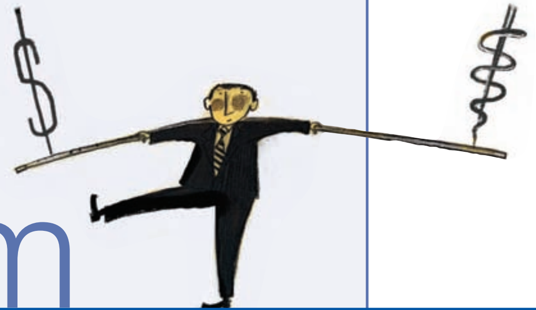
Making Consumerism Work



A Practical Guide for Transforming Healthcare

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Making Consumerism Work
A Practical Guide for Transforming Healthcare

Introduction from Rishabh Mehrotra, SHPS President

It's my pleasure to offer our readers, clients and business partners SHPS' point of view on the biggest trend affecting healthcare today–consumerism. This booklet is designed to help employers, as well as the health community that serves them, recognize the key considerations of a healthcare consumerism strategy and provide a roadmap for its successful implementation.

Healthcare consumerism has taken the narrow, plan-focused approach of consumer-directed healthcare and broadened it into a comprehensive health strategy that combines plan design, care management, wellness, incentives and health advocacy services. Creating the appropriate incentives, empowering employees with information and tools to address their medical status and changing unhealthy behaviors or rewarding healthy ones, is the very core of healthcare consumerism.

Why should employers care about healthcare consumerism? Beyond the opportunity to improve the quality of life for millions of people, there are several practical business reasons:

- Poor health reduces profits, productivity and ultimately the ability to compete in a global market;
- Healthcare costs continue to rise at several times the level of inflation;
- The primary drivers of higher costs are personal behavior, lifestyle choices and lack of information to support cost-effective personal health management;
- America's aging workforce creates additional challenges through increased competition for skilled labor, the cost of retiree health coverage and the need to sustain productivity until retirement; and
- By creating a consumer-centric healthcare delivery system, employers can not only reduce costs but also improve the quality of care.

SHPS is in a unique position to partner with many organizations to help develop and implement an effective healthcare consumerism strategy that will help to significantly reduce their healthcare cost trend. We hope you will not hesitate to contact us with questions or to talk more about the most prevalent healthcare strategy this decade.

Bringing you good health and sound financial results,

Rishabh Mehrotra

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Executive Summary

The total impact of a comprehensive healthcare consumerism program is a reduction of 65 to 75 percent of the prevailing annual increase in healthcare costs.

In SHPS' booklet, "Making Consumerism Work," we provide a practical, in-depth discussion on healthcare consumerism.

Our goal is to help employers, as well as their health advisors and service vendors, develop a deeper, more thorough understanding of consumerism, thereby enabling the successful development of viable solutions for their work environment. The ultimate result of such solutions: better employee health outcomes and lower healthcare costs.

Whether you are a health expert, a benefits administrator, a chief executive officer or a chief financial officer – you're likely very concerned about healthcare costs and have pondered the value of consumer-driven healthcare. And like SHPS, you understand that the health of the American workforce is a matter of competitiveness and economic resilience for organizations, while also a critical personal issue impacting the quality of life for every individual. This booklet provides you a valuable overview of the economic and personal sides of healthcare consumerism – and will help you manage the rapidly evolving market to meet the demands of a dual audience.

In the booklet's introduction, we analyze the American healthcare system as it exists today – a paradoxical system that delivers the best acute care in the world, but consumes 16.2 percent of the nation's gross domestic product. That's twice as much as any other country, yet costs are still rising at unsustainable levels. Preventive care is inconsistent, obesity (and its complications) is rampant nationwide and evidence-based medicine is employed a mere 52 percent of the time. Disability-adjusted life expectancy is substantially lower than most other advanced countries. Employees are angry about increases in healthcare premiums, but have little insight into the true cost of care. Employers watch helplessly as double-digit increases destroy their competitiveness, but don't deploy the use of incentives as a way to manage costs. Provider pricing and quality are completely hidden, and provider bills are often indecipherable. And arguably, overseas price controls on prescriptions are subsidized by Americans who pay full market prices.

The structural flaws in our health system boil down to three fundamental issues: the increasingly poor health status of Americans, unsustainable increases in healthcare costs and the lack of economic incentives within the current healthcare system to manage either.

Consumer-directed healthcare (CDHC) was proposed as a first generation solution to address these structural flaws. By combining high deductible plan design with individual health spending accounts, consumers would have market incentives that could bring about radical transformation. However, early research suggests CDHC outcomes are mixed and unclear. Yet the concept of realigning the provider, payor and employer interests by reframing the employee's

role in the equation makes eminent sense – and as a result – employers are rapidly adopting portions of CDHC.

