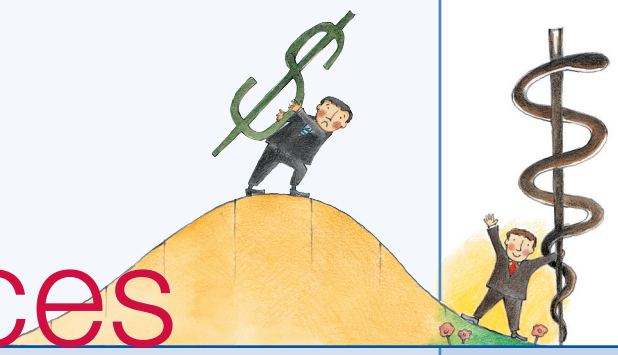
2007 SHPS Health Practices Study

What Every Self-Insured Employer Should Know



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Contents

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Introduction from Rishabh Mehrotra SHPS President & CEO

What can we learn about healthcare from a steel company, or a bank, or a soft-drink bottler? Quite a bit as it turns out.

For all practical purposes, every self-insured employer manages its own unique health plan. It underwrites the cost of healthcare and owns the financial risk associated with the health of their employees. Yet, not all employers are equally adept at managing their health plan. Several recent studies by leading health actuarial firms have noted the same observation: there is a widening gap in the cost of healthcare between employers that cannot be explained by differences in workforce demographics, location or coverage. Some employers have experienced double-digit increases in healthcare costs for several years in a row. But there are also employers who are effectively administering many of the most-efficient health plans that exist in our nation today.

The premise behind the *2007 SHPS Health Practices Study* is to understand why some employers are so much more efficient in delivering health benefits to their employees than others. Which strategies and tactics work? Do some benefits policies lead to higher costs? At the most basic level, the study revealed an interesting dichotomy – companies that spend less on healthcare focus on improving the health of their employees, while those that spend more focus on the administrative aspects of healthcare, such as procurement.

The results of the *2007 SHPS Health Practices Study* offer clear direction for self-insured employers. To manage healthcare costs, employers need to take a sharply focused, outcome-oriented and *relentless* approach to measuring and managing the prevalent clinical risks within their covered population. Employers need objective health analytics combined with administrative, clinical and financial programs that support a culture of health. Sometimes, this means confronting employees directly with the need to change personal habits and health behaviors. However, the results of our study show that employers already navigating this path have reaped an enormous competitive advantage through improved health and productivity at lower cost. In companies where employee health is valued, the employer and employee both benefit.

Not all of the study findings reflect well on our industry. Some challenge traditional benefits practices, some make good intuitive sense and others go against the grain of conventional thinking.

I hope you will find the results of our inaugural health practices study illuminating – and worthy of discussion on how we can create a better, more practical financial model to deliver healthcare – for all involved.

Wishing you good health,

Rishabh Mehrotra

Why Do Some Companies Pay More For Health Benefits Than Others?

The *2007 SHPS Health Practices Study* began with a simple observation. While most employers experience year-over-year increases in healthcare costs averaging three to five times the rate of inflation, SHPS observed that a handful of its clients consistently managed their healthcare costs down to the rate of inflation without cutting health coverage or shifting costs.

What made this observation especially puzzling was that none of the clients appeared to have much in common. They represent diverse industries, possess distinctive workforce demographics and corporate cultures, offer dissimilar health plans, and are located in different parts of the country. For unexplained reasons, they consistently outperform other employers in managing healthcare costs. An informal investigation of these clients revealed a framework for effective healthcare practices. This framework is documented in our 2006 publication titled *Making Consumerism Work: A Practical Guide for Transforming Healthcare*.

So, why do some self-insured employers pay more for healthcare than others? SHPS designed the study to answer this question. One hundred and fifteen companies representing almost four million covered lives completed a 230-item survey.

Classic benefits benchmark studies focus on forecasting actuarial trends and allow companies to compare health benefits against their peers. In contrast, this unique survey considered a much broader range of practices – health benefits strategies, plan design, vendor procurement, health analytics, care management programs, provider quality, network discounts, administration and communication. After factoring out differences in location and workforce composition, SHPS then correlated these practices with total healthcare expenditures per employee. This study is not designed to specifically report on the health practices in use by employers, but instead focuses on which practices have a positive or negative impact on healthcare costs.

A National Trend

Recent studies by leading health consultants noted substantial differences in per employee healthcare costs – on the order of $1,200 to $2,500 or more per benefit-eligible employee per year. For a company with 20,000 employees, this cost differential could yield an enormous competitive advantage – $24 million to $50 million per year in discretionary dollars that could be invested elsewhere or passed on to shareholders.

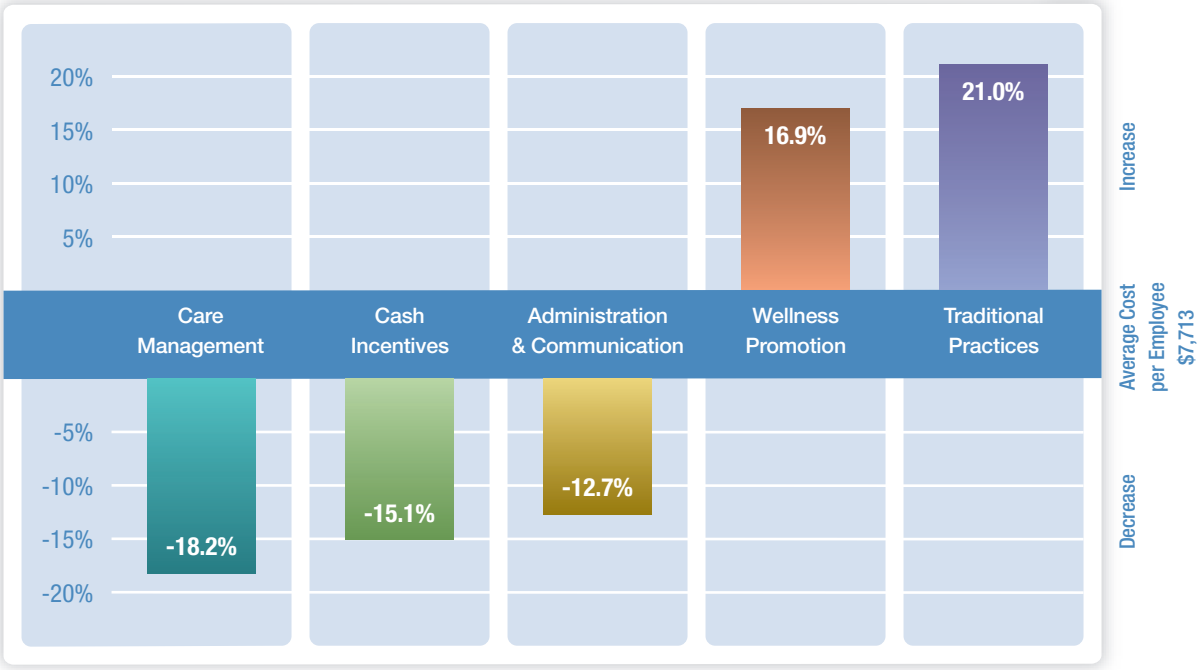
The results of the *2007 SHPS Health Practices Study* challenge many traditional practices. Based on the survey data collected, the average employer spent $7,713 in healthcare costs per benefit-eligible employee. The study shows that the use of certain practices in healthcare management could explain enormous differences in per employee costs – as much as 30 to 50 percent between two otherwise comparable employers (see Exhibit 1). The charts on the following pages summarize the findings.

