

# How Companies Consider Value in Health Policy and Design:

## *Results of the Survey of Employer Decision-making for Health and Productivity*

**The American College of Occupational and Environmental Medicine**



AMERICAN COLLEGE OF  
OCCUPATIONAL AND  
ENVIRONMENTAL MEDICINE

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## About This Report . . .

In the spring of 2004, 174 senior-level decision-makers from U.S. employers responded to an internet-based survey. The survey asked about factors related to health-based decisions, policies, and programs from the following perspectives:

- To what degree are employers considering the potential value (reduced absence or improved productivity) of policies and interventions?
- How important are value-focused outcomes compared to direct health care costs?
- And what types of value-focused activities do employers implement most commonly?

This report provides detailed findings from their responses.

## Key Findings . . .

Readers will find extensive detail about these findings within the report. Highlights include:

### ***In general, employers have implemented few value-focused activities (VFAs).***

Out of 32 possible activities, the average employer reported doing only six, and considering three more.

### ***Employers reported wellness related activities and programs most often and provider and health plan strategies least often.***

The most common activities employers used to achieve value-focused outcomes included flu shots, wellness programs, and incentives for HRA. Few reported making choices about health plans or implementing provider arrangements specifically to achieve reduced absences and/or increase productivity outcomes.

### ***Employers doing more VFAs tend to:***

- Have more types of data available to decision-makers;
- Hold decision-makers more accountable for absence and productivity outcomes;
- Value benchmarking;
- Have decision-makers who recognize the importance of other outcomes (besides health care costs); and
- Have 2,500 employees or more.

These relationships are statistically significant and suggest a mindset of broader thinking about the importance of value-focused outcomes.

### ***Medical decision-makers differ significantly from non-medical decision-makers.***

Results showed significant differences in philosophy, beliefs, accountability, roles in decisions, and perceived barriers. The differences indicate strong divisions of responsibility and attitude that may hamper collaborative decision-making.

## Project Overview . . .

This report describes the results of a survey of employer decision-makers for health-related policies and programs.

The purpose of the project was to describe the degree to which employers consider value-focused outcomes (such as absenteeism or worker productivity) in decisions about health benefits and health programs and to what extent they are implementing these value-focused activities (VFA). Additionally, the survey investigated factors that affect decisions such as beliefs, professional background, accountabilities and internal decision-making processes.

The survey asked respondents about a broad set of “value-focused” activities (VFAs), including health plan choices, health management/disease prevention programs, provider arrangements, pharmacy benefit features, and employee incentives. This report summarizes the frequency of VFAs, as well as a description of factors contributing to the likelihood of doing more VFAs.

## BACKGROUND

In the past five years, there has been increased recognition of the value of having a healthy workforce, both in presence on the job and the ability to perform productively. A small, but growing number of employers consider employee health and health care benefits as part of a broader strategy where the value of health and health services are linked to broader corporate business objectives. This survey examined how often employers choose activities that consider total business value in addition to strict cost management.

These pioneering employers have experimented with methods for measuring productivity loss and have initiated approaches intended to reduce productivity loss. The kinds of approaches these companies consider are termed value-focused activities (VFAs). These activities take into account not only the cost to deliver but also the overall value of the activity including its effectiveness at reducing absences and/or increasing on-the-job performance.

The study was designed to assess how far the value-focused concept has evolved into the mainstream of corporate health care. We also wanted to know how value-focused decisions are made, and what particular decision-maker characteristics might move a company in a more value-focused direction.

Finally, the study sought to understand how professionals in two key corporate health departments (HR/benefits and Occupational Medicine) view the field of health and productivity management. This was an important issue that emerged from an earlier ACOEM survey (*Strategic Management Needs in Health & Productivity*) conducted in January of 2003. We felt that understanding the differences and similarities of these two groups could help develop a dialogue between corporate medical directors and HR/benefits directors that could foster the adoption of more value-focused, productivity-oriented healthcare policies.

### **SURVEY METHODS**

#### **Data Collection**

The American College of Occupational and Environmental Medicine (ACOEM), Lynch Consulting, and Riedel & Associates Consultants, Inc., conducted this Internet-administered *Survey on Employer Decision-making for Health and Productivity* in May and June of 2004.

Data for this study came from 174 respondents who completed the questionnaire between April 26 and June 29, 2004. Questionnaires were e-mailed to a sub-section of ACOEM membership who were identified as either Corporate Medical Directors or Contracted Medical Directors providing occupational health services to one or more employers. These corporate and contracted medical directors were asked to share the survey with their colleagues in HR/benefits. The purpose was to attract “matched pairs” (Corporate Medical Directors and Benefits Directors from the same company). A total of 28 matched pairs participated. Because there were 28 matched pairs, the 174 respondents represent 146 employers.

Questionnaires were also e-mailed to corporate HR/benefits directors who were either members of a Business Coalition on Health (Canton Healthcare Coalition, Mid-America Coalition on Health Care, New York Business Group on Health, St. Louis Area Business Health Coalition) or represented a large corporation (10,000 or more employees).

Based on a feature of the Internet-based survey that did not allow for partial completion of the questionnaire, the amount of missing data was minimal. Since survey respondents self-selected to participate, the results should be viewed as representing CMDs and HR/benefits directors who are interested in these topics.

#### **Question set**

The survey used an Internet based questionnaire specifically designed for this project. The survey consisted of 37 items addressing four key areas: 1) role within the organization; 2) beliefs about employee health; 3) decision-making processes, and 4) value-focused activities. Because many of the 37 items had sub-categories the total number of questions was 119. Five versions of the survey, with systematic variations in ordering, were administered to minimize bias in items that used lists of responses. For any item consisting of four or more sub-items, the order of sub-items was systematically altered so that any sub-item had an equal likelihood of appearing first in the list.

#### **Analysis**

Survey responses were analyzed using statistical software (SAS for Windows, Ver. 8). Analysis consisted primarily of frequency tabulations, cross-tabulations, and correlations. New aggregate variables were created to provide summary scores for various attributes and actions. Percentages were compared using a Chi-Square statistic. Ordinal and integer variables, such as ratings and counts, were compared using t-tests. Statistical significance was assigned at  $\alpha=0.5$ , with detailed p values reported in cases where that level of significance was not reached.

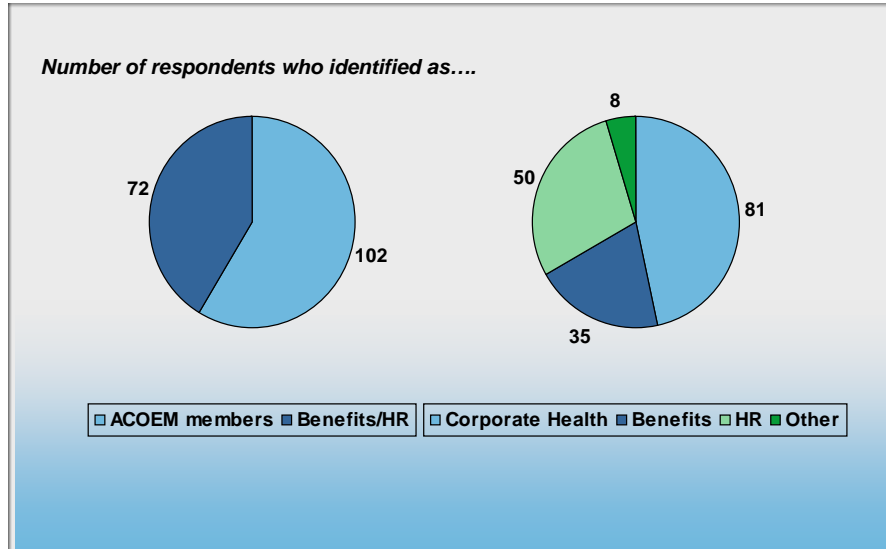
### **ABOUT THE RESPONDENTS**

#### **People**

One hundred and seventy-four decision-makers responded to the survey. Of those, 102 were ACOEM members. Eighty-one respondents were from corporate health departments, while 85 were from benefits or HR (See Figure 1). Pairs of responses – one from an ACOEM member and one from the HR/Benefits area – were received from 28 companies.

Job titles of respondents included corporate medical director (64), chief medical officer (15), director (36), manager (32), and vice president (15).