While SHPS supports the principles of CDHC, we propose adoption of a broader framework– healthcare consumerism. This framework brings together the original financial structure of CDHC, but marries it to comprehensive care management, health advocacy and decision support tools in an integrated system that drives total behavioral change and provides personalized support for consumers.

Empowering employees with information and tools to address their chronic conditions and change unhealthy behaviors, or reward healthy ones, is the very core of healthcare consumerism. The challenge for employers is creating a genuine culture of health that permeates all aspects of behavior. Moreover, healthcare consumerism will not succeed unless it engages the entire workforce. Without the inclusion of chronic and catastrophically ill populations – the small percentage of the workforce that drives the majority of healthcare costs – true savings are not possible.

The total impact of a comprehensive healthcare consumerism program is a reduction of 65 to 75 percent of the prevailing annual increase in healthcare costs. In other words, best practice companies are achieving two or three percent increases in healthcare cost annually, consistent with inflation, compared with 9 percent average cost increases across all employers. When applied to a sample employer with 20,000 employees, this approach results in an annual savings of tens of millions of dollars in healthcare costs and significant market capitalization impact. Furthermore, employers that don't implement consumer-based health strategies will risk exposing themselves to adverse selection, thus becoming targets for people who practice poor health habits.

The strategic framework for developing such a healthcare consumer strategy for your organization is provided in Chapter Three. We examine each tactic needed – including plan design, spending accounts, care management, decision support tools, incentives and care advocacy – and offer insight into when and how to use each of these tools individually and together. Interestingly, consumerism demands a level of program integration that was heretofore unnecessary. All services need to be synchronized and personalized as if they were a single program for the participant, based upon life events and episodes of treatment.

In addition, individual ownership is a cornerstone of healthcare consumerism. When aligned with the appropriate personal accounts such as

flexible spending, health reimbursement and health savings accounts, it can bridge the deductible gap, provide motivational incentives and raise general awareness of healthcare costs. Some companies that have replaced their traditional health insurance with high deductible plans, combined with health savings accounts and/or health reimbursement arrangements, have seen their health costs fall by more than 10 percent, even as the use of preventive services by workers increased by as much as 23 percent.

In Chapter Four, we discuss practical considerations for implementation. How does healthcare consumerism change benefit departments? What plan design works best? How high of a deductible is appropriate? Is one spending account better than another? How many health and wellness programs are needed? Every employer, and their covered population, has unique needs based upon the employer's financial profile and the unique characteristics of the workforce. We use these considerations to show how employers can use similar theories around consumerism to develop radically different tactics – tactics that make sense for their organization. A successful program must take an integrated, strategic approach to consumerism that includes financial motivation, behavioral change, administrative support, consumer advocacy and carrier exchange. In the case of large employers, the selection and use of health networks, which are critical to both cost savings and employee satisfaction, should be evaluated independently and not bundled with integrated program delivery. Finally, we contemplate the future of health networks, which will likely see a dramatic evolution over the next few years.

In Chapter Five, we discuss the specific measurement and financial strategies needed to drive a healthcare consumerism program, and determine total levels of investment. We introduce the concept of integrated health metrics, a single set of numbers that measure actuarially validated financial and health outcomes that tie back directly to corporate financial statements. With integrated metrics, it is possible to assess the impact of the overall program as well as the individual contributions of each program element. This allows for continuous improvement in health and productivity over a period of years. We specifically look at the challenges of return-on-investment calculations and the use of an alternate methodology, net savings, to help determine the appropriate investment in improving workforce health.

SHPS acknowledges there is still significant research needed on healthcare consumerism – and much is still unknown. This booklet serves as the beginning of our inquiry. Embedded in the book are research findings and thoughts of others, intertwined with our own hands-on experience working directly with carrier, consultant and broker business partners, as well as directly with some of the largest and most sophisticated U.S. corporations and state and federal agencies. We are united in our passion for ensuring the achievement of personal health and the transformation of our national healthcare system. SHPS owes our knowledge and insight into healthcare consumerism to our direct and open dialogue with our clients and business partners, and we dedicate this book to their employees, dependents and members for whom we are proud to serve.

Chapter 1: What's Driving Healthcare Consumerism?

Fifty percent of health costs are driven by individual behavior.

The need for healthcare consumerism boils down to three fundamental issues: the increasingly poor health status of Americans, coupled with unsustainable increases in healthcare costs and the lack of a coordinated strategy within the current healthcare system to manage either.