It is important to note that best practice employers did not achieve their healthcare cost savings overnight. The best practices identified in this study typically require several years to reach their full potential. Employers who are only now starting to develop effective health practices will need patience and perseverance to achieve parity with companies who have had programs in place for at least three years.

Study Methodology

SHPS' study findings are based upon a statistical regression model and do not prove strict causality. However, they do demonstrate that certain employer health practices have a strong positive or negative correlation to the cost of healthcare. In reality, these practices will co-exist rather than stand alone as reported in this study. The model estimates the savings (or increases) in healthcare cost per benefit-eligible employee that would result for a typical company who adopted that practice. Actual savings (or increases) will vary based upon employer-specific factors and would be observed over a multi-year period. Some practices described in this study might not be appropriate for all employers. SHPS recommends that employers obtain guidance from an independent, third-party health benefits professional to determine the right approach for their company.

Exhibit 1: Impact on employer annual healthcare cost*



* Impact on annual healthcare costs is based on a regression analysis of the correlation of specific benefits practices with total healthcare costs. The study did not factor in the length of time practices had been in place. It is important to note that impact will vary by employer.

What Best-Practice Companies Do

Finding	Summary	Observed Healthcare Cost Difference
#1. Implement clinically based care management programs	Employers with lower healthcare costs report the use of clinically focused care management programs to manage the clinical risk of their covered population. Case management for catastrophic conditions has the highest impact. A mix of disease management for chronic illness, biometric testing, employee assistance programs (EAPs) and on-site physicians also impacts costs.	18.2 percent average decrease (savings of $1,400 per benefit-eligible employee)
#2. Use cash-based incentives to drive health behaviors	Employers with the lowest costs don't just ask their employees to participate in health programs, they provide incentives to do so. These employers use premium reductions, direct cash payouts or contributions to spending accounts as rewards for desirable health behaviors. Desirable behaviors can include anything from annual check-ups and biometric screenings to participation in a condition management program for a chronic disease or the completion of a smoking cessation program.	15.1 percent average decrease (savings of $1,165 per benefit-eligible employee)
#3. Practice excellence in benefits administration and communication	Employers who rank their company's performance as 'good to excellent' in seven specific administration and communication practices have lower healthcare costs. These practices include centralized recordkeeping, accurate eligibility management and targeted communications. Low-cost employers use vendors who can exchange data effectively. They create a seamless experience for participants across their health and benefits lifecycle and communicate all health-related messages through a single look and feel.	12.7 percent decrease (savings of $980 per benefit-eligible employee)

Health Practices with No Measurable Impact

The *2007 SHPS Health Practices Study* analyzed a broad range of common health benefits practices, many of which did not have an impact on healthcare costs, including:

- **Consumer-driven health plans (CDHPs):** While 39 percent of employers report offering a high-deductible plan with a health account, the study found no meaningful correlation between CDHP usage and overall healthcare costs. Because CDHPs are fairly new and participation rates vary greatly among employers, it is too early to measure the impact of CDHPs.
- **Pay-for-performance networks:** 15 percent of employers report using a pay-for-performance network. However, the study observed no relationship between these networks and overall healthcare costs.
- **Premium cost sharing:** Study results show the employee contribution to healthcare premiums averaged 28.5 percent but had no relationship to health spending. Increasing the employee share of premiums produces a one-time savings but does not appear to reduce overall healthcare costs.

What Best-Practice Companies Don't Do

Finding	Summary	Observed Healthcare Cost Difference
#4. Implement wellness promotion and education	Employers who manage employee health solely through the use of Web-based health portals and lifestyle management coaching spend almost 17 percent more on healthcare than those who do not. Many employers consider health promotion and education programs to be a substitute for more rigorous care management programs. These programs are primarily designed to educate members on healthy habits. However, they must be part of a more comprehensive program that focuses on managing the clinical and lifestyle risks that drive higher healthcare costs.	16.9 percent average increase (increase of $1,300 per benefit-eligible employee)
Traditional Practices		
#5a. Manage provider quality through network procurement	Employers who report difficulty distinguishing the quality of care in their provider network have higher healthcare costs than those who don't have quality issues. Since most provider networks now have significant coverage overlap and offer similar discounts, the impact of network selection on cost and quality is increasingly trivial. This approach forces employers to look for alternate ways to manage provider quality and healthcare costs.	The presence of any one individual factor resulted in a 15.7 to 29 percent increase – average of 21 percent (increase of $1,620 per benefit-eligible employee)
#5b. Offer employees multiple plan design options	Consumer choice sounds nice in theory, but the presence of multiple plan designs appears to increase cost and complexity without adding value. Employers who offer different plan design options report higher healthcare costs than those who do not. Employers should streamline plan design but offer multiple networks.	
#5c. Use deductibles and co-pay levels to drive health behavior	A select but statistically significant group of employers in the study report using deductibles and co-pay levels as a primary incentive strategy to drive changes in employee health behaviors. When this practice is analyzed separately, the companies who report using it have healthcare costs averaging 29 percent higher than those who don't.	
#5d. Use health benefits to become an 'employer of choice'	Although the strategy of using benefits to recruit and retain employees might be appropriate for a few employers, it has a negative impact on the healthcare costs of most other employers. Research into the causes of turnover continually shows that employees stay or leave companies based upon intangibles such as supervisor behavior, workplace climate, career opportunities and hiring practices – not benefits.	
#5e. Have undesirable levels of employee turnover	In the study, turnover rates vary dramatically among employers depending upon their operating model, but they typically have a small impact on healthcare costs. However, when a company reports that its employee turnover is 'too high', its healthcare costs tend to be substantially higher.	