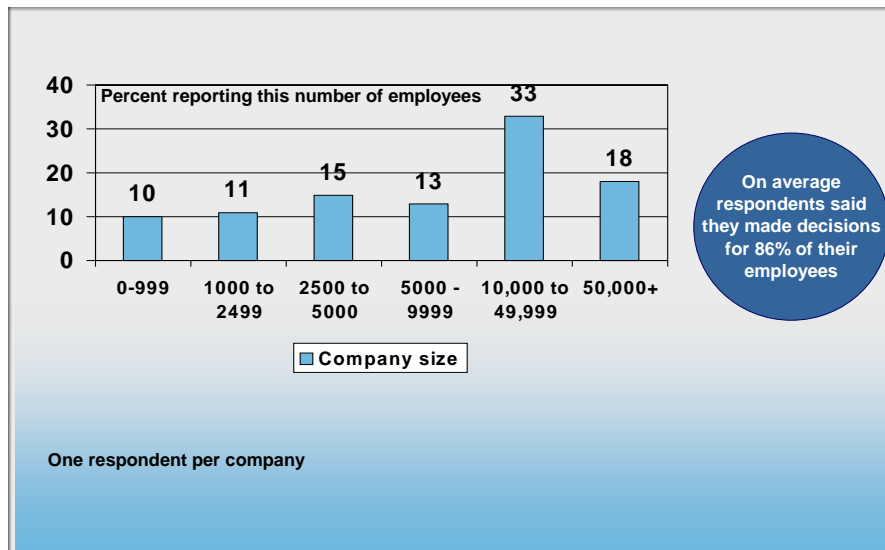
Figure 1 - Respondents: Who and what department?



**Companies**

Taking pairs into account, responses were received from decision-makers at 146 different companies. These companies ranged in size from fewer than 1,000 employees to more than 50,000 U.S. employees (see Figure 2). Respondents reported that they often were responsible for a subset of the employee population rather than for all employees. On average, decision-makers had responsibility for 86% of all U.S. employees. Participating employers belonged to a diverse set of industries. These included manufacturing, health care, telecom, finance, transportation and utilities, government, pharmaceuticals, professional and scientific, and many others.

Figure 2: Company size



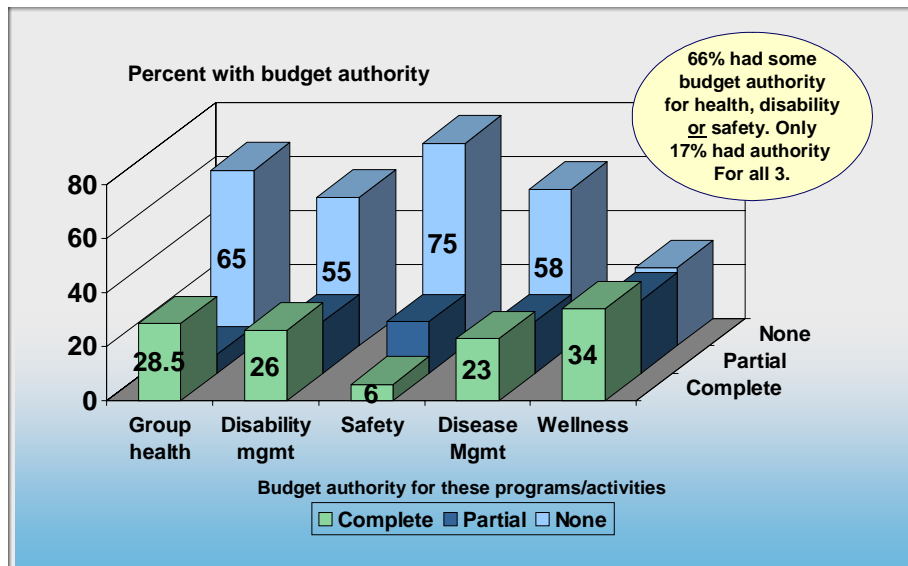
## Corporate Decision-making about Health . . .

A number of survey items addressed circumstances surrounding decision-making within the respondent's organization. These included processes and functions within the organization, as well as specific beliefs and philosophy of individual decision-makers.

### BUDGET AUTHORITY

Fewer than 30% of respondents reported having complete budget authority on overall health-related policies and program, with the exception of 34% reporting complete authority for wellness (see Figure 3). Surprisingly, more than 50% of respondents reported having no budget authority at all for group health or disability benefits. As will be discussed in later sections of the report, budget authority was much greater for HR/benefits professionals than for corporate health professionals. Further, the same individuals do not have authority over multiple areas. While 66% reported having some (partial or complete) authority over health, disability or safety, only 17% had authority in all three areas.

**Figure 3: Budget Authority**

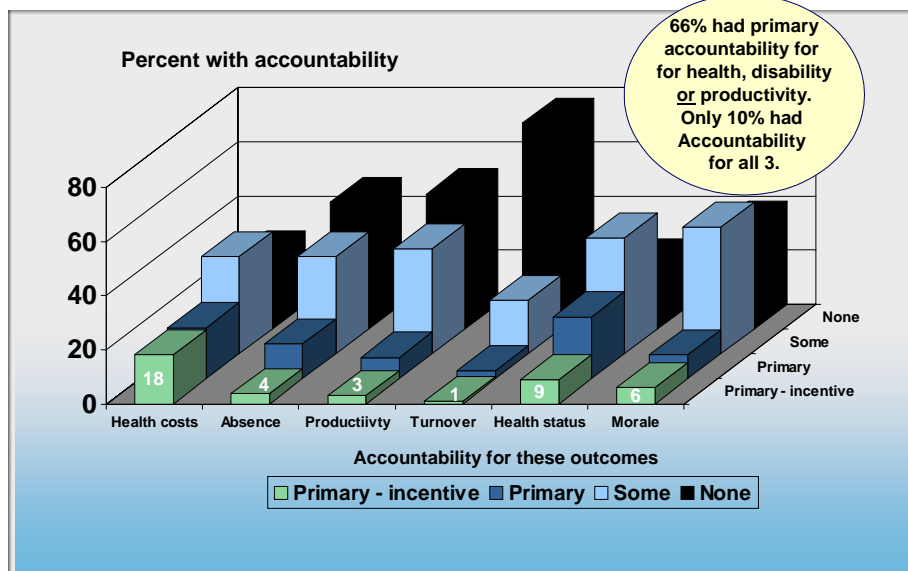


### ACCOUNTABILITY

The survey asked respondents whether they were held accountable for various business outcomes including health care costs, absence rates, turnover, morale and productivity. Accountability could be primary with an incentive (where it was defined as their primary responsibility and part of their compensation was based on results in this area), primary without an incentive, partial, or none. Relatively few decision-makers are held individually accountable for outcomes and, instead, usually share accountability (see Figure 4). Very few have primary accountability with incentives.

Virtually none of these decision-makers were held even partially accountable for turnover and a majority had no accountability for productivity, morale or absence rates.

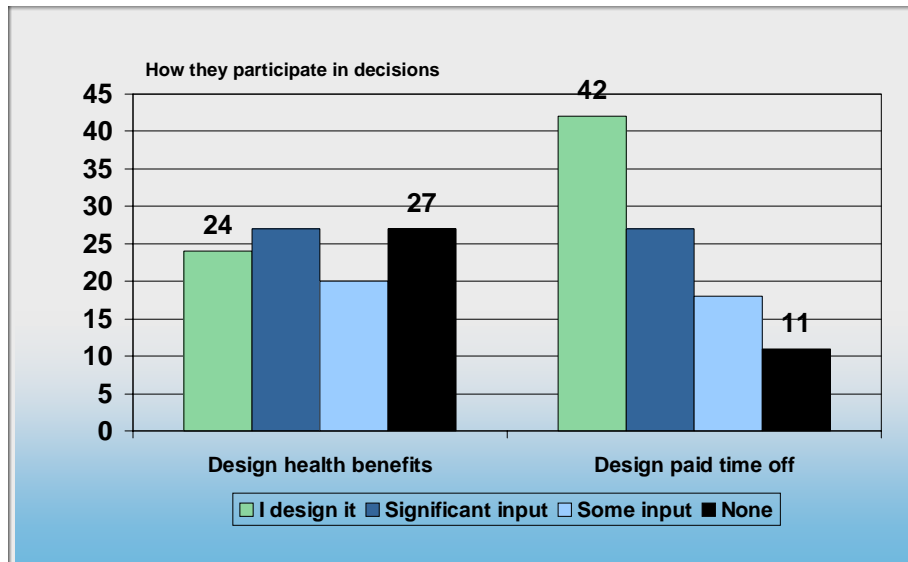
**Figure 4: Accountability**



**ROLE-IN STRATEGY DESIGN**

There is considerable variation in the roles respondents play in decisions about group health and disability benefit design (see Figure 5). Some design the benefits independently; others play no role at all. A larger portion of respondents reported having sole design responsibility for disability benefits (42%) than for group health benefits (24%). Almost half of respondents reported having only some or no input in health benefit design and almost a third reported having some or no input in paid time off policies.

