Introduction: Shifting the Focus From Cost to Value

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TARGET AUDIENCE

Managed care pharmacists and other health care practitioners

LEARNING OBJECTIVES

Upon completion of this program, participants should be able to

1. describe the concept of value in health care and indicate the ways in which current health care must be improved before true value is achieved;
2. identify the ways in which various stakeholders in health care view value and the barriers each perceives;
3. indicate metrics that are most appropriate when examining cohorts of health care recipients;
4. list several innovative approaches to medication management, disease-managed, and patient-centered health care delivery that alone or in combination contribute to value; and
5. differentiate between randomized controlled studies, observation studies, and cost-effectiveness analysis in terms of strengths and limitations and describe how these studies can be integrated when preparing a value proposition.

J Manag Care Pharm. 2006;12(6)(suppl S-b):S3-S5

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Managed care's general approach to escalating health care costs began in around 1985. It involved using a concerted cost management strategy of volume purchasing, screening access to utilization, and substituting less expensive services for more expensive services. On the medical side, managed care employed strategies like restricting physician and hospital networks, implementing benefit design, using prior authorization, and requiring patients to consult primary care physicians prior to specialists. These strategies significantly lowered the average premium costs from the late 1980s through the mid-1990s. The decreased trend, unfortunately, was not sustainable.

Over the past 10 years, premiums have increased at rates far exceeding inflation. As managed care is pressured to control costs, efforts have focused on managing pharmacy costs. Management of pharmacy costs followed the same cost management principles with restricting formularies, restricting networks, benefit design, prior authorization, and generic substitution. The focus on pharmacy benefit management further intensified when President Bush signed the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), expanding coverage for pharmaceuticals for seniors. The MMA sets new parameters and incentives for health plans and pharmacy benefit managers (PBMs) to perform the role of prescription drug plans (PDPs) to manage pharmaceutical costs. While many of the same cost-management tactics will continue to be applied, the one major difference is the delegation of financial risk to PDPs.

As payers continue to be pressured to manage cost trends, experts question whether or not the historical cost-management model is sustainable. While Figure 1's V-shaped curve demonstrates that costs have responded to these management strategies and utilization tactics, costs have rebounded. With the increase of health care cost trends, payers are again developing and considering strategies to manage costs. Although the strategies are not mutually exclusive, payers appear to be focused on 3 primary strategies: cost management, demand management, and value management.

Cost Management

Much has been written about using silo management in health care; this is the practice of keeping similar items—funds, budget line items, departments—separate. Health care managers in all settings have often addressed pharmacy and medical costs separately or, in other words, in silos. Contracting out (or carving out) services to providers who specialize in specific services, like pharmacy benefits, has provided leverage to (1) negotiate the best unit price and (2) control access to the most costly goods or services.

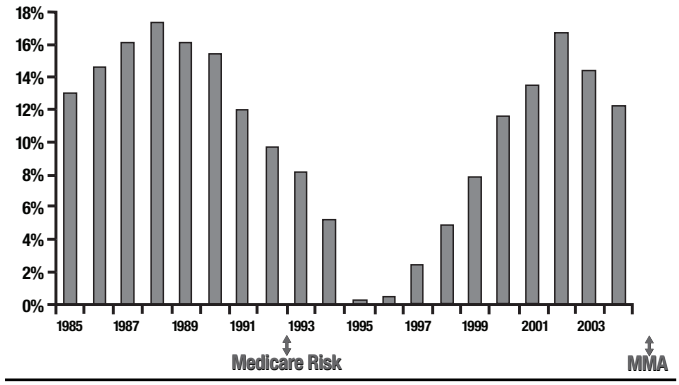
This strategy can be tremendously successful, but it has a few problems. Cost management ignores any isolated decision's impact on overall costs, potential outcomes, and future innovation; it may

actually increase overall cost, result in poor outcomes, or discourage innovation. In the marketplace, it creates a vicious cycle. For example, some pharmacists and health care providers may prefer to defer formulary decisions until real-world evidence is available as opposed to using available clinical trials data. This limits access. But limiting access removes any chance of acquiring real-world data, and without data, outcomes cannot be measured. Lacking outcomes, research cannot be conducted to demonstrate value, and this cycle goes around and around. Thus, denying access is a problem; barriers to demonstrating real value within the marketplace or in the real world make measuring outcomes difficult.

Demand Management

Demand management—e.g., drug policy tools such as prior authorization—in health care follows the basic business school model. Decreasing demand reduces cost. However, this shifts risk to consumers as purchasers. Third-party payers can limit how much they will subsidize a product or service, so the individuals must decide what they want or are able to afford.