Finding #1 Companies that focus on managing the health of their covered employees through targeted, clinically based care management programs have an average of 18.2 percent lower healthcare costs. This represents $1,400 per benefit-eligible employee in annual spending over an unmanaged trend.

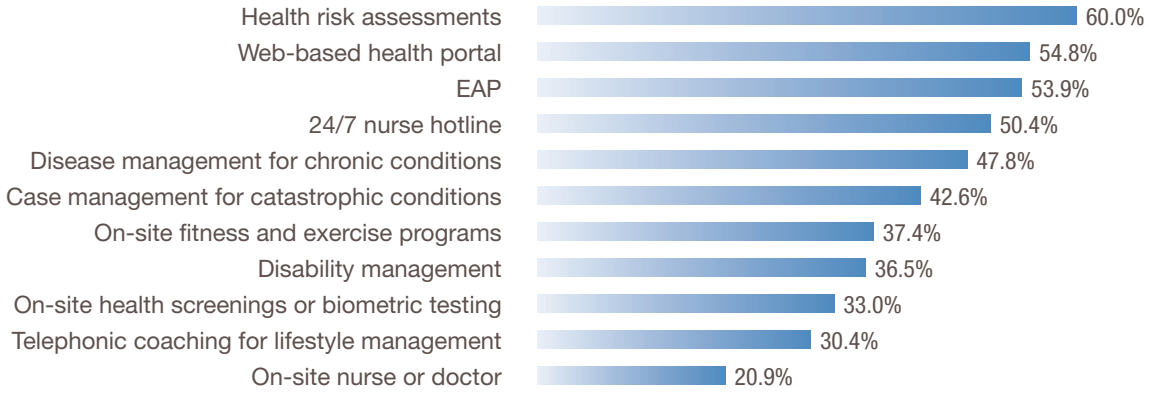
Case management programs that monitor quality of care and provide nurse-counseling support for catastrophically ill or injured patients have the greatest impact on healthcare costs. Programs that manage chronic disease, along with biometric screening, the presence of an on-site physician or nurse, and EAP programs will increase the cost savings. Furthermore, employers who reported the use of specialized programs, rather than the standard, 'check-the-box' offerings did better.

Interpretation

With all other factors equal, a healthier population costs less to insure than an unhealthy one. Employers who succeed at improving health outcomes for employees should expect to reduce utilization and achieve savings over time. Many care management programs are currently offered by employers (see Exhibit 2). But which work best?

Analysis of health claims consistently show that in a typical employee population, nearly 80 percent of annual healthcare cost will be driven by 30 percent of the population who have a manageable condition and 1 percent of the population may account for 20 percent of spending. Therefore, the primary drivers of total health spending, by order of impact, will be treatment for catastrophic medical conditions, followed by episodic inpatient and outpatient care arising from complications associated with a chronic disease such as diabetes, asthma and coronary heart disease.

Exhibit 2: Percentage of employers offering care management programs



For this reason, an effective healthcare strategy is typically two pronged. First, employers ensure best standards of care when inpatient care is required. Second, they reduce future demand for inpatient care through effective management of chronic conditions, biometric screening to identify clinical risk and the promotion of healthy lifestyles. When this strategy is implemented effectively, preventive care and prescription costs often rise, while the long-term costs from inpatient and specialty procedures decline.

Employers with the lowest cost directly manage the clinical risk of their population, giving priority to the highest acuity conditions through use of case management. For catastrophic illnesses and injuries, the ability to counsel patients, review care plans and identify high-quality providers results in significant cost savings. This approach improves the overall outcome, reduces the probability of complications and lowers readmission rates.

Subsequently, employers can make broader investments into the health and wellness of their population as appropriate for their specific workforce. Disease management might be appropriate for populations with a high incidence of, or improperly treated, chronic conditions. Biometric screening makes sense for most populations as they identify individuals at risk for chronic disease. Employers that have a significant workforce population in one location might benefit from an on-site clinic.

Different employers will select different combinations of programs to address their unique needs. The common success factor across all employers is the use of programs that employ a metrics-driven approach. Health analytics allow the employer, or third-party vendors acting on its behalf, to identify and prioritize the clinical risks in its population, and design and measure the impact of care management programs. More advanced analytics also permit the identification of providers not complying with evidence-based medicine guidelines and target the employees most appropriate for clinical intervention.

Normally, care management programs require several years to achieve full impact, so program impact will depend partly upon tenure. For some workforce populations, particularly where there is high incidence of undiagnosed or untreated chronic disease, a condition management program can actually increase first-year health costs, as participants seek out preventive care and comply with medication protocols. However, a mature care management program should save the average employer approximately $1,400 per employee in annual spending over what they would have paid otherwise.

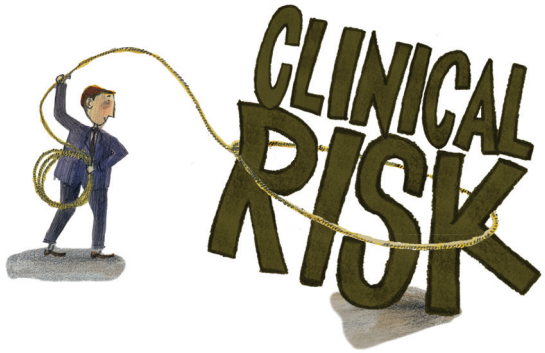
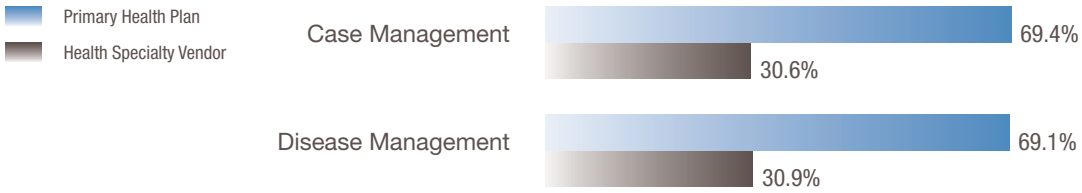


Exhibit 3: Percentage of employers using a specialty vendor vs. the primary health plan for care management programs



The study asked which type of vendor provided certain care management programs (see Exhibit 3). The results show an increase in overall cost savings when an employer uses a specialty health vendor rather than a health plan to deliver care management programs. We can speculate on the reasons for this, but it is likely due to the scope and intensity of services provided by a specialty company.

