

Perspective**The Value of Dividends in Health: A Call to Align Stakeholders**

Cyndy Nayer, MA

*Center for Health Value Innovation, St. Louis, Missouri, and River City Partnership on Health, St. Louis, Missouri***ABSTRACT**

Objective: The purpose of this paper is to describe the philosophy and utility of value-based designs (VBDs), with an eye toward defining a pathway for a shift to VBDs across US businesses involved in the health care discussion.

Methods: A 12-question survey of 36 companies that had been identified as emerging leaders in health and productivity management was administered by telephone interview and, later, by online interview. Information collected included company size, business sector, prevention, wellness, data accessibility and integration, condition management, C-suite visibility, and culture of health. Answers were scored on a scale from 1 to 10 per category; the maximum score was 50 points. These scores were used to indicate patterns of development and define the pathway to maturity. Experts resurveyed the data to quantify change over time, which was used as a proxy for dividends. A pathway, or continuum, was graphed based on the scoring.

Results: Three segments were found to be clearly correlated with the reported experiences from the surveys—patterns of data use, targeted population change, and services and metrics. The movement through the continuum begins with a focus on prevention and wellness across the entire population, next uses data to identify current waste (inefficiencies in specific segments of the population regarding chronic care, accessibility, and quality/reimbursement, and inefficiencies in care delivery), and finally merges the total health and wealth of segments of the population into one coordinated strategy to maximize the total health value of every dollar spent at the individual and system level.

Conclusions: The market for VBDs has grown rapidly. The pathway to success—including the data needed, designs created, services acquired to change behavior, and dividends over time—can be shown to be replicable, scalable, and sustainable.

(*Clin Ther.* 2009;31:2689–2696) © 2009 Excerpta Medica Inc.

Key words: value-based designs, VBDs, health value continuum, levers.

INTRODUCTION

The value of every health care dollar is the driver in every health care discussion currently under way, no matter who appears to be the initiator. Return on investment (ROI) has been a key refrain in recent years, particularly with value-based designs (VBDs) emerging as an important tool for aligning benefits across stakeholders. The real question, however, is not one of ROI, but rather one of dividends accrued through the use of health dollars. By restating the question in terms of dividends, the short-term quick fix is removed and a focus on sustainable and systematic change is achievable.

Innovative stakeholders across the entire health value chain (including health systems, providers, employers, payers, governments, and consumers/patients) have begun to consider this philosophic shift and to implement new strategies to drive incremental improvements in health, including individual health, organizational health, and community health. Furthermore, the dividends can be measured, accrued, and reinvested over time, thereby mitigating external market forces such as downturns in the economy.

Recent surveys by Towers Perrin,¹ the Midwest Business Group on Health,² and the Center for Health Value Innovation³ have revealed a common theme: Financial investment in health must deliver measurable dividends that support the purchasers' goals. Health information technology (HIT) can improve the

Accepted for publication September 22, 2009.

doi:10.1016/j.clinthera.2009.11.023

0149-2918/\$ - see front matter

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accuracy of intervention, management, and, ultimately, financial inputs/outputs. On its own, HIT will not improve health care but will rather improve the availability of data for decisions concerning financial investments into the care needed (eg, new equipment, a new test, a new health plan, a new incentive). The ultimate value of health is the financial dividend that accrues through healthier people working at healthier organizations and creating healthier economies for their communities. Thus, a system of steps that aligns the stakeholders becomes a strategy for health and economic improvement. When the stakeholders are aligned and the focus is on the health outcomes that accrue to all stakeholders across the continuum, then engagement is also aligned, resulting in sustainable health and economic outcomes for all.