The United States has the best acute healthcare delivery system in the world and spends twice as much per capita as most other industrialized nations, yet ranks 24th in the world for disability adjusted life expectancy according to a study conducted by the World Health Organization. One of the study authors, Christopher Murray, M.D., Ph.D., summarizes this finding by saying, "Basically, you die earlier and spend more time disabled if you're an American rather than a member of most other advanced countries."

From a business perspective, unsustainable rising costs affect a company's ability to be competitive in a global economy. On an employee level, the current healthcare cost trend continues to outpace the rate of wage growth by a wide margin (see figure 2). Furthermore, as employers look to shift more healthcare costs to the employee, the individual's ability to purchase other goods and services is limited. Therefore, the healthcare cost trend is both a business and a personal issue.

The existing healthcare model does not provide incentives for insurers or other players in the supply chain to manage cost or improve health. Providers get paid based on volume, not quality, and there is a focus on high-margin acute treatments. Fifty percent of health costs are driven by behavior (see figure 3), yet individuals have no understanding of price and quality and continue to make unhealthy lifestyle choices. Employers are left footing the bill for actions incurred by the rest of the supply chain but have little or no control on the consumption or price of services rendered.

Fig. 1: American patient care is ranked lower than those of other developed nations.

*Health expenditures per capita figures are adjusted for differences in cost of living. Source: B.K. Frogner and G.F. Anderson, "Multinational Comparison of Health Systems Data", 2005 (New York: The Commonwealth Fund, April 2006).

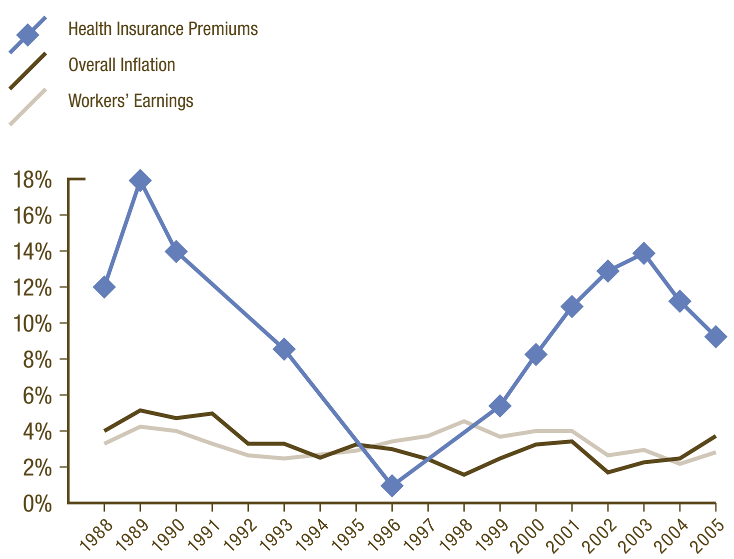
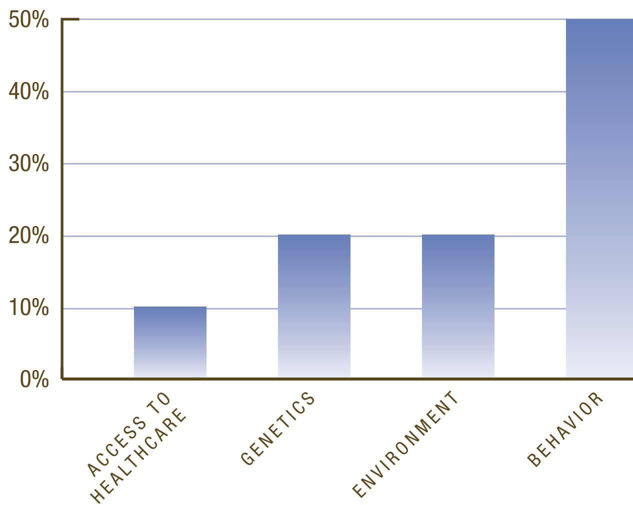


Fig. 2: Healthcare costs continue to outpace worker's earnings.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999 – 2005; KMPG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): (April – April), 1998 – 2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April – April), 1988 – 2005.

Fig. 3: Determinants of Health



Source: IFTF, Centers for Disease Control & Prevention

Healthcare consumerism represents a paradigm shift and a potential solution to the current system's structural flaws that follows the example of at least one recent industry makeover. Similar to how the defined contribution approach transformed the pension industry and therefore how individuals viewed funding retirement, healthcare consumerism promotes personal ownership, information transparency and behavioral change in order to transform the entire healthcare supply chain and empower healthcare consumers.