Some health plans offer comprehensive care management services for an additional fee, while others offer less comprehensive services free of charge as a loss leader to entice customers to their administrative service only (ASO) and network services. For that reason, care management programs can be as simple as a limited review of procedures post-billing or as complex as providing pre-treatment consultation to physicians, redirection of patients to treatment centers of excellence, and personal coaching to patients and their families.

Finding #1 Recommendations

- Focus on improving the clinical health of employees as the primary health benefits strategy.
- Utilize population health metrics to identify and prioritize employee clinical risk and to monitor care management programs.
- Deploy a robust care management program that provides the ability to redirect high-acuity patients to the best provider.
- Implement additional clinically based health and wellness programs as appropriate, including:
  - Disease management programs for populations with a high incidence of chronic disease;
  - Biometric screening to objectively identify employees who have high pre-disease risk; and
  - On-site clinic for centralized locations.

Finding #2 Cash-based incentives, when used to drive desirable health behaviors, strongly correlate to reduced healthcare costs, while other forms of incentives have an insignificant, or even negative, impact.

Employers report using many types of incentives (see Exhibit 4) but those using cash-based incentives average a 15.1 percent reduction in total cost per benefit-eligible employee, or approximately $1,165 per employee. Cash-based incentives included one or more of the following:

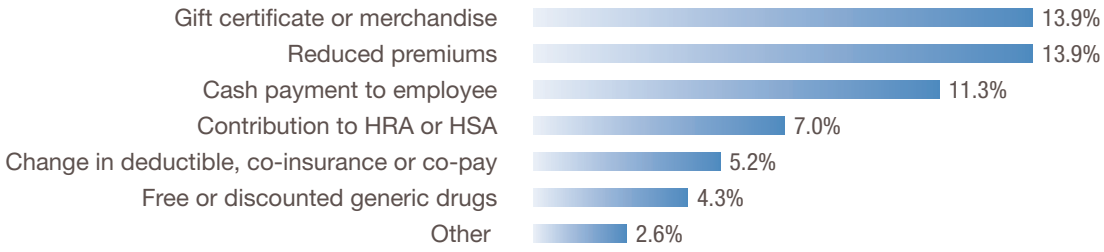
- Reduction in plan premium;
- Direct cash payout; and/or
- Contribution to a health reimbursement arrangement (HRA) or a health savings account (HSA).

Interpretation

Cash is compelling. Cash-based incentives force a clear, direct conversation about healthcare between employers and employees. While initial attitudes regarding cash incentives are often mixed, the results suggest that employees will make behavioral changes that lead to lower health costs.

The study also showed a high correlation between the use of cash incentives and care management practices. While the study did not specifically identify how each respondent used cash-based incentives, SHPS' experience indicates that most companies use them to drive vigorous participation in high-value programs, such as preventive screenings, health risk assessments and participation in wellness and disease management programs. Generally speaking, incentives make sense only if there are strong care management programs and metrics already in place.

Exhibit 4: Percentage of employers using incentives to drive desired health-related behaviors



Desired behaviors, outcomes and measurements need to be precisely defined before the launch of an incentive program. Cash-based incentives may increase upfront costs, require careful legal review prior to launch and be difficult to administer. Moreover, many employees perceive health-related financial incentives as a coercive penalty rather than a bonus. But, when well-designed and executed, cash-based incentives deliver measurable healthcare cost savings.

Why are non-cash incentives less effective? There are two likely reasons. Non-cash incentives, such as merchandise, might trivialize key health programs or might not be important to employees. In addition, incentives based upon plan design (i.e., deductibles, co-pays and free generic drugs) impact behavior only at the point-of-sale. This approach may affect out-of-pocket spending but not lead to better health. In fact, non-cash incentives might actually discourage the use of preventive care which is critical in the management of chronic disease. It's best to link any incentive directly to a *desirable* health behavior.

A challenge for any incentive program is to design the program so that it encourages all employees to take a more active role in the management of their personal health. In practice, an employer may choose to have tiers of incentives so that every employee has the opportunity to receive at least one incentive.

Finding #2 Recommendations

- Develop a well-defined point of view around the behaviors that have the greatest impact on overall population health risks.
- Deploy cash-based incentives as part of an overall plan design to drive specific health behaviors.
- Implement care management programs and information resources to support these behaviors.
- Clearly communicate benefits and expectations to employees.
- Identify critical objectives and establish outcomes-based metrics.
- Use spending accounts, such as an HRA or HSA, as a mechanism for providing the incentives.
- Continue to 'raise the bar' for receiving the incentive each year.

Finding #3 Excellence in benefits administration and communication has a direct correlation with 12.7 percent lower healthcare costs per benefit-eligible employee when integrated with the delivery of health programs.

Study respondents were asked to rate their company's performance on a range of administrative and communications practices using a scale of 1 (unacceptable) to 5 (excellent). The results identified seven key practices where performance excellence was found to have a high impact on cost savings, including:

- Selecting vendors who have the ability to share information/data with each other;
- Using vendors who provide a seamless experience for members;
- Ensuring member eligibility data is accurate and up-to-date;
- Having a unified, coordinated process for data processing and recordkeeping;
- Communicating all health-related messages with a common theme, 'look' or 'brand';
- Devoting a specific communications vehicle to the promotion of employee health; and
- Targeting health communications to both employees and their families.

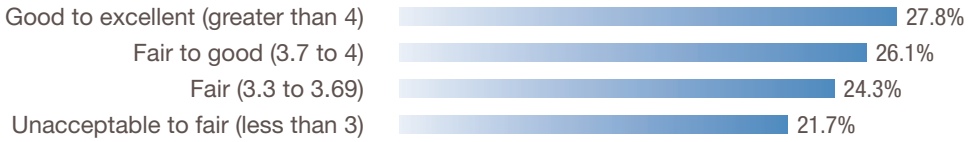
In the study, a one-point change in the average performance score of these seven practices correlates to a 12.7 percent reduction in total healthcare costs per benefit-eligible employee (e.g., an average score of 4 versus an average score of 3). This change in score equates to a difference in cost of $980 per employee annually for the average employer.

Exhibit 5: How would your company perform?

	Unacceptable 1	Poor 2	Fair 3	Good 4	Excellent 5
1 Vendor sharing of information and data with each other	○	○	○	○	○
2 Ability of vendors to provide a seamless experience for members	○	○	○	○	○
3 Ensuring member eligibility is accurate and up-to-date	○	○	○	○	○
4 Having a unified, coordinated process for data processing and recordkeeping	○	○	○	○	○
5 Health-related communications have a common theme, 'look' or 'brand'	○	○	○	○	○
6 There is a specific communications vehicle devoted to promoting employee health	○	○	○	○	○
7 Health communications target both employees and spouse/families	○	○	○	○	○

Employers' scores are based on the average of the above seven factors. A one-point change in the average score of these seven practices correlates to a 12.7 percent reduction in total healthcare cost per benefit-eligible employee.

