable care organizations) is beginning to influence this. “It will evolve over time,” said Dr. Feifer. “It will take longer for



health systems to take responsibility for the full spectrum of population health. In the meantime, providers will take increasing responsibility for areas within their control and their ability to directly influence.”

**Narrow Networks.** For years, efforts to trim broad provider networks have been focused on obtaining greater discounts, said Dr. Feifer. “Going forward, narrow networks will play a more fundamental role in enabling high value providers to be successful.” The only way that new initiatives in provider accountability will work, he suggested, “is if we accept the notion that narrow networks are part of the solution. The only way we can help efficient providers win is if we channel more patients to them over their less efficient counterparts.”

**Benefit Design, Health, and Wellness.** The workplace is perhaps the most important place to encourage health promotion, said Dr. Feifer. “People spend a lot more time at the workplace than they do at the doctor. Health promotion will always be relative to where they spend the most time—at work.”

Health benefit design is usually structured without a great deal of thought given to wellness and health promotion. For example, the implementation of high-deductible health plans and/or health savings accounts (HSAs) has produced suboptimal results in terms of wellness, adherence, and health promotion, according to Dr. Fronstin, who reviewed EBRI’s work on HSAs involving a large employer; the HSA design was implemented in 2007, and data were collected over 4 years on 18,000 people. “The findings were mixed,” he commented. “The HSA saved the employer money, but at a cost. For instance, adherence on medications went down. In year 3, we saw an increase in ER visits, which was highly significant by year 4.” Dr. Fronstin thinks it was in relation to the lower adherence on medications. “You see employers with HSAs actually increase the benefit. They did find that in terms of wellness programs, even token incentives (e.g., \$20) persuaded people to get health risk assessments (HRAs), jumping participation rates to nearly 95%.” Their analysis did find that “those who participated after the incentive was introduced had more health problems,” according to Dr. Fronstin. “Our own survey of workers found that of the nonparticipants, they would participate if offered \$200.” He emphasized, “We need to get the people into the program who can really benefit from it. Employers need to reevaluate their use of incentives.”

The use of incentives to have workers complete HRAs is a first step, indicated Dr. Parry. He cited a Harvard University analysis of a 150,000-employee database. “Most HRAs ask the person which chronic diseases were diagnosed by a physician,” he explained. “Harvard did something different: It analyzed responses based on what conditions they have (regardless of whether it was diagnosed and treated).” Exaggerated reporting on HRAs needs to be considered. Dr. Fronstin said that biometric data are very important, along with HRAs, to ensure better data.

Dr. Sherman added that in the evolution of benefit design, chronic disease management has not been well considered. “Cost shifting has caused financial stress,” he said. “Half of those filing for personal bankruptcy have health insurance. Some can’t afford to pay their deductible.

People have priorities other than their own health care—financial, work-related, caregiving, and other issues come first.” He noted that in one survey, personal health ranked only number 9 among individuals’ priorities.

One of the results, Dr. Sherman suggested, is low participation rates in wellness programs, despite the use of incentives. He stressed, “Even if they have first-dollar coverage for the management of chronic diseases,” they often don’t take advantage of the benefit. “Instead of incentives,” Dr. Sherman urged “focusing on what matters to these people. If we don’t, we will not get their attention to better manage their health.”

An audience member agreed, saying that 5% of people account for 50% of health care spending, but the healthiest Americans account for only 3% of spending. “We are spending a lot on incentives for those who don’t benefit from the programs. How do we get those with chronic disease into the care they need, when incentives are going in the wrong direction?” he asked. Dr. Sherman replied that we first really need to understand why that 5% is accessing health care.

**Stressing the Critical Importance of Emotional Stress and Obesity.** Dr. Parry referenced a study in which IBI was engaged with 10 employers to examine the total economic impact of poor health. He noted that for these 10 employers, although cancer is the most costly condition, the conditions that most affect productivity are depression followed by obesity.

One audience member related that although “we have typical chronic disease management programs in the workplace, we need value-based programs for stress management.” This person, working in an educational system, “sees teachers in the tougher schools disappear to the tune of 30% per year. Even younger teachers in tougher schools have worse health. We have to find a way to keep the teachers in the classroom. What would a program for stress and depression look like?”

Dr. Feifer responded that these programs “need to flex and vary based on people involved. There are proven behavioral health techniques that help but they need to be applied,” he stated. “We shouldn’t be narrowly focused on the ROI of a stress-reduction program. Rather, we should be looking at value more broadly, which in your case involves reducing teacher turnover.”

“If I’m managing the total economic impact of poor health for the 10 employers studied,” said Dr. Parry, “I’m going to focus my scarce resources on depression and obesity.” Dr. Sherman agreed, saying that employers have not fully grasped the importance of obesity in terms of comorbid costs. “That said, most available wellness programs are directly or indirectly addressing obesity. When dealing with low-age worker population, stress results in more eating, smoking, or other unhealthy behaviors,” he emphasized.