The Cost of Healthcare

- Dramatic annual increases in healthcare each year (in 2005, healthcare cost trend increased by 9.2 percent)
- By 2009, total corporate healthcare costs will surpass total corporate profits
- The United States spends more for healthcare than any other industrialized nation
- Americans do not have healthy lifestyles:
  - 65.2 percent of adults, 15.8 percent of children and 16.1 percent of teens are overweight (body mass index of 25 or greater)
  - Only 32.8 percent of adults exercise three or more times a week
  - 33 percent of adults have high blood pressure and 50 percent have unhealthy cholesterol levels
  - 21.5 percent of adults smoke cigarettes and 21.1 percent drink alcohol three or more times per week

Source: Centers for Disease Control, American Diabetes Association, National Heart, Lung, and Blood Institute, and American Heart Association.

Chapter 2: What is Healthcare Consumerism?

Healthcare consumerism has taken the narrow, plan-focused approach of consumer-directed healthcare and broadened it into a comprehensive health strategy that combines plan design, care management, wellness, incentives and health advocacy services.

"Consumerism" in the broad context refers to the protection of the rights and interests of individuals, especially with regard to price, quality and safety, so they can trust the products and services they purchase. Healthcare consumerism transforms the health benefit plan by putting economic purchasing power–and decision-making–in the hands of individuals. It supplies the information, decision support tools and financial incentives to encourage personal involvement in altering health and healthcare purchasing behaviors.

How is Healthcare Evolving?

Every decade since the 1940s has seen a transformation in how healthcare has been administered in the United States. In the 40s and 50s it was the expansion of fully-insured employer-sponsored healthcare plans. In the 60s it was the introduction of Medicare and Medicaid. In the 1970s, it was the passage of ERISA and the movement of large employers toward self-insurance; the 80s saw the birth of the HMO and managed care. And in the 90s it was the shift of risk to providers.[1] The evolution of the American healthcare system has created the structural deficiencies that cannot be corrected with a "business as usual" attitude.

Early consumerism efforts, known as consumer-directed healthcare (CDHC), focused on a high deductible health plan (HDHP) as one of many plan options. The premise was that a high deductible health plan, combined with a tax-advantaged spending account, would give employees a sense of awareness and ownership over the dollars they spend on healthcare, as well as the opportunity to save money through thoughtful decision making. Early plans, featuring a health reimbursement arrangement (HRA) or health savings account (HSA) showed initial promise of saving money–quickly eliminating egregious waste, such as an unnecessary trip to the emergency room, or the use of brand name drugs when suitable generic drugs were available.

However, the ability of CDHC to fully address the structural flaws inherent in the healthcare system is limited. While SHPS supports the principles of CDHC, we propose a broader framework–healthcare consumerism. Healthcare consumerism is much more than just plan design. Figure 4 summarizes how consumerism has evolved.

From a structural point-of-view, healthcare consumerism involves a combination of administrative, financial and clinical tools to help individuals purchase healthcare more wisely, improve their health and ultimately reduce healthcare expenditures. It appropriately aligns your health strategy across the entire supply chain to:

- Give employees a financial stake in their healthcare;
- Provide employees with incentives, information and tools to better manage and purchase healthcare;
- Encourage providers to deliver better health outcomes;
- Enable payors to create networks based on employee needs;
- Deliver clear and visible measurements around healthcare price and quality;
- Simplify and automate benefits administration; and
- Provide actuarially validated analysis on the economic impact of early identification of risk factors and clinical interventions.

[1]Ron Bachman, "Consumer-Driven Health Care: The Future is Now," *Benefits Quarterly* (2004): 15.