Exhibit 6: Employer performance across all seven administration and communication factors



Interpretation

Outsourced health benefits administration is often perceived as a commodity service. It is purchased based upon cost and administrative convenience as part of an overall human resources outsourcing initiative, rather than for its potential to add value. High-quality, outsourced benefits administration can ordinarily be purchased for $60 to $200 per employee per year. The purchase cost is only a small fraction of its putative value to reduce healthcare costs. Yet the study shows substantial variations in the quality of administration practices used by employers, with a large number of respondents ranking themselves in the unacceptable or fair categories (see Exhibit 6).

Similarly, communications practices vary widely in quality between employers, ranging from highly choreographed campaigns to randomly distributed brochures provided by multiple vendors.

What explains the large impact that benefits administration and communications have on employer healthcare costs? Centralized administration impacts an employer's ability to effectively:

- Coordinate delivery of all health benefits and programs among multiple external vendors by providing a single member record;
- Support accurate health analytics and permit mining of enrollment data;
- Manage eligibility across all health plans and third-party services;
- Reconcile eligibility data with claims data to identify "leakage" (ineligible members);
- Link enrollment processes with the administration of financial incentives, including contributions to spending accounts and premium reductions;
- Use annual enrollment and life events as opportunities to communicate key health messages directly to employees; and
- Conduct specialized "campaigns" to target audiences.

In addition to the potential cost impact, another advantage of high-quality benefits administration is improved premium billing and eligibility reconciliation with health plans. "Leakage" is the accumulation of over-enrolled members resulting from failure to promptly terminate coverage. Employers often pay for health benefits that employees are not eligible to receive. In addition, as many as 10 percent of employees may have an ineligible dependent enrolled on the company's health plan.

SHPS' experience shows that these errors always exist and commonly reach levels as high as 5 percent of the enrolled population. Overpaid claims, ASO fees and premiums alone can cost even a moderate-sized employer a few

million dollars annually. If a company has poor health benefit administration practices, **bringing premium leakage under control** is one of the fastest ways to achieve a quick reduction in overall healthcare costs. Many human resources and finance departments are not fully aware of the financial impact of leakage.

Streamlined administration, when combined with consistently branded communications, allows the employer to deliver critical messages to all members. Clear communication eliminates the confusion that often occurs when multiple vendors communicate independently with employees and their families.

Studies by benefits consulting firms consistently show that employee perceptions regarding the value of their benefits are far more influenced by the quality of communication materials rather than the actuarial value of the benefits being provided. If employers ineffectively communicate health benefits, they lose the impact they might otherwise receive for offering competitive health benefits.

In short, excellence in health benefits administration and communication creates a foundation upon which effective employee health management strategies can be developed and implemented. Without such a foundation, an employer's ability to effectively execute their health management practices is greatly limited.

Finding #3 Recommendations

- View benefits administration and communication practices as the backbone for delivering effective healthcare strategies.
- Develop or upgrade administration and communication capabilities that:
  - Support appropriate care management programs, health analytics and financial incentives;
  - Provide a foundation to easily administer incentive programs; and
  - Enable reconciliation of eligibility and/or claims data to reduce premium leakage.

Finding #4 Using wellness promotion and education as a primary health management strategy results in higher overall healthcare costs. The use of Web-based health portals, along with telephonic coaching for lifestyle management, is correlated with 16.9 percent higher healthcare costs or $1,300 per benefit-eligible employee.

Interpretation

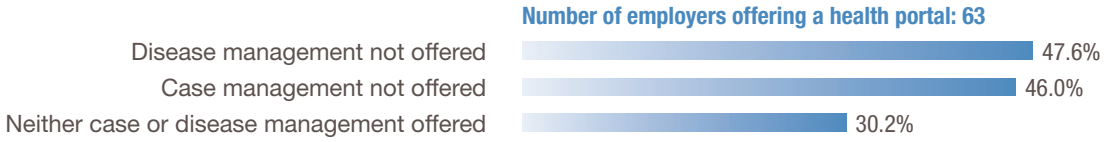
Though surprising, this finding is statistically significant and cannot be ignored. Given the popularity of wellness promotion and education programs, SHPS took a cautious approach to interpreting this finding. To understand the interpretation, some perspective on health portals and telephonic lifestyle coaching might be helpful. Consider the following:

- There is a wide variation in the content, design and quality of Web-based health portals and telephonic lifestyle coaching services. Most focus solely on disseminating health information.
- Health portals are still in their infancy. Many programs have only been implemented within the past few years.
- Telephonic lifestyle coaching services are usually offered to individuals who are at-risk for chronic conditions. Theoretically, these services reduce the risk of disease onset and will therefore be most effective in reducing healthcare costs three to six years after implementaion. Their financial impact is unlikely to be observed during the first few years.
- A well-designed health portal can improve program delivery by centralizing employee access to all health-related resources and tools.
- It is reasonable to expect promotion and education programs to increase healthcare costs as employees become more aware of health issues and take action to manage their personal health (i.e., new medication to control high blood pressure).

So what are the drivers behind the negative study results? After carefully reviewing the data, SHPS concluded that use of a health portal or telephonic lifestyle coaching does not necessarily increase costs. Many employers use them on a standalone basis to substitute, rather than supplement, more rigorous clinically focused programs, such as case or disease management (see Exhibit 7). In addition, most wellness promotion and education programs are not outcome-based. They do not have the rigor to manage clinical risk. It is problematic if these programs become the primary health strategy for several reasons:

- **The programs do not address the primary drivers of healthcare cost:** Standalone, wellness promotion and education programs are not designed to address the specific needs of employees with chronic or catastrophic health conditions. This group accounts for 30 percent of the population but drives 80 percent of health spending. For any employer who underwrites health risk, the absolute first priority must be to ensure the best standards of care when expensive inpatient care is required. The second priority is to reduce future demand for inpatient care through effective management of chronic conditions. Moreover, in a high-turnover workforce, the cost savings gained from a wellness promotion and education program will not be realized.

Exhibit 7: Employers using a health portal as a standalone program



- **There is limited access to reliable health metrics:** Health programs are only as good as the metrics used to manage them. Promotional and educational programs often only rely upon self-reported health information in the form of a health risk assessment. Self-reported data is far less reliable and precise than either biometrics or medical claims. Without reliable health analytics, it is difficult to accurately identify individuals in need of clinical intervention for at-risk, chronic or catastrophic conditions.
- **Wellness promotion and education programs lack an integrated, population-based approach:** Within any workforce, there are employees who are well, at-risk and chronically ill. When managing the clinical risk of a population, employers must address the health status of all employees. As a result, wellness promotion and education programs must be designed to fit within the overall continuum of care, not as a standalone program.