**Figure 5: Role in design decisions**



**PHILOSOPHY**

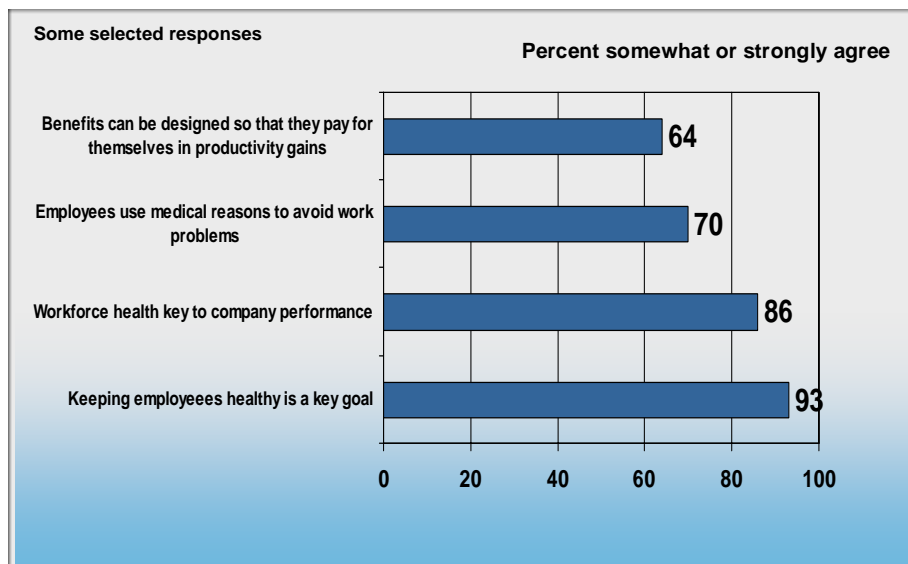
The survey asked respondents to choose a statement that most closely resembled their own philosophy about workforce health. Of five possible choices, three were chosen most often. (Those not chosen included a belief that employers should not offer health benefits at all and a statement that health benefits are only a factor in attracting talent) The three most commonly selected statements were:

1. Keeping employees healthy is crucial to business success. It is our duty to keep them safe and well (47%).
2. Employees are responsible for their own health. Our job is to provide tools to let them do that, without dictating how to live their lives (35%).
3. Health is one component of Human Capital. If we compensate them, they will value their health (13%).

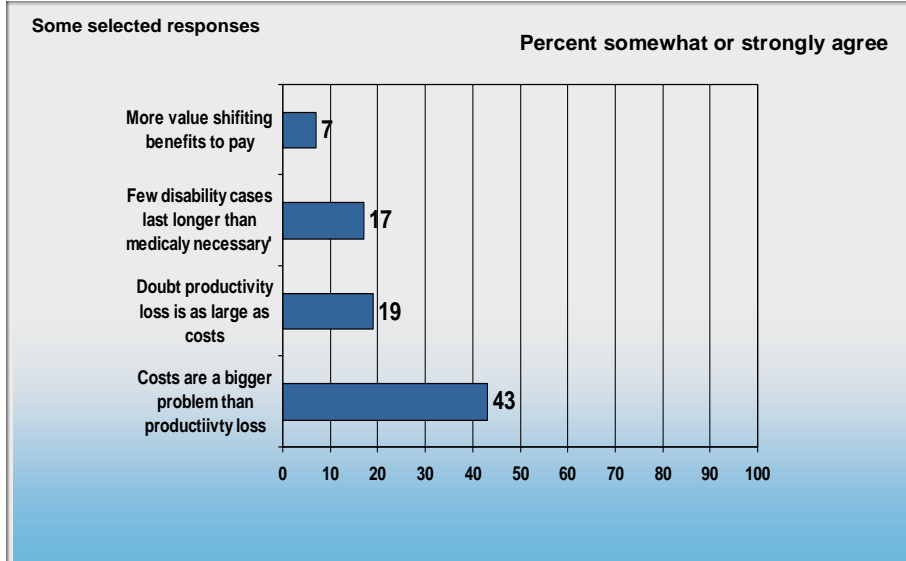
**BELIEFS**

The survey asked a number of questions about respondent's beliefs. The beliefs most relevant to overall results are shown in Figure 6. In general, respondents agreed with broad statements about the importance of workforce health to their business. For example, 90% agreed that keeping employees healthy was a business goal, and 86% agreed that workforce health was important to business performance. However, respondents also tended to agree that lost-time benefits may be used inappropriately by employees. Seventy percent agreed that employees sometimes use paid time off for non-medical reasons, and only 17% believe that few disability cases last longer than medically necessary. With regard to the relative importance of productivity costs compared to health care costs, 19% doubt that productivity costs are as large as health care costs and 43% agree that health care costs are larger. Interestingly, a majority (64%) believe that benefits can be designed in a way so that the costs pay for themselves in terms of productivity gains. Lastly, only a few (7%) agreed that their organization would get more value if they eliminated health care benefits and transferred those funds to higher pay.

**Figure 6: Beliefs....**



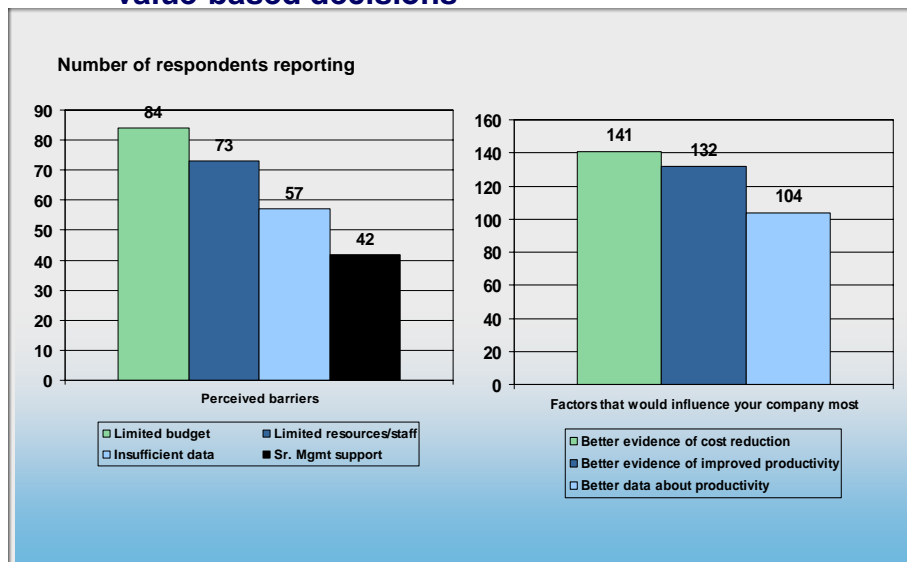
**Figure 6 continued  
More Beliefs....**



**BARRIERS**

Many respondents reported experiencing barriers when considering offering VFAs. Most commonly, they reported budget and staff limitations (see Figure 7). Others reported a lack of supporting data or senior management support. When asked about what sorts of resources would influence their organization most to consider VFAs, the most common responses referred to better evidence: evidence of cost savings, evidence of productivity improvement and better data about productivity.

**Figure 7: Barriers and influences that affect value-based decisions**



**FACTORS**

**INFLUENCING DECISIONS**

The survey asked respondents to rate the importance of various internal and external factors in their influence on decisions made by their organizations. Internally, senior management opinion was rated as more influential than other factors. On a scale of 1 (no influence) to 10 (the most important influence), respondents were most likely to rate senior management opinion as 8 or above (59%), followed by internal data (42%), and group consensus (28%).

With regard to external influences, benchmarks of similar organizations were rated as an 8 or above by 40% of respondents. Benefits consultants and benchmarking against leading organizations were rated as highly important by 37% and 34%, respectively. When asked about important external influences on pharmacy benefits specifically, benefits consultants (36%) and industry benchmarks (34%) were rated highly more often than PBMs (24%) or benchmarking against innovative companies (25%).