**Medical/Pharmacy Database Integration in Chronic Disease Management.** Another question from the attendees involved the state of medical and pharmacy data integration to track gaps in care. Dr. Parry believes that employers must recognize that the health plan is only a part of the solution, because employers tend to work with many suppliers of services in managing workforce health. “Plans are not so good at generating actionable analysis based on the reports from the databases, because they typically only have a partial view of the whole,” he said. “We need a more holistic, population-based health perspective. Employers are ahead of the market on this issue.” From a payer’s perspective, improving care by leveraging integrated medical and pharmacy data (which is just part of the data available) “should be an expectation of plan sponsors, whether carved in or carved out,” according to Dr. Feifer.

It is difficult to do a comprehensive analysis of the data if several pieces of information are missing. Dr. Fronstin mentioned his own frustrations in getting additional information from employers, including Zip Codes and employee educational levels. Dr. Parry agreed that having the data is key to making good decisions. Employers need to “be able to deal with this pragmatically, not starting with granular detail, but understanding what they did not know about their population that they now know.”

## How Can Pharmaceuticals Be an Investment in a Company's Workforce?

**Panelists:** **Julie Cameron**  
Sr. Benefits Director  
Comcast, NBCUniversal, and  
Comcast-Spectacor

**A. Mark Fendrick, MD**  
Director  
University of Michigan Center for  
Value-Based Insurance Design

**Duane Putnam**  
Director Consultant Relations  
Walgreens Co.



(L to R) Tom Parry, A. Mark Fendrick,  
Duane Putnam, Julie Cameron

### Investment Through Pharmacy and Patient Engagement.

As mentioned in the session, a company's focus on the customer must also include the employee who is facing the customer. Mr. Putnam stated that if companies say their employees are their most important asset, then this overall health investment, and specifically in pharmacy and pharmaceuticals, "must start with corporate culture. We need to get to a culture where the employees feel appreciated. Happy and healthy employees make for happy and loyal customers. The message of well-being needs to be part of the corporate culture to stick." It is important for that message to filter down undiluted from the C-suite to senior leadership, to department heads, and to front-line staff. "The message that a culture of well-being is critical to the company's sustainability shouldn't be lost along the way," he said.

In practical terms, Mr. Putnam commented, "People who can't meet the deductible won't engage. If employees don't follow the medical regimen, no one wins." He pointed out though that adherence is not the end goal; adherence drives outcomes, which is the real target.

Two of three ACA pilot programs focusing on improving adherence emphasized the critical importance of the pharmacy, according to Mr. Putnam. "If you're trying to improve health care engagement, take advantage of the pharmacy, where your employees spend significant time, to complement the physician visit." He complained that most times, when programs that try to improve adherence are presented to employers, the pharmacist and pharmacy has been left out of the solution. "If we want to get return on the money we spend for medications, we need to capitalize on the patient trust and expertise of pharmacists," he said.

**Aligning Copays and Deductibles With Evidence-Based Medicine.** Dr. Fendrick has long been a proponent of changing the discussion on health care today "from how much we spend to how we spend it." Dr. Rhee, Vice President and Chief Health Officer of IBM, pointed out in

## PANEL SESSION 3 CONT'D

his presentation that the adherence rate of persons taking their prescribed life-saving drugs is only two-thirds. “Would there be any other key quality metric at IBM where a 66% success rate would be considered a good result?” he asked.

Overall, individuals are being asked to pay more for every aspect of health care, according to Dr. Fendrick, regardless of whether interventions have value in terms of individual and population health. He related the case of a patient with diabetes who did not have insurance before signing up with a high-deductible health plan (HDHP) through the state exchange. Only one visit to her internist was covered prior to meeting the plan deductible; she would have to pay for her medications, laboratory testing, eye exams, and additional visits in their entirety until the deductible was fulfilled. As this patient had insufficient money to pay the deductibles, she told him, “I’ll either see you next year in the office or when I am in the hospital.”

Dr. Fendrick said that HDHPs are also misaligned with trends in physician accountability and quality-reporting requirements: The key diabetes quality measures—HbA1c levels, rates for medication adherence, foot exams, eye exams—should be linked through the medical benefit to office visits that do not count towards the deductible, making it easier for patients to access (and physicians to report).

“The benefit design should make it easy for patients to access interventions that have been shown to work in terms of producing health,” asserted Dr. Fendrick. For employers concerned about possible cost increases with this approach, he commented that if they cut back on coverage for low-value services, they can afford to pay for the high-value ones.