Wellness promotion and education programs don't make healthcare costs go up per se, but they create a false illusion of progress, allowing employers to 'check the box' on care management without having a real impact. They can be helpful tools when used properly as part of a comprehensive healthcare strategy. However, they fail to impact employee health when used as a standalone service.

Finding #4 Recommendations

Wellness promotion and education programs can play a vital role in improving employee health when deployed as part of a comprehensive care management strategy. Because they are essentially a form of preventive care, they should be used by companies who have low-turnover workforces.

Health portals and lifestyle coaching should only be introduced once an employer has:

- Developed a metrics-driven, outcomes-based health strategy;
- Implemented clinically focused care management programs to address chronic and catastrophic conditions; and
- Defined the objectives of all health programs to support a diligent procurement process.

To be effective, wellness promotion and education programs should:

- Target 100 percent of the covered employee population;
- Employ biometric screening and/or mandatory preventive physicals to obtain reliable health data;
- Use strong incentives (e.g. mandatory for coverage) to drive program participation; and
- Integrate with case and disease management programs.

Finding #5 *The 2007 SHPS Health Practices Study* identified five traditional practices, including benefits strategies, tactics and/or organizational issues, that resulted in substantially higher healthcare costs. The presence of any one practice individually correlates to an average 21 percent increase in healthcare costs and their impact is additive. The presence of all five practices correlates to a doubling of healthcare costs.

These five factors are:

- Managing provider quality through network procurement;
- Offering employees multiple plan design options;
- Using deductibles and co-pays to drive health behavior;
- Using healthcare benefits to become an 'employer of choice'; and
- Incurring undesirable turnover.

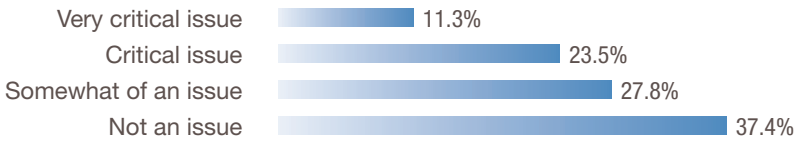
5a. Manage Provider Quality through Network Procurement

The study asked respondents to indicate if their company experienced problems managing provider quality (see Exhibit 8). Those reporting "little or no ability to distinguish provider quality of care" as a critical issue have higher healthcare costs.

Interpretation

Discounts and provider coverage for most medical networks today are fairly similar. If the networks are the same, why do some employers report quality issues while others do not? The study data suggests that high-cost employers place emphasis on network procurement as their primary tool to impact cost and quality rather than actively guiding employees to high-quality providers through plan design, care management programs and effective communications. Savings don't occur unless the patient starts with the right physicians and facilities.

Exhibit 8: Employers who report little or no ability to distinguish quality of care from provider networks as an issue



The Relationship between Cost and Quality of Care

Cost has little impact on the quality of care, but poor quality care invariably drives higher costs. A recent study in Pennsylvania* found variations in the cost of a coronary by-pass procedure, ranging from approximately $20,000 to more than $100,000, with no demonstrable relationship to patient outcomes. However, the true cost of any procedure must consider the total episode of care. Poor quality care can lead to complications, higher readmission rates and extended convalescence, often doubling the total cost.

* The Pennsylvania Health Care Cost Containment Council, June 2007.

In practice, an employer need not focus on provider quality across the entire network to achieve a material reduction in cost. By pinpointing the most severe clinical risks prevalent within its specific workforce, the employer can focus on precisely targeted specialties. For example, identify a preferred provider for coronary care within a specific region and create mechanisms to funnel employees to that provider.

Finding #5a Recommendations

- Monitor provider quality and identify high-quality providers, or create specialty networks, for the handful of medical conditions where cost and quality are most critical.
- Adjust health plan coverage and care management services to funnel employees to those providers.
- Use health analytics to identify and prioritize critical clinical risks and quality issues.
- Focus on provider quality initiatives, such as employee education, after specialty care management programs are in place.

5b. Offer Employees Multiple Plan Designs

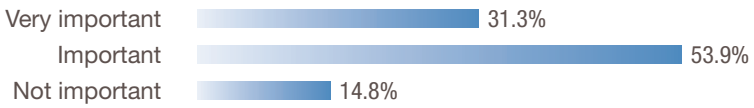
The 2007 SHPS Health Practices Study shows that employers pay a 20 percent premium – about $1,400 per benefit-eligible employee – to offer their employees the privilege of choosing among multiple plan designs (see Exhibit 9).

Interpretation

For some employers, this practice remains a legitimate business decision. For others, however, it is simply an unquestioned artifact from a bygone era when healthcare costs were lower and Americans were healthier.

The tradition of offering multiple plan designs originated from actuarial science rather than a profound belief in consumer choice. Health actuaries developed complex price and coverage schedules to entice employees to migrate to the plan design that was actuarially projected to minimize their health spending given their particular risk profile. For example, an employer could price an HMO with strong cost controls advantageously for employees with chronic disease, while offering a PPO with rich maternity benefits, but a limited provider network, to entice families anticipating children.

Exhibit 9: Percentage of employers who report that offering multiple plan choices is important



In practice, these tactics address a clinical problem – the health status of employees – with a short-sighted financial solution. In a good year, an effective migration strategy can provide a one-time dip in the healthcare cost trend, but it can also backfire. Employees select more generous coverage only in the years when they know their medical expenses will exceed premiums. For some companies, annual enrollment has evolved into a game between employer and employee, replete with complex plan comparison charts, competing vendor literature and computer-aided decision tools. Ultimately, this complexity does nothing to alter the inherent clinical risk of the employee population, which is the primary driver of rising healthcare costs over the long term.

Establishing one primary plan design streamlines all benefits delivery: administration, communications, metrics, incentives and care management. It places all employees on an equal footing, and provides better visibility into the employer's contribution to healthcare costs. Rather than studying coverage schedules, employees can focus on their personal health, learn about the company's care management programs and incentives, and think about how to best spend their healthcare dollars.

The plan design can be tailored to the needs of individual employees through the thoughtful design of incentives and the use of discretionary spending accounts. In regions where a provider network has spotty coverage, the best strategy is to maintain an identical plan structure but permit multiple networks.