Recognizing that senior management opinion was considered an important influence on decisions, respondents were also asked how important they thought managing health costs, absences, and productivity were to their senior management teams. Respondents reported that they believed health care costs were most important to senior managers (55% at 8 or above), followed by productivity (45%) and absences (35%).

**DATA AVAILABILITY**

Respondents described the types and levels of data available to decision-makers in their organization. Using only one response per organization, the percent having each type and level of data are shown Table 1. More organizations have detailed data about health care costs than other outcomes (40% had data sources that allowed specific queries). Few companies have detailed data about productivity (11%), while 40% reported having no data about productivity. While only 3-5% of companies reported having no data about health costs and disability rates, 20% had no data about absences. As can be seen, a significant number of companies report have limited information about many types of health outcomes – especially absences and productivity.

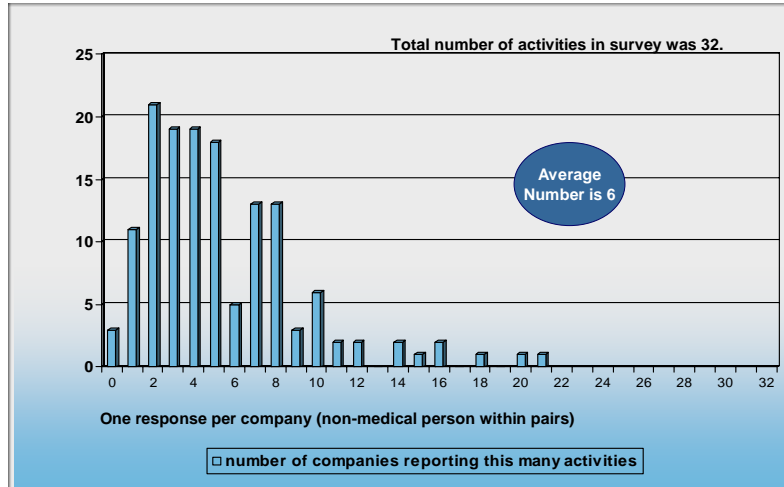
**Table 1: Availability of Data**

Level of data	Percent reporting this level of data available for outcomes			
	Health care costs	Incidental Absences	Disability data	Productivity
No data	3	20	5	40
Standard reports	17	25	24	24
Group reports with some flexibility	40	33	39	25
Customized queries of integrated data	40	22	32	11

## Value-focused Activities . . .

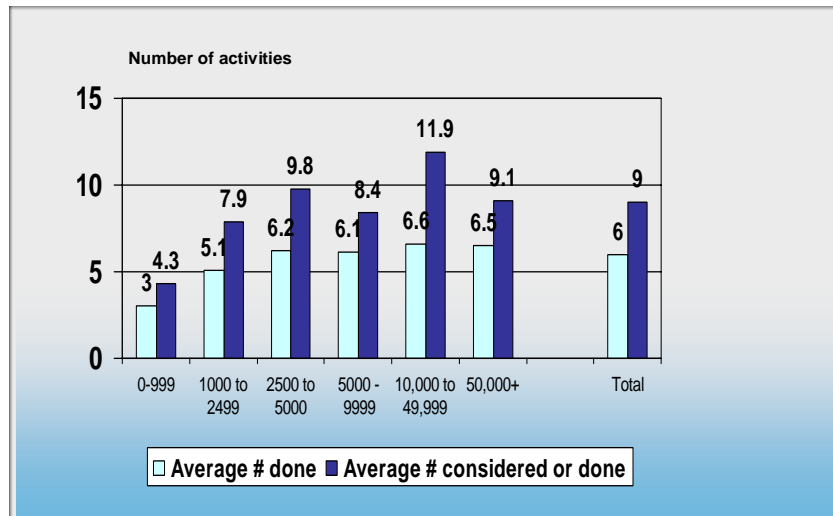
Appendix 1 lists the 32 VFAs investigated in the survey. Respondents were asked to indicate whether their organizations were doing each activity currently, planning to do it within the next year, considering it, or not doing it. The percent of companies doing specific activities ranged from 1 percent to 90 percent. The average number of activities done by companies was 6, with three more being planned or considered. The range was zero to 21 activities (see Figure 8).

**Figure 8: Variation in Number of Value Focused Activities**



The total number of VFAs reported by companies was significantly related to company size (see Figure 9). Companies with fewer than 2500 employees tended to report fewer activities than larger companies. Also, there was some indication that different industries were more likely to report doing VFAs. For example, government groups reported doing only 3.8 activities on average, while telecom companies reported 9.4 and manufacturing reported 5.6. However, because sample sizes were small – and companies self-selected to participate – no solid conclusions can be drawn.

**Figure 9: Value-based activities by company size**

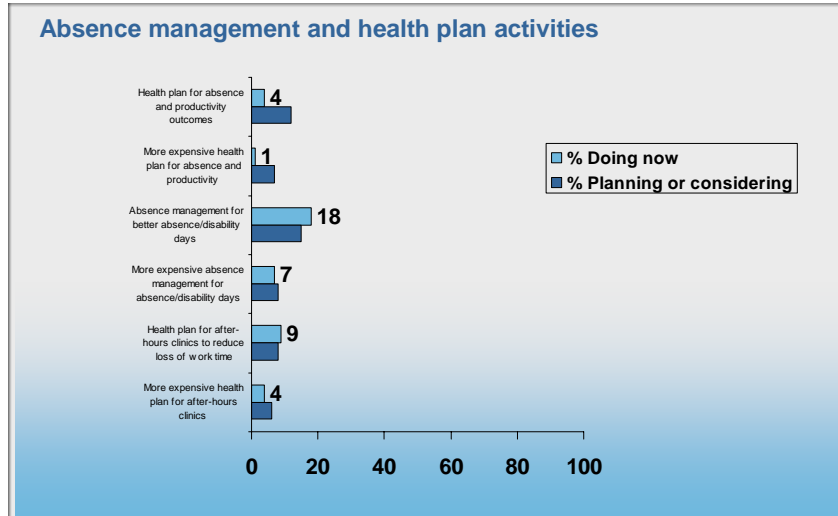


TYPES OF VALUE FOCUSED ACTIVITIES

Health plan and absence management

Very few employers reported using value-focused criteria in health plan choices (see Figure 10.). Fewer than 10% of employers reported choosing a health plan because it could improve absence rates, and fewer than 5% reported valuing absence outcomes from health plans enough to pay more. As one might expect, more employers (18%) reported that absence management programs were chosen for their superior absence management outcomes. However, only 7% reported that they had been willing to pay more for absence management programs that had better absence outcomes.

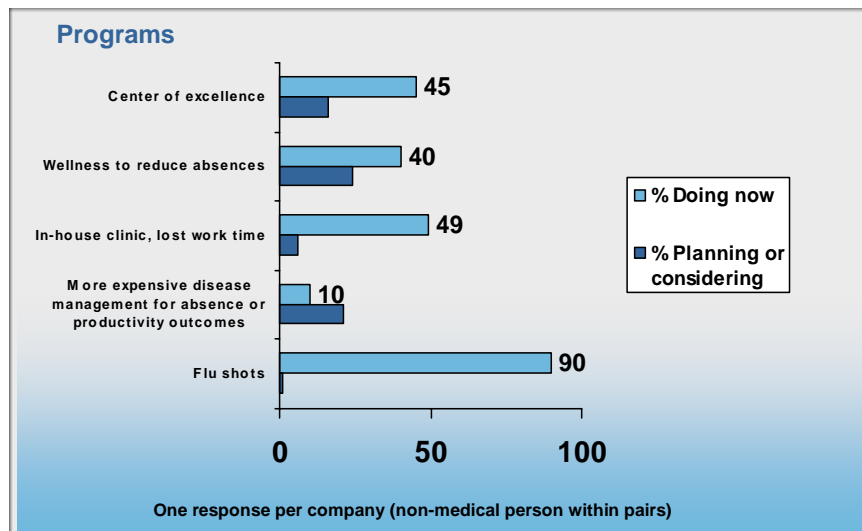
Figure 10: Specific Value-focused activities



Programs

Employers reported offering health-related programs, a category of VFAs, more often than other types of activities (see Figure 11).