He pointed out that HDHPs are also not aligned with value-based insurance designs (VBIDs), which align patients’ out-of-pocket costs, such as copayments, with the value of services. These innovative products are designed with the tenets of “clinical nuance” in mind. These tenets recognize that (1) medical services differ in the amount of health produced, and (2) the clinical benefit derived from a specific service depends on the consumer using it, as well as when and where the service is provided.

Dr. Fendrick assigned responsibility of the inability to incorporate clinical nuance into HDHPs to the Internal Revenue Service, as existing guidance “does not allow the pre-deduction exemption (that allows colonoscopies) to also allow insulin or other drugs and services that have high value.”

With regard to pharmaceuticals, Dr. Fendrick’s message was simple: “Make sure people who require a specific drug (even specialty) in specific clinical scenarios can get it.” He suggested that plans consider “rewarding the good soldiers,” a benefit design that lowers consumer sharing for those who diligently follow the required steps to treat their condition but require an additional therapeutic option. Payers and plan sponsors should reward patients who do everything they are supposed to do (e.g., by first trying the low-cost drugs) by lowering the cost share for their use of the more expensive drug.



“Zero-cost preventive services is the most popular part of ACA (even for those not in favor of the ACA),” said Dr. Fendrick. “Why can’t pharmacy benefit managers do step edits with copay relief? Of course they can, if they already do step edits.”

Dr. Fendrick emphasized the need for “clinical nuance” as part of VBID. That is, thinking about the value of medications not just within a drug class (e.g., generics vs. brands) but across drug classes: Should a medication to treat toenail fungus have a lower copay than a medication to treat diabetes? As Dr. Fendrick’s colleague Michael E. Chernew has said, “A one-size-fits-all benefit design is irrational.” Clinical nuance is a key to rational benefit design and cost sharing.

Ms. Cameron said that at Comcast, “we don’t have HDHPs; we use low-deductible health plans for 80% of employees (having an actuarial value of 91%). We want to keep it that way, because we want to be at the dining room table with our employees at the worst of times and at the best of times.” The employees highly value their health benefits. She added that in order to keep a rich benefit plan, “we needed to figure out ways to remove waste from the system. In the fall of 2013, we realized that we had low-hanging fruit with our prescription drug plan,” which wasn’t rigorously managed (limited use of step therapy, generic substitution, quantity limits, or other pharmacy tools).

“With our PBM, we put into place an incentivized value plan in January 2014 that left in place [tier 1 and tier 2 copays] but implemented 80% coinsurance for tier 3 medications (those with generic or therapeutic alternatives). We do have tiering exceptions and overrides in place,” Ms. Cameron said. Although not the point of this discussion, she did note that the changes made to the benefit saved a lot of money, and it has enabled the company to avoid any rate increases in 2015 and 2016 for their lowest-earning employees (< \$75,000/yr). “We may even be able to keep our premiums constant for 2016 throughout all of our salary bands,” she stated, mostly due to the pharmacy benefit design change.

Health savings accounts themselves may be a disincentive to adherence and gaining better outcomes. In an HSA, money not used at the end of the year rolls over as personal savings. In contrast, a health reimbursement account requires that the money deposited in the account in that year must be spent on health care—this money doesn’t roll over. Mr. Putnam commented that at Walgreens, they opt not for an HSA but for a health reimbursement account, “because we don’t want employees to save money on their health care; we want them to *spend* money on their health care.”

The Forum’s moderator, Dr. Parry, remarked that his organization reviewed in 2014 the impact of copays and deductibles on adherence and productivity. “We found that things that reduce adherence, though yielding short-term cost savings, also increase productivity losses through worker absences.” He believes a greater proportion of employers will move to full-replacement HDHPs as a way to avoid the Cadillac tax, which may further threaten medication adherence, health, and productivity.

## PANEL SESSION 3 CONT'D

Dr. Fendrick stated, “I think the deductible is the biggest challenge that we have on the consumer side—by far. If the office visits are not being made because they are subject to the deductible,” needed prescriptions that are covered outside of the deductible will not be written. “I like the use of high deductibles for the care you don’t need. But just because [some intervention] is outside of the deductible doesn’t mean it has to be free,” he said, alluding to copays and other cost sharing to prevent inappropriate utilization.

**An Evolving Role for PBMs?** Dr. Parry asked, “How can PBMs be part of the full value proposition? How can they focus outside of just the pharmacy spend?” Ms. Cameron answered that Comcast considers the PBM as its partner who understands its philosophy. The PBM helps her organization dig into the data to make sure it is doing the right things. In addition, the PBM helped design its compounding strategy in 2015, which contributed to savings.