Finding #5b Recommendations

- Cost-justify the practice of offering multiple plan designs and streamline plans unless there is a compelling reason to do otherwise.
- Where possible, move to a single, primary plan design with clear guidelines around:
  - Use of multiple networks;
  - Preventive coverage;
  - Options for selecting providers;
  - Care management programs;
  - Financial incentives;
  - Wellness and lifestyle management; and
  - Employer and employee premium contributions.
- Use incentives to support the specific needs of individuals, tailoring them for different life stages and health status.
- Where appropriate, offer additional provider networks to ensure sufficient coverage within a specific region or create private networks.
- Focus annual enrollment on personal health management rather than plan selection.

5c. Use Deductibles and Co-Pay Levels to Drive Health Behavior

A select but statistically significant group of employers in the study reported using deductibles and co-pay levels as a primary incentive strategy to drive changes in employee health behavior. When this factor is viewed in isolation, the companies who report this strategy have healthcare costs averaging 29 percent higher than those who don't.

Interpretation

The data did not provide any additional patterns to explain this result. Employers who use deductibles and co-pays as incentives are highly diverse from each other in terms size, workforce composition, industry, locations, care management programs, network selection practices, use of carriers and use of pay-for-performance programs.

One possible cause of the higher healthcare costs associated with using deductible and co-pays is that these 'point-of-sale' incentives might drive the wrong behaviors – causing employees to avoid needed treatments for chronic conditions, which is a primary driver of high healthcare costs.

Finding #5c Recommendations

- Avoid health incentive strategies that include changes to deductibles and co-pays, unless there is a compelling business reason to do so.
- If using deductibles, use different tiers or levels to link them to compliance with preventative care.
- Use cash-based incentives that drive desirable health-related behaviors.
- Clearly communicate the incentive program and expected outcomes to employees.

5d. Use Health Benefits to Become an 'Employer of Choice'

The study asked employers two critical questions:

1. In your company's overall benefits strategy, how important is it to position the company as an 'employer of choice' to attract talent?
2. To what extent has your company succeeded in positioning the company as an 'employer of choice' to attract talent?

The *2007 SHPS Health Practices Study* showed that a large number of employers believe that being an 'employer of choice' is an important objective for their health benefits strategy (see Exhibit 10). And when they do, they incur higher per benefit-eligible employee healthcare costs than employers who do not.

Interpretation

What is it about 'employer of choice' strategies that lead to higher health costs? The answer is not clear. More generous coverage, passive health management policies and the presence of greater clinical risk in the insured population are all valid explanations. Companies with rich benefits often have higher member to employee ratios, which increase healthcare costs. A health plan that costs $18,000 per employee makes perfect sense for a law firm or investment bank with 80-hour work weeks and revenues in excess of $500,000 per employee. What does the typical employer gain by spending an average of $1,400 more per employee to be an 'employer of choice'? Some companies would likely benefit from managing their health costs more efficiently and reallocating the savings to other human capital programs such as staffing, training and incentive compensation.

We observed no statistical relationship between employers who report success in becoming an employer of choice (see Exhibit 11) and how much they spend on healthcare. This finding makes intuitive sense. While new recruits expect credible health coverage, how many would choose a company primarily for its health plan? Studies of employee recruitment and retention consistently show that other factors such as supervisor behavior, job conditions, workplace climate, hiring practices and career opportunities are far more important in determining which companies get the best talent.

Health benefits won't attract and retain a high performance workforce but a workplace that values employee health will.

Exhibit 10: Percentage of employers who ranked being an 'employer of choice' as important in their benefits strategy

Finding #5d Recommendations

- Do not use 'employer of choice' criteria to drive health policies or procurement decisions unless there is compelling business logic to do so.
- Reallocate savings achieved from improved healthcare efficiency to other human capital programs that will impact 'employer of choice' status.
- Adopt a health benefits strategy based on:
  - Fair, credible coverage for employees;
  - Improvements in health and productivity; and
  - Clear, high-quality communications.

Exhibit 11: Percentage of employers who indicated they were successful in being an 'employer of choice'

5e. Report Undesirable Employee Turnover

The study asked companies to submit their voluntary, involuntary and total employee turnover. It also asked them to characterize whether their level of turnover was too low, too high or about right (see Exhibit 12). Overall turnover rate ranged from 5 to 200 percent and only had a nominal impact on healthcare costs. However, when companies **characterize their turnover as too high,** they have substantially higher healthcare costs.

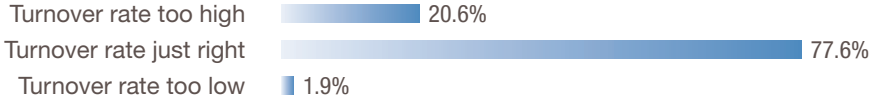
Interpretation

Clearly, undesirable turnover is a factor in having higher health costs. There are some likely reasons. As discussed earlier, health benefits are an ineffective tool for recruitment and retention. However, undesirable turnover is usually an indicator of poorly managed human capital coupled with a competitive labor market. In this type of environment, managing healthcare costs may be a lower priority. Additionally, many care management programs are not particularly effective in high-turnover populations and therefore, are not used to manage costs.

Finding #5e Recommendations

- Identify the root causes for undesirable employee turnover and implement practices to reduce turnover.
- Provide fair, effective health coverage, but do not use health benefits to improve retention.
- Implement care management programs, such as case and disease management, to address catastrophic and chronic conditions.
- Implement wellness promotion and education programs when turnover rates have reached acceptable levels.

Exhibit 12: How employers characterized their level of employee turnover



Turnover rate is only significant when it is reported as being 'too high' by the employer.

Conclusion

According to the *2007 SHPS Health Practices Study*, the best way to lower employer health costs is to improve the health of employees. It is that simple.

Employers with the lowest healthcare costs focus on the critical activities that allow them to measure and manage the clinical risk of their covered population:

- Implement clinically based care management programs appropriate for their workforce, addressing high-acuity health risks first. They also empower personal health management through outcome-based programs that might include condition management, biometric testing, on-site physicians and/or EAPs.
- Encourage employees to participate in health programs through cash-based incentives that could include premium reductions, cash or contributions to a spending account.
- Utilize strong, centralized recordkeeping processes that manage eligibility closely and provide a seamless interface for employees.
- Speak to employees and their families about health programs with branded, specialized communications.
- Identify high-quality providers for specific conditions and adjust coverage, programs and incentives to guide employees to use these providers.
- Refrain from short-term fixes such as standalone wellness promotion and education programs or managing provider quality through procurement.
- Avoid high-cost practices such as offering multiple plan choices to employees.
- Don't simply tweak the health benefit but instead focus on identifying and confronting the health risks of their covered population.