There are 4 crucial perspectives in defining the value and measuring the dividends of health care: those of the payer (health plan and employer/government), the provider (clinician and delivery system), the consumer/patient (community), and the supplier (manufacturers of treatments, processes, and devices to improve health outcomes). The economic tension throughout this contiguous productivity chain, which combines the supply and delivery sides of health care, is such that any performance tuning in any one segment profoundly affects goals and achievements in every other segment. How the dividends are defined by each stakeholder and how they are measured by stakeholders and their communities are, therefore, important considerations. How the dividends are accrued and lack of alignment in accrual lead to friction in the marketplace and uneven dividends across segments.

THE PAYER PERSPECTIVE

Payers want to know what increments of health value they are getting with every dollar they spend and how this drives their shareholder value. Shareholders define profitability for large and small companies, as well as for public entities, which must be good stewards of the public monies raised by taxpayer response and managed through approved budget expenditures. Payers have used insurance design and benefits to attract and retain employees and to reward competence in managing specialized treatments; the delivery system has rapidly adopted new technology and interventions and developed reimbursement rates based on the level of specialization and technology. Health plans (including pharmacy benefits plans, disease

management companies, and care coordination entities) are evaluated based on the financial dividend of their services. Payers frame the value question in terms of reduction in risk, safety incidents, and total cost trend. Dividends to the payer market are defined by productivity achieved through health improvement and reduction of waste, inefficiencies, and redundant care. The tension in this sector is the investment in health over time to achieve dividends: investments accrue over time, typically 6 to 15 months, whereas dividends accrue across a longer period (typically 15 months to 3 years).

THE DELIVERY SYSTEM PERSPECTIVE

The frame of value for the delivery system is one of reimbursement for services. However, hospital systems and providers/clinicians are often at odds about this, and both are often the targets of reduced reimbursement by payers. Hospital systems, originally the source of acute care competence, are routinely used for chronic care and subacute use, at high cost to the hospital, community, and payer (health plan/employer). Clinicians are contractually reimbursed based on units of service, yet “units” do not always include the extended-care communications or services needed to bring a patient to full recovery. Since the delivery system is expected to deliver improved health but is reimbursed in terms of widgets of care, the dividends in the delivery system are undergoing painful realignment. Reframing of value in this sector hinges on competence and capacity for improved outcomes, reduced redundancy of services/treatments, and effective interventions—whether in the community in which the patient resides or through distance treatment (eg, medical travel, telephone/Web-enabled intervention, convenient care, urgent care clinics). Investments are front-loaded in this sector, as time is the commodity. Providers invest time, but must wait for billing and payment periods to receive reimbursement—there is often a lag of 6 to 9 months or more. Furthermore, some of the time is not billable (eg, longer discussion periods), and recoding/rebilling can extend the actual time to receive an ROI even further.

THE CONSUMER/PATIENT PERSPECTIVE

Over the past 20 years, the value of health services to the patient has been framed in terms of out-of-pocket costs incurred rather than in terms of health status. Consumers are slowly changing their purchasing deci-

sions as health savings accounts and other financial instruments are instituted through VBDs. The current economic instability has accelerated this process, as consumers are purchasing—or not purchasing—based on their perception of the likelihood of maintaining their benefits or even their job. In this group, the value of health is the likelihood of employment: How critical is the personal dollar spent on health relative to continued employment in the short term? The dividend time in this sector is not only variable but also highly emotional, and more rapid ROI for the consumer is measured in faster relief of symptomatic and/or emergency situations. Resolution of these situations may or may not be connected to chronic care management, but it is always the consumer's highest priority.

THE MANUFACTURER PERSPECTIVE

Over the past 30 years in America, medical diagnosis and treatment have come to be perceived as a “right.” Higher levels of purchasing and payment were driven by the development of new treatments and technologies. Higher prices were fueled by the development of highly sophisticated diagnostic and treatment procedures, and were amplified by the development of treatments (eg, pharmaceuticals) designed to be applied to the ongoing management of chronic conditions. Hence, the development of new/improved interventions, along with the resultant increase in payment, was an economic imperative for manufacturers. The time to the receipt of dividends in this sector can be quite short, as in the filling of a prescription, or quite long, as in the adoption of a new intervention/contract/benefit design. Again, this sector is not aligned for dividends with any of the other 3 sectors.