Figure 11: Specific Value-Focused activities



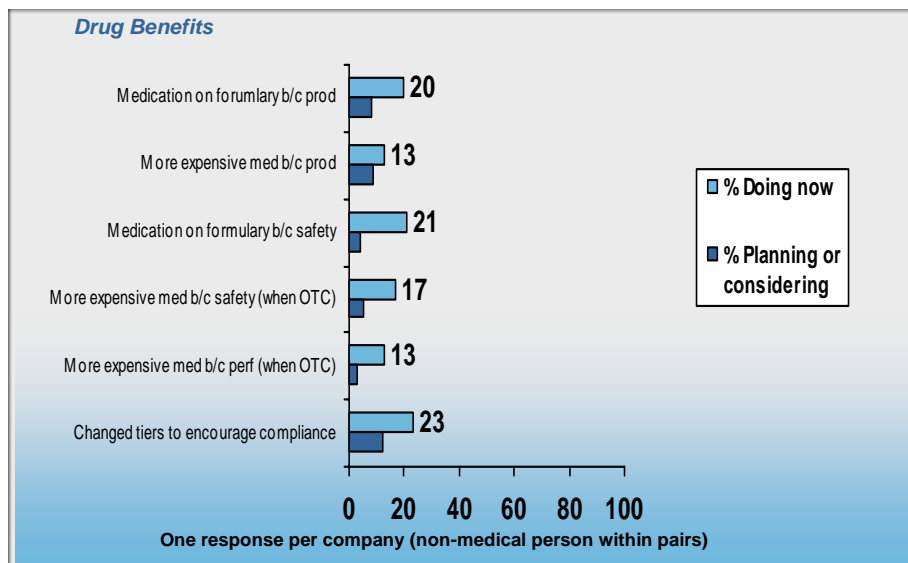
Most commonly, employers reported offering flu shots (90%), followed by in-house health clinics (49%) and access to centers of excellence (45%). Survey questions asked about these programs in the context of value-focused decisions. For example, the question about flu shots asked specifically if the organization had chosen to provide flu shots to better manage avoidable absences. However, it is not possible to ascertain whether respondents reported doing these activities for other than value-based purposes.

Employers frequently reported offering wellness programs (40%), which was also the most frequently reported activity being considered in the future (25%).

### Drug Benefits

Value-focused decisions about drug benefits were included to investigate recent trends in benefit design that focus on productivity outcomes. Results indicate that a minority of employers have altered drug benefits through the activities listed (see Figure 12). Almost one-quarter of employers reported changing the tiers of a medication to encourage compliance, or included a drug on formulary to improve safety outcomes. One in five included a medication on formulary to improve productivity outcomes. Fewer reported choosing a more expensive alternative due to a value-oriented outcome.

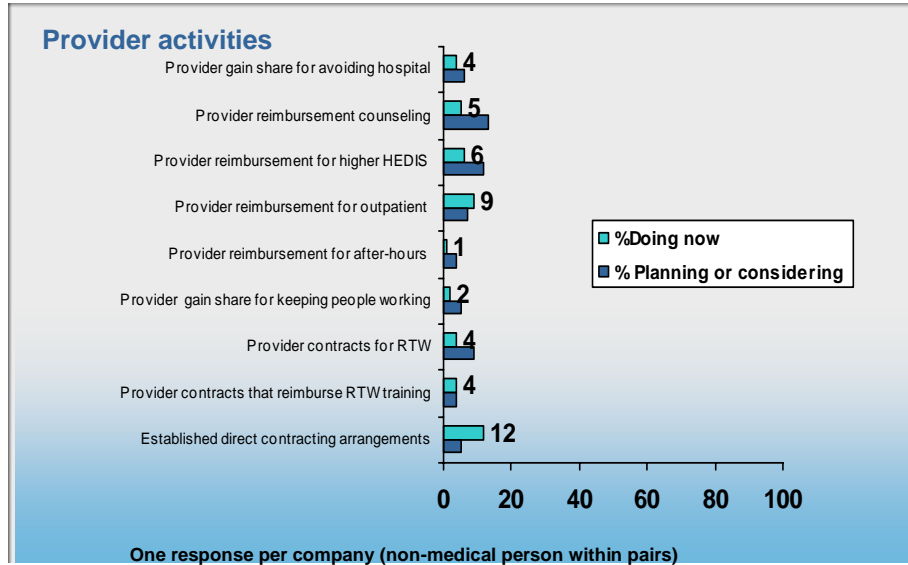
Figure 12: Specific Value-Focused activities



### Provider activities

Due to recent interest in direct contracting and pay-for-performance, the survey included a variety of activities related to employers' involvement in provider choice or provider reimbursement. As seen in Figure 13, provider-oriented activities were not commonly reported. While 12% reported direct contracting arrangements, fewer than 5% of employers reported taking part in reimbursement strategies to improve return to work, off-hours care, or functional outcomes. Although rates for this category of activities were among the lowest overall, over 10% reported considering some alternative reimbursement arrangements in the future.

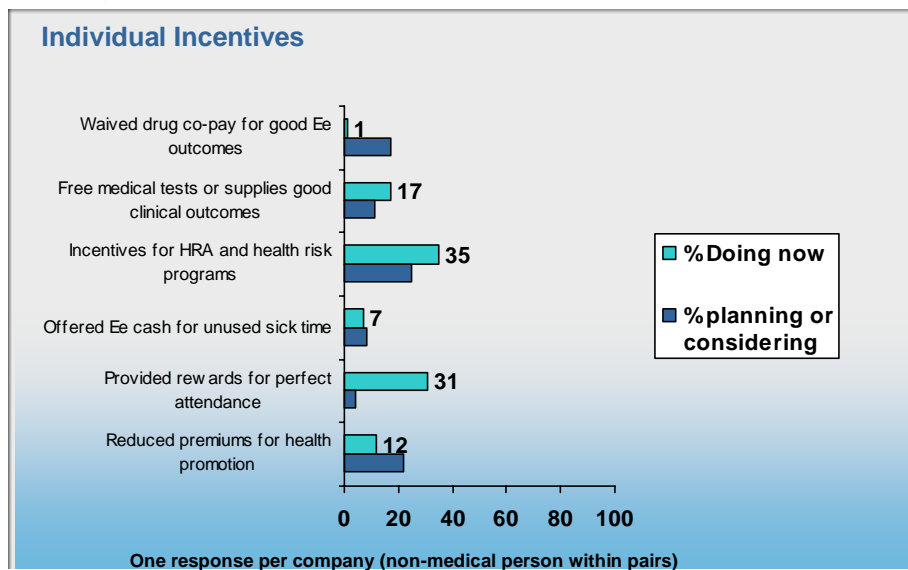
Figure 13: Specific Value-Focused activities



Individual incentives

About one third of employers reported providing individual incentives for participating in HRAs and rewards for perfect attendance (see figure 14). More than 20% are considering incentives for HRA and reduced health care premiums for participation in health promotion. Very few have considered waiving co-pays for medications in return for good clinical outcomes, or providing cash for unused sick time.

Figure 14: Specific Value-based activities



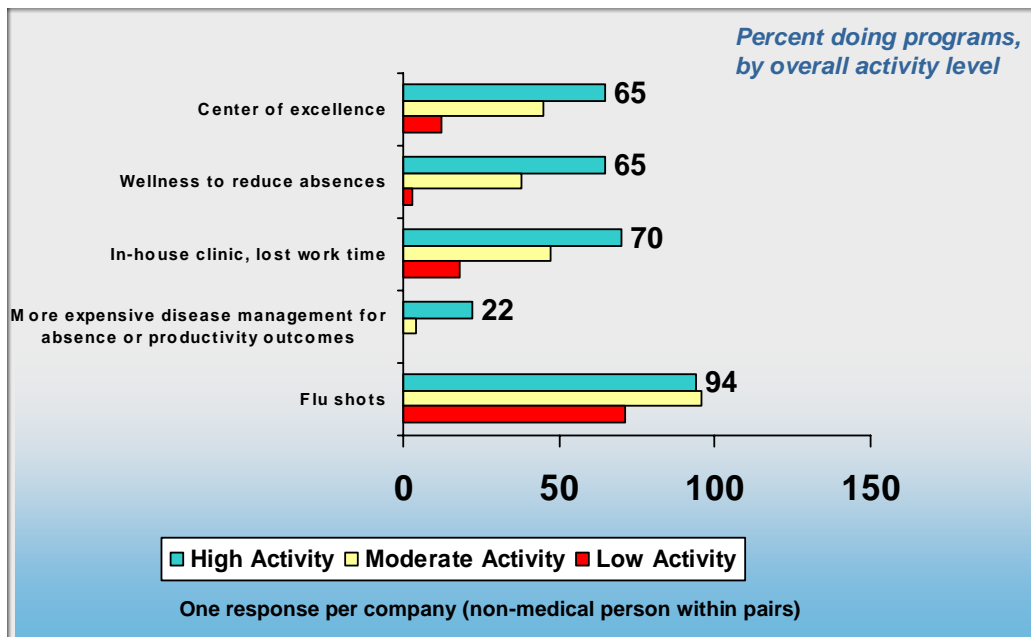
**TYPES OF ACTIVITIES OF EMPLOYERS DOING MANY OR DOING FEW VFAS**

In an effort to describe the types of activities that employers do “first,” low activity employers (those doing fewer than three) were compared to moderate (3 to 6 activities) and high activity (more than 6) employers. One would expect that the activities adopted first will be those that low activity companies report most often. And, as shown, low activity companies reported program activities more than other activities (see Figure 15).