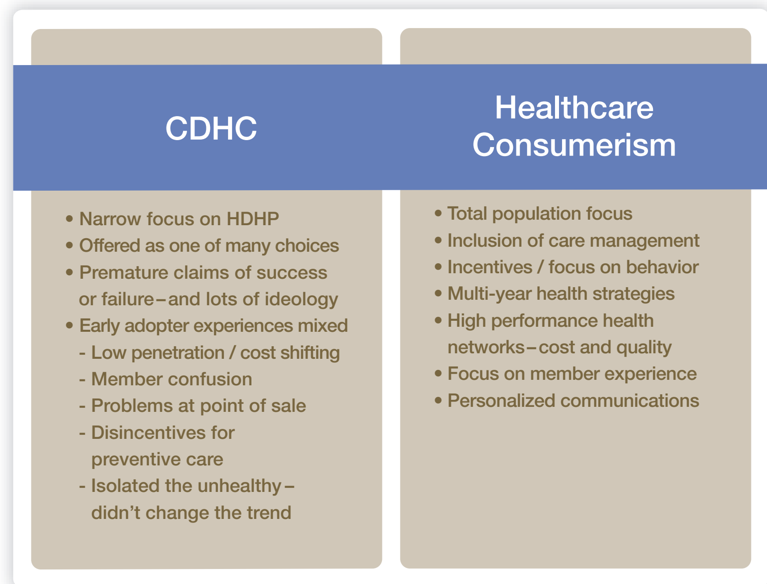


Fig. 4: The Evolution of Consumerism

Economic Impediments Built into the Current Healthcare System

Theory of Moral Hazard

- The term "moral hazard" refers to the lack of incentive an individual feels toward mitigating risk on the basis of having insurance. With regard to health insurance, it means that if you believe major expenses are covered, you have less incentive to obtain preventive care or to practice good health habits.
  If you are a payor, you have the ability to simply pass on rising health costs by increasing premiums.

Theory of Information Asymmetry

- Information asymmetry occurs when one party to a transaction has more or better information than the other party. In healthcare, providers and their networks keep their fee schedules and discounts confidential and they do not generally publish their quality ratings.

How Healthcare Consumerism Addresses These Impediments

- Healthcare consumerism mitigates moral hazard by placing more financial responsibility on the individual and providing incentives for obtaining preventive services and practicing healthy behaviors.
  Information asymmetry is negated by offering a broad range of decision support tools and increasing the visibility of provider cost and quality metrics.

Why is this important to the employer?

Given the impact of the current healthcare trend on your profitability, competitiveness and the ability to address retiree health challenges in a global market, healthcare consumerism may be your first, best defense. Even if the government were to play a larger role in funding healthcare, fundamental market mechanisms are needed to reform the current system. Shifting the burden of payment to employees or the government alone will not change the underlying market dynamics.

Furthermore, employers who continue to offer traditional health plans in lieu of adopting a consumer-based strategy may inadvertently become the "employer of choice" for individuals seeking low deductibles and co-payments with no financial penalty for poor health habits and spending decisions. A consumer-based program can achieve cost savings and reduce healthcare cost trends from double digits to gain parity with inflation. (Consider the example found on page 14.)

A review of SHPS' clients shows that best-in-class companies are experiencing a three to five percent point reduction in their healthcare cost trend, while those not implementing consumerism concepts are experiencing increases well in excess of the average healthcare cost trend for 2005.

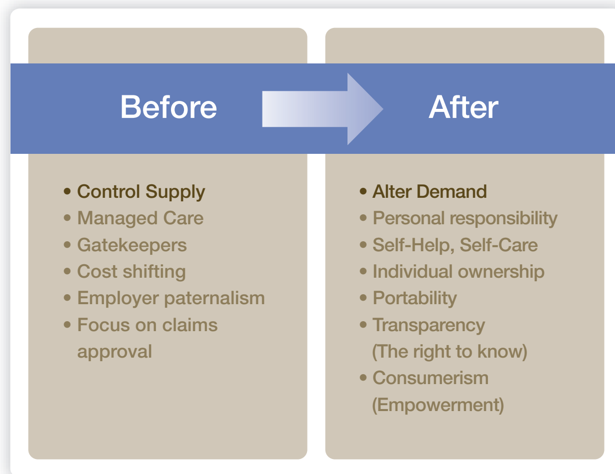


Fig. 5: The trend toward healthcare consumerism and the impact it has on healthcare delivery is linked closely to mega-trends moving across society.

Every employer's circumstance is different and not all employers will have the opportunity to develop comprehensive programs. But employers should recognize that they can accomplish many of the goals of consumerism even if their ability to offer care management or a high deductible health plan is limited. There are a range of options for creating the financial, administrative and clinical services necessary to drive behavioral change. In the following chapter, we provide a strategic framework for developing a healthcare consumerism strategy appropriate for your organization.

Example of Healthcare Costs:

A large auto parts manufacturer with 20,000 employees and an average annual premium cost of $10,800* per employee, spent a total of $216 million in 2005. Over a ten-year period, the company's 10 percent trend will increase its healthcare costs to more than $560 million annually. If that same company could manage its costs to achieve a three percent trend, its healthcare costs will be $290 million in year ten, which is a difference of $270 million.

*Average annual premium cost for a family of four in 2005

Myths & Truths About Healthcare Consumerism

Myth: Healthcare consumerism means buying healthcare will eventually be like buying a car.
Truth: Healthcare is profoundly personal and emotional – decisions are not always black or white, nor are choices in care.

Myth: One size fits all.
Truth: Each consumerism program must be designed to work for all individuals in your organization to be truly effective.

Myth: Consumerism is achieved by simply offering a high deductible health plan.
Truth: Consumerism is achieved through a commitment to changing unhealthy behaviors by individuals, supported with a full spectrum of programs.