CREATING ALIGNMENT OF THE DIVIDENDS

Understanding the focus on valuable dividends in these 4 stakeholder areas is critical to the evaluation of every health service that is currently available or in the pipeline. Movement away from the cost-only perspective and into the “dividend investment” perspective is often a result of the market force of consumer purchasing. If the plan sponsor is pressing for improved productivity output, the plan designer will shift, the covered life will respond, and the provider will apply new skills. The tension that holds the health value chain together is also the tension that causes the ripple of change to spread throughout all the stakeholders.

Alignment of the proposed dividends is paramount in decisions on every clinical intervention. The benefits

of health must be quantified not only in terms of reduction in cost, but also in terms of improved productivity as defined by the individual, the payer, the professional delivery system, and the manufacturer. Resources must be used to improve the outcomes for every stakeholder, which can be a daunting task. Therefore, the dividend that must be delivered is the “health dividend”—a dividend that is quantifiable for each of the stakeholders, including the consumer/patient. Goals must be set, metrics determined, and the timeline for accomplishment of the health improvement, productivity improvement, and/or economic improvement must be established in order for a health benefit to be meaningful.

If all the dividend questions are reframed based on a business approach, allowing for individual differences in care choice as well as care delivery, then we will have a new matrix for decisions that is truly focused on the incremental value of every health dollar spent. To this end, the levers that encourage appropriate use, effective and efficient care, and improved economic impact should be the focus of every discussion on dividends. As an example, the actual costs of diabetes care may in fact increase when the patient is compliant with the recommended medications and examinations (just as the cost of medications and examinations may be lower when the patient is not compliant with recommendations), but the actual impact to the system is one of lowered total costs as a result of less need for emergency treatment, comorbid interventions, and so forth.

The question of dividends hinges on the value of every health dollar spent. The new question must be, “How many incremental units of health will that deliver?” Instead of “How much will that cost?” the most important question becomes “How will that plan design/program/service improve the health of the people it affects, and/or how will it improve my bottom line?” While it may not seem that this will influence the consumer particularly, it is, in fact, the basis for the consumer-driven movement. By asking about the total impact on improved health and economic security, the dividends question can create a predictable, sustainable impact on the bottom line for each stakeholder.

A SYSTEM OF IMPROVED HEALTH, NOT HEALTH CARE COST

What if the outcome of the health care intervention was focused on the health–wealth goals of the indi-

vidual and on the responsibility residing within that individual? The ultimate decisions for investing in the health–wealth intersection (health–wealth portfolio⁴) would be the responsibility of each person as a “covered life.” This means that each person would be responsible for making the decisions that influence his or her health, with the impact of health decisions driving a correlated impact on present and future wealth. This model basically views the individual consumer as if he or she were the chief executive officer (CEO) of a company; in business terms, the consumer is the CEO of his or her own health.⁴ Actions can be initiated by any of the stakeholders—typically, initiation of an action would require not only a level of distress sufficient to “nudge” for a new answer, but also a vision of what the alternative might be. This CEO consumer must see the benefit of the changed health behavior offered by the payer, provider, or manufacturer; what is important is that he/she asks the new question (“How does this drive improved health?”) and takes the first steps to the realignment of resources (“the health improvement plan”).

Engagement is the first step toward managing the health–wealth portfolio. The science of behavioral economics indicates that engagement for behavior change must overcome the bias toward letting things remain as they are.⁵ Choice architecture—how one presents and subtly influences the choices—becomes a paramount consideration in behavior change, beginning with engagement. VBD is the business-based application of engagement and behavior change for improved health. VBD refocuses the conversation on the clinical and financial relevance to the person/patient,⁶ thereby improving the resources residing in the health–wealth portfolio of the individual. This health–wealth impact is the foundation for high-deductible and out-of-pocket considerations at the consumer level. As the economic and unemployment downturn has shown, the consumer has been affected across purchasing decisions and quality of life.⁷ VBD can shift and realign incentives across stakeholders when economic influences cause an inappropriate response that results in short-term savings and long-term health decline.