Conversely, one would expect that the high activity companies represent the “early adopters” of VFAs. The activities that the high activity companies report today are likely to be the ones that other companies would follow in the future. Activities that *neither* high nor low activities report are not yet being considered by anyone.

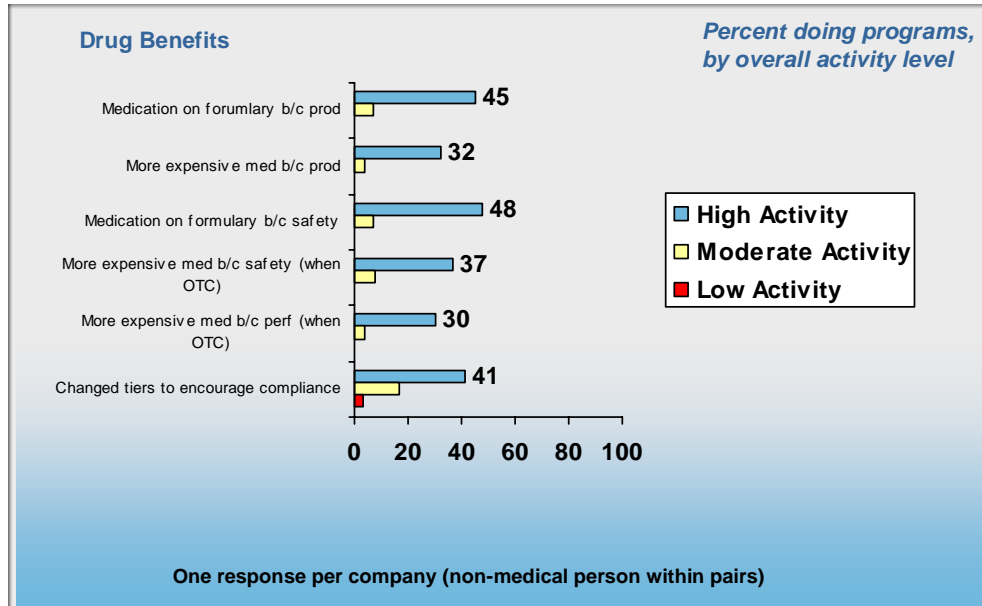
Thus, an indicator of likely future directions is those activities showing the greatest *differences* in rates between high and low activity companies. For example, flu shots were reported by a high proportion of low-activity and high-activity companies, indicating that it is a first-step activity. Choosing health plans based on absence outcomes was not reported often by any of the groups, indicating that this is not being adopted as a strategy for value.

**Figure 15: Companies who do many versus few activities**



Large differences in reported rates for high-activity and low-activity companies are a possible indicator of what “early adopters” are doing. One area showing such differences were in drug benefit design (see Figure 16). High activity companies reported doing most of the drug benefit VFAs, while low activity companies were virtually absent from these activities. In fact, of the eight largest differences in rates of activities, half were drug benefit activities (see Table 2).

**Figure 16: Companies who do many versus few activities**



**Table 2: Largest differences between what high and low activity companies are doing**

Activities	Percentage
Implemented a <b>wellness program specifically to reduce absenteeism</b>	62%
Included <b>access to a center of excellence</b> because it has significantly lower complication rates and <b>faster recovery times</b>	53%
Opened an <b>in-house medical clinic to avoid lost work time</b> for minor non-work related medical issues	52%
Included a <b>more expensive prescription medication</b> on the formulary when an alternative is available over the counter, <b>because of safety</b>	48%
Offered incentive programs for participating in <b>health risk assessment</b> and health risk reduction programs	46%
Chose to include a <b>medication on formulary</b> because it had proven productivity outcomes	45%
<b>Changed tiers</b> of medications used to treat specific chronic diseases to <b>encourage compliance</b>	38%
Included a prescription <b>medication on the formulary</b> when an alternative is available over the counter, <b>because of safety</b>	37%

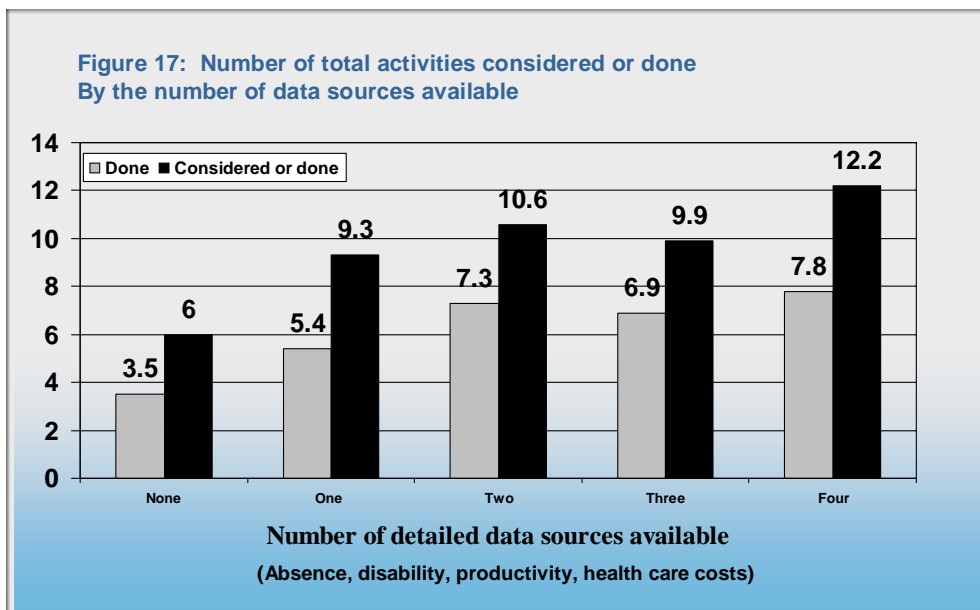
**FACTORS ASSOCIATED WITH VFAS**

Employers reporting higher numbers of VFAs were different in several respects from employers reporting fewer VFAs. Four differences will be highlighted here:

- Greater availability of data
- Higher importance of benchmarking
- Greater reported accountability
- More recognition of absences and productivity loss as a costly outcome

**Availability of data**

Respondents who reported having more detailed data sources (the number of sources for which detail was available) also reported doing more VFAs, (correlation =0.41, p<.01)). Those reporting four data sources reported doing twice as many as those who reported having none (see Figure 17). Because the most common source of data was health care claims data, this implies that companies with access to sources other than health claims alone do more VFAs. This, logically, connects having data about value-related outcomes with doing activities that manage those outcomes.



Employers who rated internal data as an important influence on decisions reported more VFAs than those who rated internal data as less important (correlation = 0.33, p<.05.)

**Importance of benchmarking**

Employers that rate benchmarking as an important influence on decision-making also report more VFAs. All three benchmarking questions (against similar organizations, against leading organizations and against innovative organizations) had a significant positive correlation with number of VFAs (correlations ranging from 0.26 to 0.35). This suggests that employers who have an interest in knowing what leading, innovative organizations do, may be innovators themselves and more interested in emerging cost management strategies.

### Reported accountability

Companies that do more VFAs also hold their decision-makers more accountable for outcomes. The number of total VFAs correlated with three aspects of accountability. Respondents from high activity companies reported having primary accountability for a greater number of outcomes (correlation = 0.26), having a greater level of accountability for absence outcomes (0.27), and participating in absence design decisions to a greater degree (0.30).

This association is similar to the logic connecting more data to more activities. When a decision-maker has greater accountability for absence results, he or she may have greater incentive to consider value-related outcomes such as lost time. Similarly, a company with more interest in value-related outcomes may be more likely to assign primary accountability for results to decision-makers.