Myth: A consumerism program can be built and executed quickly.
Truth: Consumerism requires a multi-year strategy and fundamental rethinking of how you deliver healthcare to your employees.

Myth: Consumerism only works in certain employee populations.
Truth: Consumerism can work in any population – employers must understand their workforce demographics and target market consumerism to their employees.

Myth: Consumers should have unlimited choices.
Truth: Choice creates complexity as well opportunity. Employers need to identify the choices that maximize program effectiveness and employee satisfaction.

Chapter 3: SHPS' Framework for Consumerism

Healthcare consumerism is about creating better healthcare consumers. However, healthcare is not consumed like cars or groceries. On the contrary, health is personal, interactive, urgent, dynamic and often consumed in times of personal crisis.

Healthcare consumerism is evolving beyond simple plan design. A successful program must take an integrated, strategic approach to consumerism that includes financial motivation, behavioral change, administrative support, consumer advocacy and carrier exchange. However, developing a program that effectively addresses these elements requires a solid framework of practical solutions.

To make healthcare consumerism work, SHPS believes a comprehensive program must:

- Address your entire workforce, regardless of income or health status;
- Develop a sense of personal responsibility for health benefits consumption and cost;
- Rapidly identify individual health risks with laboratory testing and real-time pharmacy data;
- Encourage your chronically ill employees to comply with evidence-based medicine;
- Promote healthy habits to prevent future health issues;
- Include benefits information, decision-support tools and incentives to drive desired plan selections and health behaviors;
- Make provider price and quality information readily available to the employee;
- Be integrated – everything that touches employees should tie into your overall health strategy;
- Tie the contribution of each program element to bottom-line financial and health outcomes using performance metrics;
- Treat the healthcare supply chain as a business, maximizing competitive forces through aggressive management; and
- Select pay-for-performance and specialty provider networks, monitor their performance and replace poor performers.

Element	Solution	Behavior Impact	Estimated Cost Impact
Health Plan Design & Individual Ownership	Spending Accounts (FSA, HRA, HSA)	Creates a sense of personal responsibility by increasing awareness of the cost of health services, encouraging well-informed spending decisions and mitigates the risk of "morale hazard"	10–15% decrease in average healthcare cost trend
Personal Health	Disease Management, Case Management, Utilization Management, Wellness Programs, Incentives and Communications	Promotes greater participation in wellness programs and compliance with evidence-based medicine guidelines resulting in improved health status and appropriate use of health benefits, which ultimately reduces healthcare costs	30% decrease in average healthcare cost trend
Transparency of Information	Health Portal, Decision Support Tools	Delivers meaningful price and quality information to support well-informed decisions regarding personal health and provides a feedback loop to monitor spending account balances, incentives and progress in health and wellness programs	5–10% decrease in average healthcare cost trend
Consumer Advocacy	Web and Telephonic Support Centers (Clinical, Administration and Financial)	Enables employees and their families to navigate the healthcare system and gives personal assistance needed to select providers, evaluate treatments / medications and understand their medical bills	10% decrease in average healthcare cost trend
Benefits Administration	Eligibility & Enrollment, COBRA/HIPAA, Individual Billing, Carrier Exchange, Program Reporting	Manages the employee life cycle from enrollment to retirement / termination and provides employers cost control through effective data management and program metrics	10% decrease in average healthcare cost trend

Fig. 6: This chart summarizes SHPS' framework for consumerism.

The total impact of a consumerism program is a reduction of 65 to 75 percent of the annual increase, which means a decrease in the annual trend of 6.5 to 7.5 percent. This ultimately results in a new healthcare cost trend of 2.5 to 3.5 percent. When applied to our previous example of an employer with 20,000 employees, this results in an annual savings of $14 to $16.2 million in healthcare costs in the first year. The compounded impact of these cost savings over ten years is $270 million and the market-cap implications are significant.

The rest of this chapter will provide an overview of key elements for healthcare consumerism, and how these drivers contribute toward achieving a culture of health and consumerism in your organization.

Individual Ownership: The Role of Health Plan Design and Spending Accounts

A critical concept of healthcare consumerism, as opposed to managed care, is that employees should have a financial stake in the cost of healthcare and have the financial incentives and information necessary to make rational purchasing decisions. Traditional preferred provider health plan designs tried to achieve these incentives through nominal co-pays, personal deductibles, co-insurance, and in/out network coverage. In practice, however, these incentives were insufficient.