Health literacy, as well as health urgency, is a critical component in engagement across all stakeholders. The desired change, and its rationale in terms of health and economic impact, must be conveyed in words and actions that are relevant to the individual and meaningful to all stakeholders. The

words used must be conducive to the action required and understandable by all those who are affected.

VBDs are not confined to improving the use of drugs for chronic disease, although that is how they are often described. VBD is more than the insurance design, which is an important distinction. In fact, the alignment of insurance plan design with incentives and disincentives (which lie outside the insurance design) has been the factor behind the success of VBD in every company that has developed and maintained a VBD. Those that have focused only on copay reductions for a particular disease have seen slower behavior change, larger out-of-pocket costs for the payer and the delivery system (therefore knocking the performance of the total health care improvement off balance), and lower rates of persistence.

The Center for Health Value Innovation is a 501(c)(3) nonprofit organization, funded through a multiple-stakeholder group of employers, health plans, health systems, provider organizations, and pharmaceutical/technology companies, driving the evidence for health and economic improvement through VBDs. Through the work of the center, >100 levers for behavior change and improved health outcomes have been identified.⁸ *Levers* are the performance tuners, the “nudges” that cause behavior change that results in improvement in the stakeholder segments across the health value continuum. Levers can be incentives/disincentives, which sit outside the insurance plan design, or they can be part of the insurance plan (such as a reduced copay for mammography). These levers have been tracked and categorized into 3 areas, all of which put the patient/consumer at the tipping point of the lever: individual health competency (improving how one manages personal health and lifestyle choices); chronic condition management (the total care continuum for improved health and reduction in preventable comorbidity); and care delivery (where and from whom one chooses to receive the care, from primary care to emergency department to medical travel). How these levers are used—by small and large companies in the public and private sectors, fully insured or self-insured—is the work of the Center for Health Value Innovation. Analyses from the Center show the relationship of the levers to behavioral economics models, as described in the following sections.

Overcoming Loss Inertia

Behavior change occurs when resistance is overcome by distress and the vision of an alternative solution. Many of the levers reduce resistance—often defined as out-of-pocket expenses, copays, or insurance premiums—based on activity levels. Conceptually, they promote health behavior change by raising the bar on financial discomfort—make the change and get lower costs and higher rewards; don't make the change and get fewer rewards and higher costs.

Social Peering

People, companies, hospitals, clinicians—human beings make changes because they want to be like the successful icons and achieve similar success. The levers that support sustainable behavior change are often those that communicate about “people like me” or “organizations like ours” that have succeeded and are reaping rewards in health outcomes. Such communication must be at the individual level, but the most successful application of levers includes communications to the delivery system. For example, improvements in practice according to evidence-based guidelines often drive improved reimbursement rates to clinicians.

Hyperbolic Discounting

Hyperbolic discounting is a scientific way of addressing procrastination by creating an urgency to change. Smokers understand that they may die of lung cancer, and people with high cholesterol understand that this may lead to a heart attack—they just don't perceive the risk as immediate. Use of levers to intensify the urgency of change makes it clear that a risk is “now and not going away.” An example would be the following lever: “We'll pay for the treatment of your high cholesterol, but if you are not compliant with the treatment, you will be charged for all of the costs.” The increase in distress helps overcome procrastination.