### Recognition of absences and productivity loss as costly outcomes

Respondents from high activity companies disagreed with the statement “health care costs are larger than costs for productivity loss” more often than respondents from low activity companies (correlation = 0.22). As might be expected respondents from high activity companies also agreed more often that “benefits can be designed so that they pay for themselves in improved productivity” (correlation = 0.20).

### Factors not associated with VFAs

Several factors that one might expect to be associated with doing more activities were not. For example, respondents were asked to rate how important absence and productivity outcomes were to their senior management team. They were also asked how important senior management opinions were to internal decisions. None of the items regarding senior management were significantly correlated with activities.

A previous survey on productivity, in 2000, (*Corporate decision-making for health and productivity: A qualitative investigation, IHPM*) suggested that employers most familiar with health and productivity issues learned about them from consultants. In this survey, the rated importance of consultants in decision-making was not correlated with the number of VFAs.

## Different Roles, Different Beliefs: Medical and Non-medical Respondents . . .

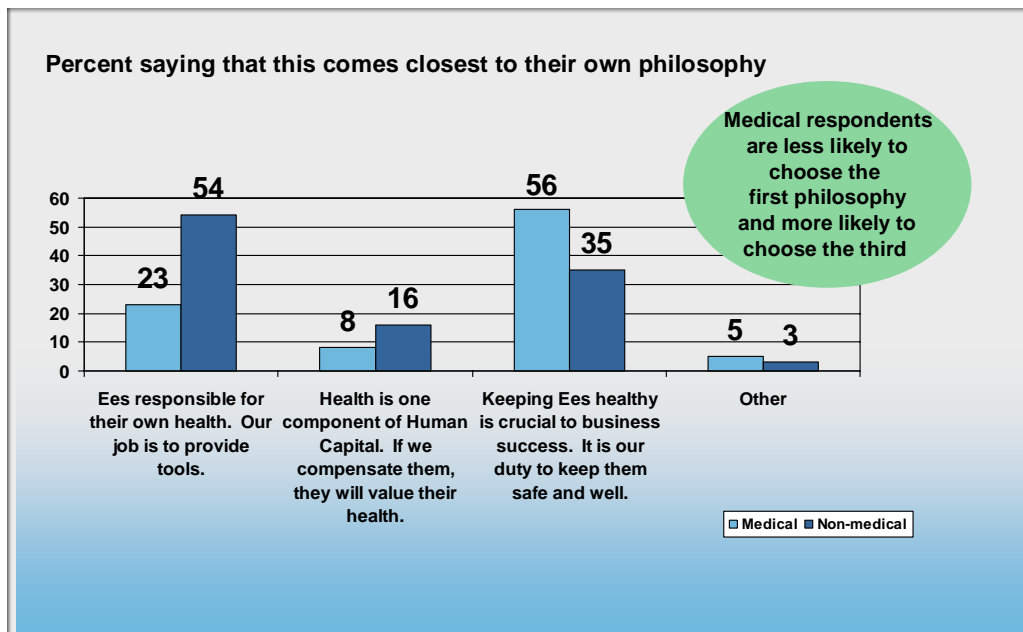
There were significant differences in responsibilities, accountabilities, opinions and philosophy between decision-makers who had a medical background (ACOEM members) and decision-makers with a non-medical background. As mentioned in an earlier section, with very few exceptions, medically trained decision-makers worked in a corporate health department. Almost all non-medical decision-makers worked in the benefits or HR departments. Consequently, the effects of department and profession are strongly intertwined.

### OPINIONS AND PHILOSOPHY

Medical respondents were far less likely to agree (36%) that health care costs are a larger cost than productivity loss than non-medical respondents (53%). They were also more likely to agree (74%) that benefits can be designed so that they pay for themselves in improved productivity, compared to non-medical respondents (51%). In general, non-medical respondents were more healthcare cost focused than medical respondents.

Philosophically, when asked which statement most closely represented their own philosophy, medical respondents were half as likely (23%) to choose the statement that employees were responsible for their own health than non-medical respondents (54%) (see Figure 18). They were also half as likely to choose a statement describing health as an element of human capital. Conversely, 20% more medical respondents chose the statement that it is the employer's duty to keep employees safe and well. This particular question illustrates a significant difference in perceived responsibility for health outcomes.

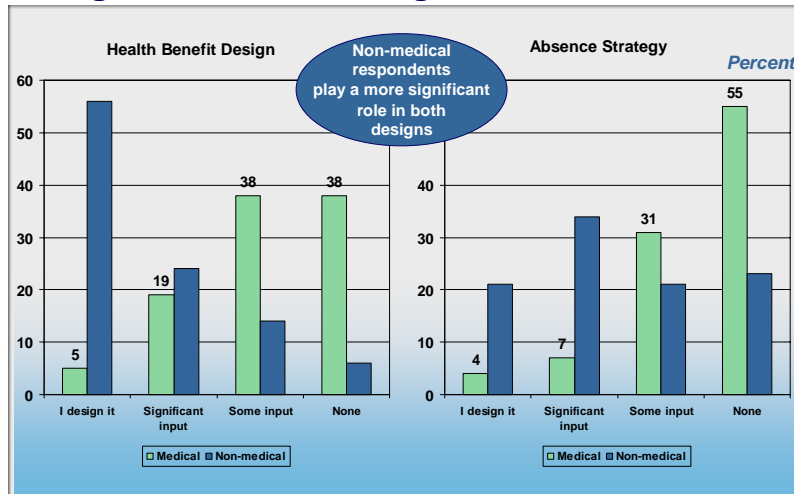
## Orientation toward health



**ROLES AND ACCOUNTABILITIES**

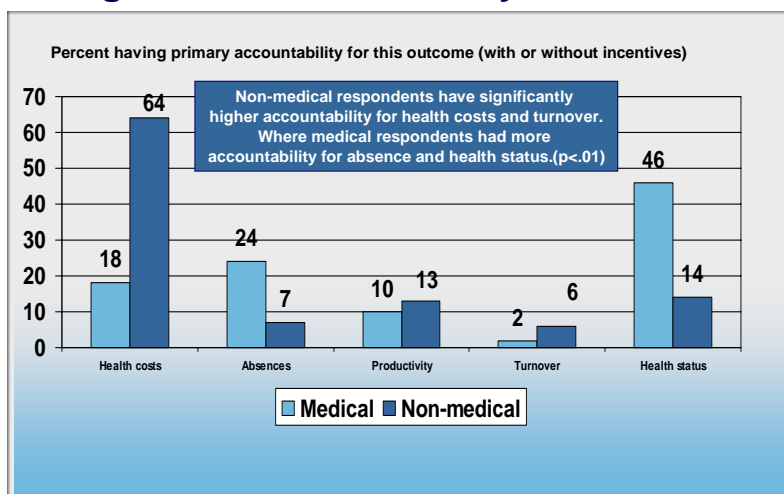
Medical respondents reported surprisingly limited roles in design of health care benefits and absence strategy (see Figure 19). Only 24% of medical respondents had significant input into health care benefit design and, an astonishingly low, 11% had significant input into absence strategy. Non-medical decision-makers had significant influence in both areas.

**Figure 19: Role in design decisions**



Medical respondents had more accountability for improving employee health status outcomes. Forty-five percent of medical respondents had primary accountability for health status outcomes, compared to only 14% of non-medical respondents (See Figure 20). Conversely, only 18% had primary accountability for health care cost outcomes, compared to 64% of non-medical respondents. Very few respondents (medical or non-medical) reported having primary accountability for either productivity or turnover.

**Figure 20: Accountability for outcomes**

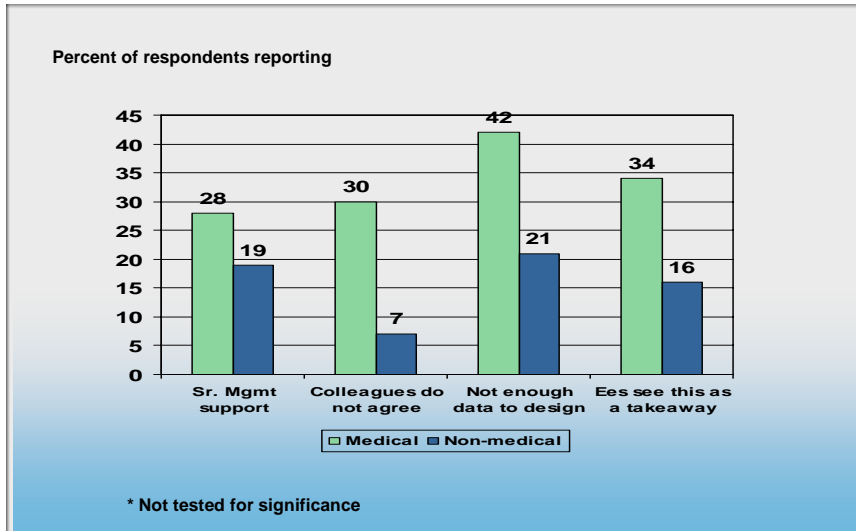


A minority of medical respondents report having budget authority for health care, disability, disease management or safety. Conversely, more than half of non-medical respondents reported having some budget authority for all areas except safety.