Under consumerism, the employee recieves similar health coverage through a preferred provider organization (PPO model), but small personal deductibles are raised from a few hundred dollars to $1,000 to $5,000, or even more. The employee essentially becomes responsible for first dollar coverage – that is, all health costs below the deductible – and gets full visibility into those costs until the deductible is exhausted. After a certain point the requirement for co-insurance is met, and healthcare costs are covered at 100 percent.

Most employees lack the free cash flow to pay for the first few thousands of dollars of health expense without assistance. To help the employee self-insure for first dollar coverage, some of the money saved by offering a high deductible plan is placed into a spending account – a pool of money set aside for the employee. The money is there if the employee needs it for healthcare. However, if the employee doesn't need the money, or finds ways to obtain less costly healthcare, the money that remains in the account accrues year-over-year, giving the employee the opportunity to save against the possibility of future healthcare spending. This practice is widely known as consumer-directed healthcare (CDHC). Presumably, the market incentives created by a CDHC plan lead employees to behave more like consumers – evaluating price, quality and value – and eliminates non-economic purchasing behaviors. This heightened awareness leads to greater focus on personal health and rational purchasing behavior, which in turn, drives more competitive provider offerings – or so the theory goes. In practice, there are limitations to the effectiveness of a CDHC plan design as a stand-alone tool.

Figure 7 shows two typical consumer-centric plan designs based upon the use of one of two types of spending accounts – a health savings account (HSA) or health reimbursement arrangement (HRA) – whose mechanisms we will explore in detail further on. What is interesting to note, however, is that while the mechanisms for first-dollar coverage are set up differently, the underlying catastrophic coverage is similiar. We see this as an important principle of simplification. While plan designs may vary, it is our belief that under consumerism, catastrophic coverage can and should become increasingly standardized and commoditized. Above a certain level of cost, coverage and services should be universally set. In addition, basic preventive care is typically also reimbursed at 100 percent. This feature is important to counteract the potential tendency of some employees to save money by not seeking out needed preventive care for themselves or a loved one, leading to the need for more expensive acute care later on.

With preventive and catastrophic coverage essentially standardized, the critical design parameters for a consumer-based plan are entirely built around the economic architecture of first-dollar coverage. These parameters include:

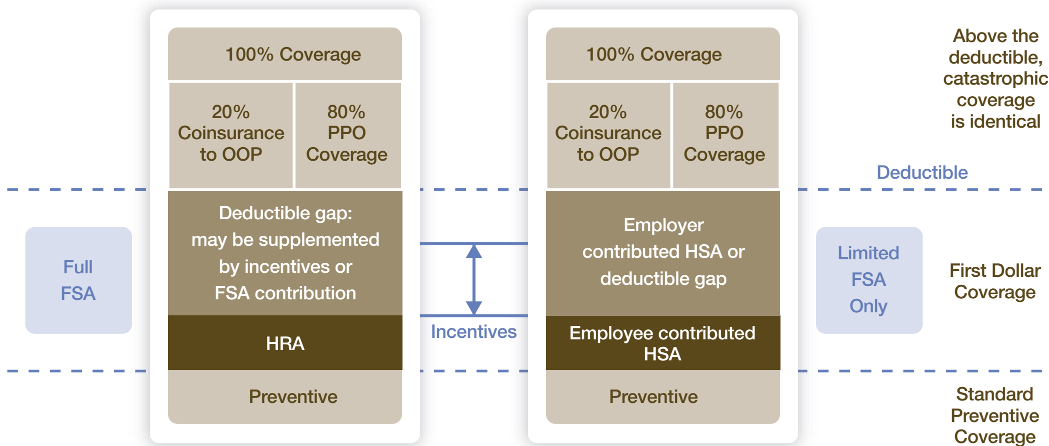
- The size of the deductible;
- The type of spending account (HRA or HSA), and the mechanisms for funding the spending account;
- The rules around how the spending account may be used, how unused funds accumulate, and who controls funds at termination;
- The types of financial incentives available;
- The specific behaviors/outcomes to be measured and tied to incentives;
- Coordination with other coverages, including a standard flexible spending account (FSA), which forfeits at year end;
- Monthly premiums; and
- The decision to offer the plan as an option among several plans (partial replacement), or as the only option for coverage (full replacement).

How do you choose among these parameters?

We will provide more details in Chapter Four. Suffice it to say that individual responses to the same plan incentives will vary highly – what motivates a six figure executive and a non-exempt employee may differ.

In general, however, most individuals, if given a choice between a standard low deductible plan and an actuarially-equivalent CDHC plan, will pick the low deductible, even if it means forfeiting the opportunity to accumulate plan savings year-over-year. This is a critical insight when considering how to design and implement a high deductible plan. Most employees do not use economic logic when making decisions regarding healthcare coverage. In a given plan year, it is not uncommon for 70 percent or more of an employee population to not access healthcare, yet the same employees will routinely over-insure themselves by purchasing the most expensive plan options, with the lowest deductibles and co-insurance.