CREATING SUSTAINABLE BEHAVIOR CHANGE TO DRIVE DIVIDENDS

What if levers are applied and the desired behavior change occurs? Then the ultimate decision-maker in any category begins to purchase health care services, treatments, sites, or providers with a new set of decision-support tools. The decision becomes a value proposition that weighs the immediacy of discomfort against

the effect on the health–wealth outcome. Instead of commoditizing the product—whether it is a minimally invasive procedure, a generic versus a branded drug, electronic medical records versus personal health records, or fries versus a baked potato—a CEO perspective is applied and the question is asked, “Will this help achieve my immediate and long-term goals of health and financial stability?” The intrinsic relationship between health and finance is enhanced. Without health, the costs of unscheduled absence and medical claims go up; without wealth, the access to appropriate care and performance goes down. Looking through the CEO lens, the entire health/productivity chain is aligned and is focused on the total health performance of the individual; products, services, and reimbursement align to produce quantities of health instead of widgets of health care.

Criteria for the success of VBDs are driven by data and are often defined by the payer. But the dividends must positively affect all stakeholders, removing friction from the health value chain. Some examples include improvement in productivity for the plan sponsor, defined as reduced absenteeism, disability days, safety risks, and presenteeism (when the employee is present at the job but not focused); improvement in health for the covered life, such as improved functional status (less pain, easier breathing, less impact on daily living); and improvement in reimbursement/reward for the providers of care, such as increased payment for consultation, e-mail consultation, behavioral health counseling, and employee assistance programs. Improvements in outcomes for adherence and compliance, with reimbursement built on the right treatment for the right condition in the right patient rather than on formulary positioning based on cost, is another example of the alignment of incentives across stakeholders.

As stated by A.G. Lafley, former CEO of Procter & Gamble, “We declared that the consumer was boss.”⁹ In the case of VBDs, the design links the consumer boss (the CEO of his or her health) with the health, productivity, and financial success of the organization through the choice of health services and systems outside the organization. The levers support the CEO's decision to continue or change outside products/services to increase the value of the internal organization (person/payer, deliverer, community, supplier). Alignment of incentives through choice architecture drives improved organizational and personal health.

DEVELOPMENT OF THE HEALTH VALUE CONTINUUM

In the development and quantification of the levers, the Center for Health Value Innovation created a rudimentary Health Value Continuum to track the progress and sophistication of companies that had installed VBD (Figure 1). The early version of the Health Value Continuum was developed through a 12-question survey conducted over 6 months by telephone interview and, later, by online interview of 36 companies that had been identified as emerging leaders in health and productivity management.⁸ The surveys were scored in 5 dimensions (prevention and wellness, data availability and integration, copay/coinsurance reductions, C-suite visibility, and culture of health), with a maximum score of 50 points.

Once the levers were identified and cross-matched with dividends, the Health Value Continuum was revised to include the complexity and acuity of levers in driving dividends (ie, the higher performance of every dollar spent). As a company identifies opportunities for improved health management, the levers are inserted based on data availability, focus of the priority (waste reduction, prevention and wellness, and/or future risk

reduction), and sustainable economic improvement. This means that the risk to the organization, both present (waste and inefficiencies) and future (development of poorer health and productivity), must be tempered with the financial realities of the company; for example, deficit spending to improve health care access may not be in the best interests of the organization.

Using the construct of the levers and the Health Value Continuum, a 4-square sophistication model was created (Figure 2). In this newer model, the movement through the continuum begins with a focus on prevention and wellness across the entire population, next uses data to identify current waste (inefficiencies in specific segments of the population regarding chronic care, accessibility, and quality/reimbursement, and inefficiencies in care delivery), and finally merges the total health and wealth of segments of the population into one coordinated strategy to maximize the total health value of every dollar spent at the individual and system level.⁸

WHAT WE KNOW AND WHAT WE MUST CONSIDER

Dividends in health value develop as competence matures, much as a company's dividends develop as compe-

