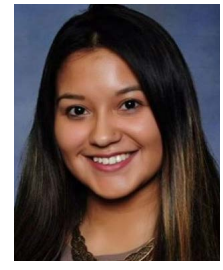
Employer-Provider Interface Council (EPIC) 2019: Managing Health Benefits In The Era Of Change

Michelle N. Segovia

The inaugural meeting of EPIC (Employer-Provider Interface Council) took place on June 11, 2019, at Rutgers University's Ernest Mario School of Pharmacy in Piscataway, New Jersey, with the theme of "Managing Health Benefits in the Era of Change." The conference, which featured a roundtable discussion among a diverse group of healthcare stakeholders, was designed to examine market changes, key trends, and some of the disruptive factors in health care. National and regional leaders addressed various perspectives of decision makers, and the presentations were followed by a reactor panel* and audience participation.

The interactive nature of the program—organized by EPIC in collaboration with the Rutgers Health Outcomes, Policy, and Economics (HOPE) Center, School of Pharmacy—facilitated conversation, and talks focused on ways to improve employer–provider relationships. Topics included new outcomes-driven initiatives and value assessment models; barriers to effective communication regarding value; consumerism; transparency (or lack thereof); and recent developments in the policy landscape. The meeting was also intended to encourage action at a pivotal time in health care, as stakeholders adapt to an era of rapid change requiring greater collaboration.



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Employers are the largest purchasers of health care in the U.S: they account for almost half of all dollars spent, and are responsible for providing coverage for more than 100 million Americans.[1] The market power that employers possess, coupled with their tremendous vested interest, affords them a potentially major voice in shaping the future of health care and improving employee well-being and productivity. During the conference, some participants questioned employers' frequent lack of engagement in assessing healthcare value. Attendees commented on the importance of understanding employers' needs and expectations and of offering the essential tools and education that will provide them with the requisite expertise to make informed decisions. As customers with significant leverage, employers can influence the market by engaging more closely with providers, aligning their common goals for the benefit of their shared priority—the employee as plan member and patient. Re-evaluating the allocation of benefits and resources, advocating greater transparency, and providing access to meaningful data and greater external support can bring about lasting innovations that will improve quality of care and outcomes.

Neil Goldfarb, CEO, Greater Philadelphia Business Coalition on Health, outlined opportunities for maintaining a healthy workforce by implementing health and wellness programs as preventive tools for employees with a high risk of developing chronic diseases (e.g., diabetes and obesity). Employers can achieve this goal through new and/or improved employer–provider initiatives that facilitate greater health-plan responsiveness, which can ultimately lead to better outcomes (and potentially greater productivity) for employees. Workplace safety and return-to-work are important factors that directly affect productivity. According to the American Society of Safety Professionals, "in the U.S. workplace, fatigue is associated with more than $300 million in lost productivity time."[2] Having access to real-time information through the use of wearable medical devices and the digitalization of health data can mitigate the risk of injury caused by fatigue, allow for timely intervention, and provide relevant clinical parameters of health. New technology allows us to expand services and achieve sustained employee engagement along with accurate measurements that are needed to close existing evidence gaps.

Mary Alice Lawless, Chair and Founding Trustee, Foundation for Health Smart Consumers, emphasized the central role of tech- and internet-savvy consumers in the ongoing transformation of U.S. health care. To develop more informed and discerning consumers, employers and providers need to encourage their involvement and reshape the overall healthcare experience so that it becomes a more positive one. Ms. Lawless, who has been recognized for innovation in health and care strategies, highlighted consumers' natural hesitance at making decisions when large sums of money are at stake, especially in a system whose method of payment for services is inconsistent and may be perceived as arbitrary and unfair. She explained that we need to engage patients and address their concerns at optimal points on the consumer journey, with self-care as the focus. Self-care behaviors, such as those provided in employer wellness programs, can greatly decrease the burden of chronic diseases and help patients avoid medical complications. This is the point on the continuum where patients are most accessible and capable of implementing disease-management strategies, as opposed to later stages when they find themselves in uncomfortable or emergent situations. According to projections by the National Council on Patient Information and Education, "$6.6 billion in

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* Reactor panelists included Charlie Pollack, MD, of the Hospital Quality Foundation; Dick Bullard, RPh, of EPIC; David Gregory, MPH, of Baker Tilly; Murray Harber, CEO of Mississippi Business Group on Health; and Paul Marden, CEO of United Health Care of New Jersey. Ed Silverman, Editor of *Pharmalot* and *STAT News*, was the panel moderator.

avoidable health costs would be saved annually if 10 percent of Americans with chronic diseases adopted self-care practices."[3] Greater involvement by consumers could be realized by alleviating their concerns and fears through earlier interventions, which would inspire them to be better, more confident stewards of their own health, with an improved ability to make informed decisions in the future.