FIGURE 1 HMO/POS Rates: Percentage Increase Per Employee Premiums



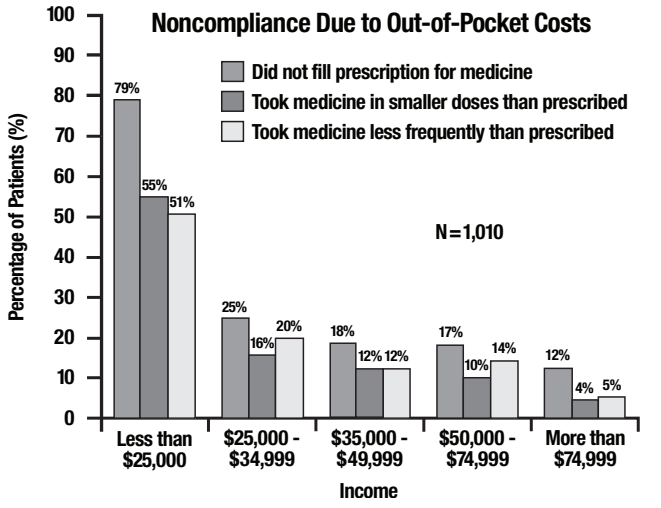
HMO = health maintenance organization; MMA = Medicare Prescription Drug Improvement and Modernization Act; POS = point of service.
Source: CSFB Benefit Manager Survey.

Consumerism

The issue of consumers—their thought patterns, preferences, and behaviors—is a subject of intense scrutiny right now. Somehow, health care needs to balance, with education, the consumer's perception of short- and long-term outcomes and their heightened sensitivity to increasing out-of-pocket expenses. Educating consumers about the direct cost benefits of their purchasing decisions is a start. Unfortunately, health care consumers are often not held accountable for their behavior and have poor adherence and compliance behaviors. These behaviors are least favorable in terms of overall cost and outcomes, and third-party payers are ultimately liable. Additionally, people's ability to pay varies widely. Based on my experience on the employer side and analysis of consumer purchasing patterns, consumers are more interested in immediate experience than in long-term benefit. Based on my personal experience as both a care provider and care manager, modifying patient behavior, even with education, is very difficult.

Health care plans' historical tendency to cover almost everything has created a culture of entitlement; today's tendency is for plans to shift and increase copayments to consumers. Historically low copayments have further magnified the impact of this shift for consumers and, consequently, may influence consumer behaviors more than anticipated. According to a study conducted by and published in *Health Care News*[1] examining the relationship of income to levels of nonadherence, significant numbers of Americans at all income levels made decisions that created situations of nonadherence when copayments increased (Figure 2). Their behaviors ranged from failing to fill their prescriptions and taking medicine in smaller doses or less frequently than prescribed. While these behaviors are more prominent among people in the lowest income brackets, they occurred in all income brackets. With the average income in the United States about $40,000, and rates of noncompliance related to increasing copayments quite high in that group, this behavior is of significant concern.

FIGURE 2 Patient Responses



Taylor H, Leitman R. Health Care News, 2001.

Further evidence of how benefit design and out-of-pocket costs influence patient behavior is the level of generic utilization in consumer-directed health plans. Preliminary data from Lumenos, in terms of the consumer-directed health plans, indicates that consumers who enroll in a $500-deductible health plan will elect to use generic medication 90% of the time.[2]

Value Management: Consumer-Centered Markets and Value

The implications for a consumer-centered market are tremendous. Value starts being defined in terms of the individual, and because each individual may define value differently, some people will value immediate outcomes while others will be concerned with long-term outcomes. A particular concern is access for people with lower incomes when copayments shift. Even the smallest of copayments can be a significant burden for patients with multiple comorbidities who are on limited incomes. The impact on long-term catastrophic cost, overall health, and overall productivity can be astounding.

Creating Value

Health care systems have the potential to create and sustain a value-driven model. Value means moving the focus from cost to cost/benefit. This creates access using the same tools traditionally used in silos but actually managing the access with demonstrated value for the payers and patients.

From a societal perspective, health care, over the past few decades, has made tremendous improvements that reflect value. Hospital days have declined 56%, the death rate has fallen 16%, life expectancy for both men and women is longer, and the rate of disability in terms of lack of function has gone down by 25%.[3,4] These accomplishments are commendable, but discussions focusing solely on unit price miss value.

From a payer perspective, value translates into a robust return on investment. Work done by Integrated Benefit Institute in San Francisco has identified the sections that contribute to overall health costs. They determined that group health and workers' compensation comprises 19% of the total, and disability adds another 10%. It is the issue of productivity, however, that consumes the largest portion of the health care dollar, and this constitutes the best reason why employers should remain active participants in health care benefit planning and provision.

In addition, based on analysis of Medstat's data,[5] chronic diseases contribute to significant loss of productivity for employers. Heart disease, diabetes, migraine, and high blood pressure are among the biggest culprits. These are all conditions that may lead to unproductive presenteeism of from 2.2 to 4.3 hours of an 8-hour day. Better management of these diseases can improve the return-on-investment of health care dollars.[6]

Health care, like any other industry, is ultimately accountable to the people who pay for goods and services. Value-based access pertains to plan designs, health plans, employers, and PBMs because ultimately it will create innovation that continually improves health and overall outcomes.

DISCLOSURES

This article is based on the proceedings of a symposium held on April 5, 2006, at the Academy of Managed Care Pharmacy's 18th Annual Meeting and Showcase in Seattle, Washington, which was supported by an educational grant from sanofi-aventis and sponsored by the Benefit Design Institute. The author received an honorarium from sanofi-aventis for participation in the symposium. She discloses that she serves as a consultant to Healthways, Inc., Amgen, Boehringer Ingelheim, Johnson & Johnson, and Novartis.

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