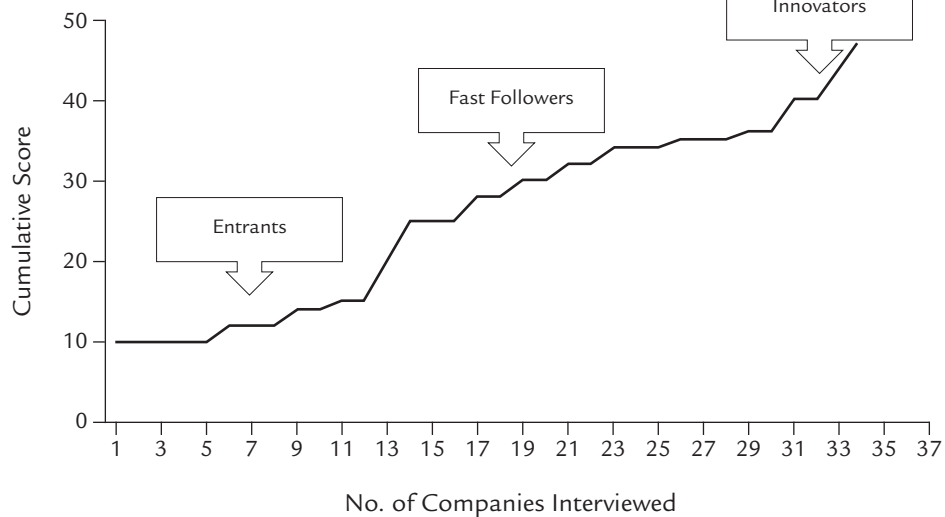


Figure 1. Cumulative scores on an early version of the Health Value Continuum. Telephone interviews were conducted with 36 companies from January through April 2007. The cumulative score was based on scores for 5 dimensions (prevention and wellness, data availability and integration, copay/coinsurance reductions, C-suite visibility, and culture of health), with a maximum score of 50 points.

tence (efficiency and quality) increases over time. When the business perspective of the CEO is applied thoughtfully across each of the 4 groups of stakeholders (payer, delivery system, consumer/patient, and manufacturer), an alignment of the incentives to improve delivery of health emerges—a much more desirable outcome than the delivery of health care. Producing and paying for health is a sustainable business model that benefits stakeholders and the community at large.

As economic improvement in a community affects the tax base, high-risk pools can be accommodated (higher-performing companies pay more taxes, thereby creating revenue that can be used for risk management and the expansion of services for the uninsured and for unreimbursable expenses). Employer-sponsored benefits are certainly the basis for VBD, but there is evidence that VBD has implications in the public sector. Governments (cities, counties, states) have documented improvements in health, productivity, and economic viability that have resulted in better outcomes for the plan sponsor and reinforcement of social services through tax dollars.¹⁰

VBD is an engagement process that realigns the goals of the disparate stakeholders into one focused

goal: improvement of health. The dividends accrue over time, depending on the risk to the organization and the appetite for managing the risk.

Development of the evidence for value in health and productivity management will fuel the science of benefit design. Benefit design will aggressively expand beyond insurance design. Benefit designs will push outcomes-based contracting, in which total health performance and improvement will be the ultimate arbiter of value. As a result of this evolution, sharpening of benefits to drive sustainable behavior change at the individual level will emerge—outcomes-based contracting will be the affordable and accessible model of comparative effectiveness, not the head-to-head science of treatment applicability but the ability to produce units of health and productivity in defined populations.

FINAL THOUGHTS AND CONCLUSIONS

Readers may have seen a print advertisement that shows the late President John F. Kennedy calling for the goal of landing on the moon. He does not call for new technology or widgets of service to drive space innovation. He simply says, “We will land on the moon.” It is time that we apply that same thinking to