**PERCEIVED BARRIERS AND SOLUTIONS**

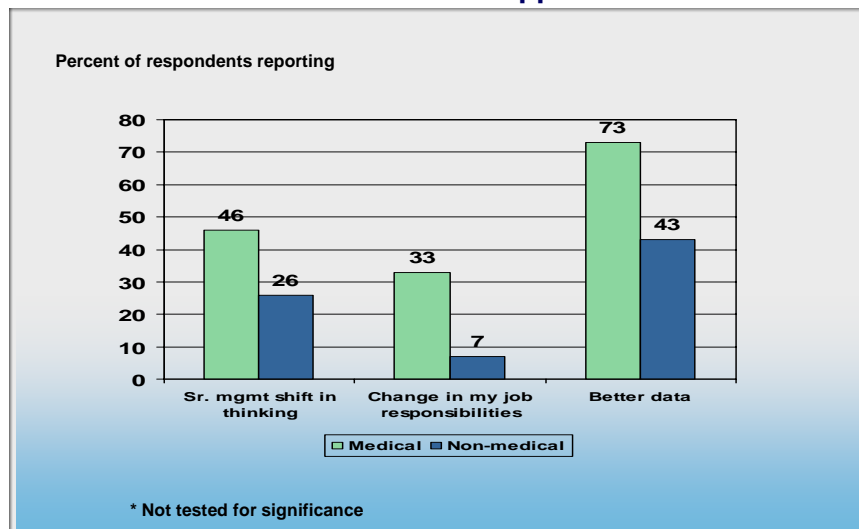
Perhaps related to having a lesser role in decisions, medical respondents reported perceiving more barriers to implementing VFAs (see Figure 21). More reported a lack of support by senior managers, a lack of agreement among colleagues, insufficient data, and concerns that employees would perceive these activities in a negative way. Differences in the frequency that these barriers were reported were notable.

**Figure 21: Medical respondents perceive more barriers to value-based decisions**



Medical respondents were also more vocal about what needed to occur to facilitate adoption of more VFAs (see Figure 22). The most commonly reported needed changes were obtaining better data, shifting the thinking of senior management, and changes in job responsibilities. One third of medical respondents reported that changes in their responsibilities should occur, compared to only 7% of non-medical respondents.

**Figure 22: Medical respondents feel more strongly about some of what needs to happen**



### *Number of Value-focused activities*

Medical and non-medical respondents did not differ in the average number of VFAs being done in their organizations. However, there were small (non-significant) differences in the rate certain types of VFAs were reported. Medical respondents seemed to report more safety-related and provider-related activities, while non-medical respondents selected more program and policy-related activities. These differences can possibly be attributed to differing levels of familiarity with certain types of activities.

## Implications . . .

### 1) Movement toward value-focused decision-making is in its early stages.

In general, employers have implemented few value-focused activities. Out of 32 possible activities, the average employer reported doing only six, and considering three more. The VFAs most frequently reported are easy to do, or may have been considered for cost-management reasons. Several types of activities (namely health plan and provider strategies) have not yet been considered in the realm of value-focused outcomes. Fewer than one in 10 employers are including value outcomes in decisions about these areas.

### 2) Employers start with common, familiar activities.

Employers reported wellness related activities and programs most often and provider and health plan strategies least often. The most common activities employers used to achieve value-focused outcomes included flu shots, wellness program, and incentives for HRA. Offering centers of excellence was also reported frequently.

Many “high activity” employers also reported making drug benefit decisions specifically to address absence, safety and productivity outcomes. One third to one half of high activity companies reported doing each of the drug benefit activities, compared to none of the low activity companies. It appears that programs (such as flue shots and wellness) come first, followed by drug benefit policies. Even high activity companies had not yet adopted health plan or provider strategies as a way to address value outcomes.

### 3) Information and accountability are strongly associated with making value focused decisions

Employers doing more VFAs tend to 1) have more types of data available to decision-makers, 2) hold decision-makers more accountable for absence and productivity outcomes, 3) value benchmarking, and 4) have decision-makers who recognize the importance of other outcomes (besides health care costs). These relationships are statistically significant and suggest a mindset of broader thinking about the importance of value-focused outcomes.

By looking at multiple sources of data, it appears that decision-makers broaden their scope of interest beyond health care costs. Information about what other companies are doing keeps employers aware of new trends and opportunities. Also, while it is impossible to know whether information drives accountability, or whether accountability drives the need for more data, it appears that two factors both lead decision-makers to choose activities that address both cost and value.

### 4) Decision-making appears to occur in silos, where non-medical decision-makers have more authority and accountability for policy and benefit decisions

Medical decision-makers differ significantly from non-medical decision-makers. Results showed significant differences in philosophy, beliefs, accountability, roles in decisions, and perceived barriers. These differences indicate strong divisions of responsibility and attitude that may hamper collaborative decision-making. Medical decision-makers tend to place more importance on value-focused outcomes, but were not empowered to make related policy decisions.

## Contributors . . .

A project of this magnitude requires the expertise and cooperation of many participants. The team responsible for this project included the following organizations and individuals:

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Appendix

List of Value-focused Activities
<b>Health plan and absence management</b>
Chose a health plan specifically because of their absence and productivity outcomes
Chose a more expensive health plan because of their absence and productivity outcomes
Chose an absence management vendor because they demonstrated a better reduction in absence/disability days
Chose a more expensive absence management vendor <i>because</i> they demonstrated a better reduction in absence/disability days
Chose a health plan because they provide after-hours clinics to reduce loss of work time
Chose a more expensive health plan because they provide after-hours clinics to reduce loss of work time.
<b>Programs</b>
Included access to a center of excellence for treating serious disease <i>because</i> it has significantly lower complication rates and faster recovery times
Implemented a wellness program <i>specifically to</i> reduce absenteeism
Opened an in-house medical clinic <i>to avoid lost work time</i> for minor non-work related medical issues
Chose a more expensive disease management vendor <i>because</i> they demonstrated better absence or productivity outcomes
Provided flu shots at a discounted cost – or free – to reduce absenteeism
<b>Drug benefit</b>
Chose to include a medication on formulary <i>because</i> it had proven productivity outcomes
Chose to include a more expensive medication on formulary (or better tier) <i>because</i> it had better productivity outcomes
Included a prescription medication on the formulary when an alternative is available over the counter, <i>because</i> of safety
Included a more expensive prescription medication on the formulary when an alternative is available over the counter, because of safety
Included a more expensive prescription medication on the formulary when an alternative is available over the counter, because of improved job performance
Changed tiers of medications used to treat specific chronic diseases to encourage compliance
<b>Provider strategies</b>
Developed gain sharing arrangements with a physician group where providers share in financial savings from keeping patients out of the hospital
Provided higher reimbursements to providers for performing chronic disease maintenance and counseling
Provided higher reimbursements to providers for higher performance on HEDIS measures
Increased reimbursements to providers for procedure options that can be performed on an outpatient basis rather than an inpatient basis
Provided higher reimbursement rates for seeing employees outside of working hours.
Entered into provider contracts that include gain sharing provisions for keeping people on the job
Entered into provider contracts that reward better return to work rates
Entered into provider contracting that includes higher reimbursement in return for training about appropriate return to work processes
Established direct contracting arrangements
<b>Individual incentives</b>
Waived co-payment on a maintenance drug (such as insulin) as long as employee improves or maintains good clinical outcomes
Provided of other medical tests or supplies (such as monitors) for free as long as clinical indicators are positive
Offered incentive programs for participating in health risk assessment and health risk reduction programs
Offered gain share arrangements where employees receive cash for a portion of unused sick time
Provided rewards for perfect attendance
Offered reduced premiums for health promotion participants