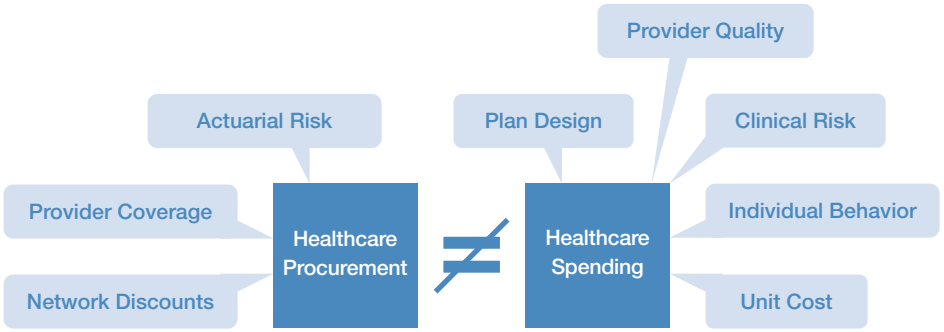
Implications for Employers

The *2007 SHPS Health Practices Study* provides strong guidance to companies around the strategic priorities for managing healthcare. Every company has unique requirements based upon its business model and workforce. Health programs that work for one company may be completely inappropriate for another. For that reason, SHPS recommends that employers:

- Work closely with an objective, third-party advisor to help select the most appropriate solutions.
- Utilize health analytics to understand the baseline clinical risk that exists in the insured population and use this data to prioritize objectives, design programs and measure outcomes.
- Develop a long-term strategic road map that identifies coverage, health programs, incentives and administrative tactics while driving procurement practices.
- Adopt an outcome-driven mindset focused on the long-term issue of employee health rather than short-term financial fixes.
- Select vendors who serve as strategic partners to build the overall program and who work well with other vendors.
- Procure benefits based on clinical risks, or network management strategies.
- Be prepared to have a direct, and at times uncomfortable, discussion with employees about their lifestyle and personal health.
- Create an integrated, consistent experience for employees.

Based on the study results, SHPS believes a key issue for many employers is the fundamental misalignment between common healthcare procurement practices and the actual drivers

Exhibit 13:



Employers need to align procurement with actual spending. Financially based procurement does not impact healthcare spending.

of higher healthcare costs. As shown in Exhibit 13, health benefits are often purchased based on an annual cycle that focuses on financial and actuarial criteria such as plan cost, network discounts and covered procedures.

The primary driver of higher healthcare costs is clinical risk, which is controllable through lifestyle choices, management of catastrophic and chronic conditions, and provider quality. In practice, a self-insured employer is running a health plan which underwrites coverage for a pre-defined population of employees and dependents over extended periods of time. In the long run, the financial liability can be lowered only by improving the health of the covered population.

As this realization sinks in, SHPS expects procurement practices to change dramatically, creating both opportunities and risks for the vendors who serve it today. The vendors who succeed will be those best able to empower the employer to improve employee health.

SHPS believes it is time to stop viewing health benefits through the stereotyped lens of cost-minded employers and entitlement-minded employees. In companies that place importance on health and productivity, there is a surprising confluence of interest. Employers and employees both benefit from a culture of health where the actual health benefits plan is not the focus. The real focus is on how to stay healthy.

The National Health Policy Debate

The *2007 SHPS Health Practices Study* raises some interesting policy issues that speak to the broader national debate on how to finance healthcare coverage. Some employers, including many small businesses, are demanding legislative solutions to get out of the healthcare business altogether. There are also self-insured employers who run the most effective and efficient health plans in existence today. Some of the most innovative thinking in healthcare comes from these progressive employers. This is not an act of altruism, but simply smart business.

Should employers be in the healthcare business? It depends. Employers who possess the ability to manage clinical risk efficiently are well-positioned to underwrite their own healthcare. They and their employees will equally benefit from this arrangement. However, not all companies have the size, resources and employment model to make this feasible. Arguably, those employers should have the ability to make other arrangements for providing affordable health coverage to their employees including the ability to create buying groups.

Similar logic applies to the public sector. No organization – public or private – should underwrite health coverage unless it is in a position to manage the health of the population it covers. It's easy to promise low-cost health coverage but hard to confront individuals with the need to change their health habits. The key lesson of this study is that as a nation, we should not just focus on how to finance the cost of healthcare but also figure out how to keep people healthy.

About the Study

The goal of the *2007 SHPS Health Practices Study* was to answer the question, "Why do some companies pay more for their health benefits than others?" In order to answer that question, SHPS surveyed employers on a broad range of practices and then correlated the data collected with the total healthcare spending.

Methodology

- Respondents representing mid- and large-sized companies with at least 1,000 benefit-eligible employees.
- One hundred fifteen companies participated – representing 3,770,200 members – with an average annual revenue range of $750 million to $1.5 billion.
- Respondents had job titles of manager, director or vice president within the areas of benefits, human resources or finance.
- The questionnaire asked about healthcare costs, health outcomes, benefits strategy and goals, cost shifting practices, plan design, network providers, benefits administration, incentives, care management programs, decision-support, employee communications, reporting and workforce demographics.
- Gwen Stern and Associates, a Chicago-based consulting firm, assisted with the questionnaire design and data analysis.
- SHPS, and its team of healthcare experts, is solely responsible for the contents of this document.

About SHPS

Our Company

SHPS is one of the nation's leading providers of health advocacy and health benefit solutions. We provide a broad range of innovative health management tools, resources and services that empower individuals to make wise healthcare decisions. By providing integrated solutions designed to improve healthcare delivery, SHPS reduces the need for healthcare, and optimizes the health and financial outcomes for employers and employees. SHPS formed as a corporate entity in 1997, but our roots extend back more than 20 years. We are privately owned by New York City-based Welsh, Carson, Anderson and Stowe.

Our Team

SHPS is a high-performance organization with more than 2,000 employees including physicians, registered nurses, benefits specialists and information technology experts.

Our Locations

- Atlanta, GA
- Chico, CA
- Louisville, KY (Headquarters)
- Minneapolis, MN
- Philadelphia, PA
- Raleigh, NC
- San Francisco, CA
- Scottsdale, AZ
- Seattle, WA

Our Clients

- Large-market employers
- Mid-market employers and benefits brokers
- Federal, state and local government employers
- Health plans and third party administrators
- Medicare and Medicaid programs

How to Reach SHPS

To arrange a meeting with an account executive, please call us at 888-421-SHPS (7477). We look forward to sharing our insights from the *2007 SHPS Health Practices Study*.

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