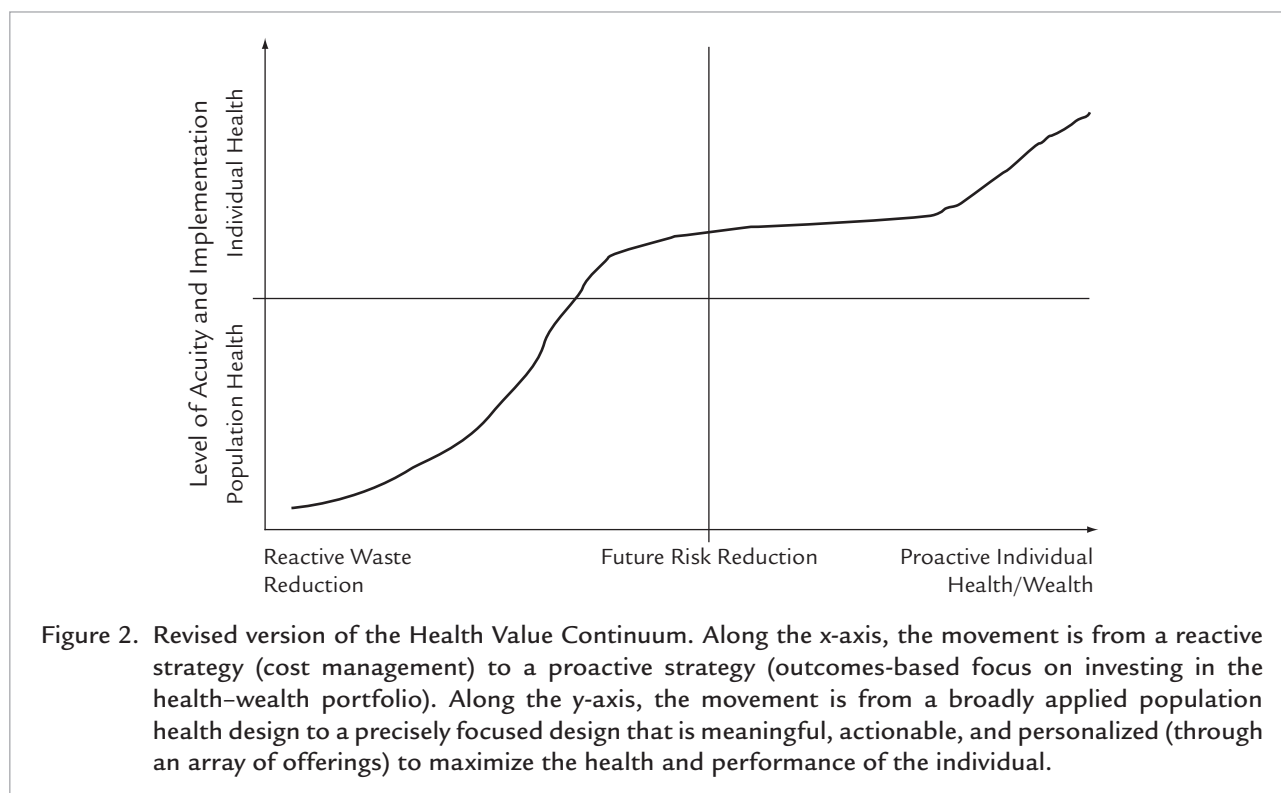


Figure 2. Revised version of the Health Value Continuum. Along the x-axis, the movement is from a reactive strategy (cost management) to a proactive strategy (outcomes-based focus on investing in the health-wealth portfolio). Along the y-axis, the movement is from a broadly applied population health design to a precisely focused design that is meaningful, actionable, and personalized (through an array of offerings) to maximize the health and performance of the individual.

the fragmented, friction-weary science of health. It is time to call for the goal of improving the health of American people, organizations, and communities. Nothing less should satisfy us.

ACKNOWLEDGMENT

The author has indicated that she has no conflicts of interest with regard to the content of this article.

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Address correspondence to: Cyndy Nayer, MA, President/CEO, Center for Health Value Innovation, c/o 20301 Grand Oak Boulevard #118–78, Estero, FL 33928. E-mail: cyndyn@vbhealth.org