This led to a discussion about expanding the use of healthcare value assessment, and the need for a recognizable standard of quality and value for consumers. Jennifer Bright, MPA, Executive Director of the Innovation and Value Initiative (IVI), raised an important point about the absence of direct patient perspectives when responding to the challenge of determining the best ways to measure value. Value does not necessarily mean the lowest price or the lowest unit cost, she said; affordability should also be factored in. There is a great deal of dispute over the value of therapies, and better means are urgently needed to allow comparisons across the various therapies. As we develop new approaches to meet society's changing healthcare needs, Ms. Bright continued, we need to target long-term returns by ensuring that patients are an integral part of the conversation.

The importance of payer strategies to support employer–provider innovations was discussed by Steven Peskin, MD, MBA, FACP, Executive Medical Director of Horizon Blue Cross Blue Shield New Jersey. Dr. Peskin spoke about driving the future by investing in partnerships that enhance creative innovations for an improved member experience. Horizon Blue plans have invested in companies and technologies that stimulate the reinvention of health care by using tools that incorporate behavioral health management, value-based benefit designs, telemedicine, and an overall improved access to care.

The policy landscape was covered by Kip Piper, MA, FACHE, President of Health Results Group. This is a very dynamic area as policies are rapidly changing and affecting the structure of health care. It is a realm that requires the thorough evaluation of risk management strategies as we face emerging challenges with decisions that have powerful implications for the future of health care. Mr. Piper mentioned potential shifts in Medicare Advantage (MA) plans with proposed flexible supplemental benefits that could cover non-medical aid and supportive services for patients. A report by the Long-Term Quality Alliance depicted this increasing interest in providing these benefits for patients with disabilities or complex needs. In February 2018, the CHRONIC Care Act was enacted, which allowed MA plans to initiate supplemental benefits in 2020 for patients with chronic conditions.[4] Although there are still limitations and challenges being explored in terms of future implementation, some of the benefits that might be offered include homemaker services, assistive and safety devices, adult day care center visits, pain management, certain meals, and non-emergent transportation. These efforts are continually being evaluated and can be a step forward in cultivating patient (employee or consumer) quality of life.

The conference concluded with a call for action that incorporates a more patient-centered approach through the formation of inclusive collaborations that will be fundamental in driving decision-making around the future of pharmacy and therapeutics. To make appropriate investments in health, policy makers in employer settings and government should be provided with the tools and expertise they need to improve the structure of health care. Novel concepts were presented for the interpretation of value, with patient-centeredness as a focus when comparing cost and effectiveness across different therapeutic modalities (drugs, medical devices, etc). For example, Ms. Bright explained the goal of IVI in transforming value assessment through an Open-Source Value Platform, which is a system focused on transparency while evaluating the value of medical technologies. This new approach "centers on the patient, allows for a broad range of perspectives, incorporates the latest available evidence, and considers the full range of scientifically defensible approaches."[5] The four elements that drive this open-source platform include developer resources, disease-specific models, tailored value assessments, and an overall interactive community.

We can build better tools for assessing interventions by acknowledging that our current measures must integrate additional factors and aspects of value to allow for the improved interpretation of data. Although employers have a broad idea of the meaning of value, they rely on provider entities and external resources for value assessment and expect a transparent return in order to make decisions. One important point stressed by Ms. Bright was the idea that value should represent the specific population in question rather than the general population to ensure the highest value of care is provided for those affected. In July 2018, the National Health Council held a dialogue in Washington, D.C., with organizations involved with value-assessment frameworks and representatives from patient groups. As a result of this meeting, 17 recommendations were developed to enhance the patient-centered approach to value assessment. These included patient-focused drug and clinical developments, improved bi-directional communication and understanding, and training for both value-assessment entities and patients on how to effectively engage with each other.[6]

Employers are also critically important for improving patient centricity, and their participation can lead to meaningful and actionable initiatives for the wellbeing of their employees. For example, they can implement cost-saving strategies, as pharmacy costs have been largely unaffected by PBMs' direct contracting with providers and by branded drug rebates that essentially exclude biosimilars in a market that incentivizes the use of brand-name biologics. Employers wield a great deal of influence in terms of purchasing power; they could initiate more favorable terms by holding provider entities more accountable, by being less reliant on providers to devise solutions, and by pushing for greater transparency in pricing.

A better understanding of the motives behind stakeholders' perspectives, and what they can bring to the table, could help dismantle the barriers to effective communication and encourage system-wide efforts that lead to a more collaborative system.

For more information about EPIC, visit https://hqf-epic.org.

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