“It is interesting how many PBMs there were before the consolidation,” said Mr. Putnam. “As time went along, they realized they needed to differentiate themselves, adding more services rather than just adjudicating scripts.” He wondered, though, as the PBMs have consolidated “whether they have gotten too big to be able to get down to the micro level or patient level as much as is needed.” Mr. Putnam is a firm believer that employers need to set the strategy, set the goals and measurements, and “instead of letting the tail wag the dog,” they need to take the lead.

The traditional PBM business model is not in tune with VBID, according to Dr. Fendrick. “I thought that a program that would lower cost sharing and improve adherence would be something they would embrace,” he said, but they didn’t because of the potential loss of rebates. “Today, the smaller PBMs and many of the larger ones will provide a value-based formulary—if asked.” Pharmacy benefit managers with exclusionary formularies may also be missing the mark, said Dr. Fendrick, if it is based not on value but on cost.

- Engage in a dialogue. As there is an array of stakeholder views, we must have dialogue to address the issues.
- VBID is not impossible—it can be done. The right way to do it is by offering copay relief when people go through the required step therapy.
- We need to integrate the medical and pharmacy data and leverage them to obtain actionable information. We also need to integrate lost time and productivity data for a full view of population health.
- Vendors sell products. Partners provide solutions. Employers need to work with health partners.
- Employers should consider the value of health to their organizations when innovating benefit programs—the corporation should care not only about medical and pharmacy spending but also that its associates are living happy lives and thus are coming to work fully productive.
- Waves of consolidation have occurred in the past. This time it is different; it will stick. However, one of the pitfalls of consolidation is that costs can rise as hospitals are able to dominate local markets.
- The data integration piece is now achievable. This is a different situation than in the 1990s: Better tools exist to analyze it, and risk can be better managed using these comprehensive data.
- Employers, payers, and other purchasers should institute not just VBID, but “clinically nuanced” VBID. This is beyond simply asking patients to pay more for low-value treatments than for high-value treatments within a disease class (i.e., generics vs. brands). This also considers how benefit designs should weigh low-value treatment across disease states (e.g., should health plans and other payers be spending more to treat toe-nail fungus than blood pressure medications)?
- Employers need to enroll people into health and wellness programs who will really benefit from them. As a result, employers should re-evaluate their wellness-related incentives and who uses them.
- Corporations need to keep the focus on the customer, and this includes focusing on the employee who is facing the customer. This means instilling a culture where employees feel appreciated.
- The value of chronic disease population health/disease management programs cannot necessarily be measured by ROI. Other aspects of value, including employees’ satisfaction and their interaction with the customer, must be considered.
- Wellness programs cannot simply be some sort of one-time incentive program. They need to be part of the corporate culture to stick.

# Strategic Plan



Academy of  
Managed Care  
Pharmacy®

## AMCP's Strategic Priorities

*The Academy of Managed Care Pharmacy continues to invest strategically in the profession of managed care pharmacy through its five strategic priorities.*

### Strategic Priority 1 –

#### Be the Leading Provider of Education, Research and Resources for Managed Care and Specialty Pharmacy

*Purpose: Make AMCP the go-to organization for cutting-edge information.*

### Strategic Priority 2 –

#### Expand Value of AMCP Membership

*Purpose: Maximize the membership value to the managed care and specialty pharmacy professional and provide services and resources.*

### Strategic Priority 3 –

#### Improve Patient Outcomes and Health Care Affordability

*Purpose: Ensure managed care and specialty pharmacy practice is at the leading edge in the delivery of quality and affordable health care.*

### Strategic Priority 4 –

#### Be the Credible and Authoritative Voice for Managed Care and Specialty Pharmacy

*Purpose: Develop a better understanding of managed care pharmacy among multiple stakeholders to increase the acceptance and use of managed care pharmacy principles.*

### Strategic Priority 5 –

#### Execute with Organizational Excellence

*Purpose: Operate efficiently, effectively and maintain fiscal health through sound business and association practices.*

**For More Information** | Please visit the AMCP website at [www.amcp.org](http://www.amcp.org).

## AMCP Vision

Managed care pharmacy improving health care for all.

## Mission

To empower its members to serve society by using sound medication management principles and strategies to improve health care for all.

## Core Values

In serving and anticipating the needs and interests of our members in the provision of high quality health care, AMCP embraces the following core values:

- Credibility
- Transparency
- Collaboration
- Innovation

## Envisioned Future

If successful, this strategic plan would move AMCP and its members to a future where...

*Managed care pharmacy is widely understood and accepted as integral to the delivery of quality and affordable health care.*

Adopted by the AMCP Board of Directors,  
October 2014

## About AMCP

The Academy of Managed Care Pharmacy (AMCP) is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's nearly 7,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit. More news and information about AMCP can be found at [www.amcp.org](http://www.amcp.org).

## Moving Forward

The Strategic Plan identifies Strategic Priorities that will guide AMCP for the next three-to-five years. Please visit the AMCP website for details.

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