Fig. 7: The critical design parameters for a consumer-based plan are entirely built around the economic architecture of first dollar coverage.



As the spouse of a well-paid executive explained it:

> "If I need to take myself, or my children, to the doctor for any reason, the last thing I want to think about is money."

In situations where employers have chosen to offer a CDHC plan alongside traditional plans, we recommend a substantial premium reduction, on the order of 20 to 40 percent or more, and/or significant employer contributions to a spending account to overcome the natural bias against a CDHC plan. Within SHPS clients, we have seen adoption rates that have varied from as few as 84 employees (out of a pool of more than 200,000 eligible), to as much as 60 percent of the population. The difference: education, premium discounts, and employer-funded accounts that were easier for low-income people to work with. In addition, where partial replacement has been used, the preponderance of chronically ill employees have chosen not to sign up for the CDHC plan, creating adverse selection against the traditional plan.

So which employees are positively and negatively impacted by a CDHC plan? The employees who benefit the most are those who are healthy, and need preventive care only. Employees who have a catastrophic event, or those with high cost therapies for chronic conditions, will pay more than under a traditional plan, but have access to treatment. Executives, who are notorious among actuaries for high consumption of preventive diagnostics and treatment, as well as at risk and mildly chronic individuals who rarely exceed their deductible, will also feel the financial impact.

Spending Accounts

When properly designed, a spending account can alleviate the negative financial impact associated with a high deductible plan without eliminating the behavioral incentives. When aligned with a comprehensive health strategy, they create a sense of individual ownership, which results in increased personal responsibility for healthcare. Studies have shown that people who use healthcare spending accounts pay more attention to what items cost, are more aware of what they consume and their out-of-pocket costs, and are overall better consumers of healthcare. Some companies that have replaced their traditional health insurance with HRAs have seen their health costs fall by more than 10 percent, even as the use of preventive services by workers increased by as much as 23 percent.[2]

There are essentially two types of spending accounts that are used in conjunction with a high deductible health plan – the HRA and the HSA. These accounts permit money to be set aside tax-free for healthcare purposes. Though seemingly similar, each of these accounts has distinctly different properties that we will explore further. However, their primary purpose is to provide employees with the ability to self-insure for healthcare expenditures that do not meet the plan deductible.

In 2002, the viability of a new consumer-directed healthcare model was ensured when the Internal Revenue Service (IRS) issued guidelines approving the right of HRA owners to carry-over amounts from year-to-year.[3] HRAs have been called "the most flexible account ever created." Administered by an employer or a plan service provider, HRAs:

- Can be designed to work with FSAs or HSAs;
- Are notional accounts, which means employers are not out-of-pocket until a healthcare expense is charged to the account;
- Are subject to substantiation of claims, similar to an FSA;
- Can be applied to any healthcare plan, not just high deductible plans, or no plan at all; and
- Can be a vehicle to encourage participation in various health and wellness programs.

The HRA gives the employee a pool of discretionary money for healthcare, but provides controls, in the form of claims review, that ensure the money is only used for healthcare.

[2] Aetna. "Aetna HealthFund® First-Year Results Validate Positive Impact of Health Care Consumerism." June 22, 2004.

[3] Ron Bachman, "Consumer-Driven Health Care: The Future is Now," *Benefits Quarterly* (2004): 18

Early Evidence Shows Spending Accounts to be Effective

A recent study of participants in a consumer-driven healthcare (CDHC) plan combined with either a health reimbursement arrangement (HRA) or a health savings account (HSA) found:

CDHC consumers were more value conscious: They were 50 percent more likely to ask about costs and three times more likely to have chosen a less extensive, less expensive treatment option. They also were much more likely to visit an urgent care center than a hospital emergency room.

Consumers were more attentive to wellness and prevention: They were 25 percent more likely to engage in healthy behaviors and 30 percent more likely to get an annual physical. Why? 51 percent of CDHC consumers agreed "If I catch an issue early, I will save money in the long run."

Consumers are more attentive to cost control and to behavior changes that could result in better health outcomes and cost savings over the long term. CDHC consumers were more likely to perform independent research to identify treatment options, for example, even when insurance was paying, and they were 20 percent more likely to comply with treatment regimens for chronic conditions.

Source: McKinsey & Company. "Consumer-Directed Health Plan Report – Early Evidence is Promising." June 2005.

In addition, the employer has the ability to set up a wide range of rules around how the HRA works within their plan environment. For example, an HRA can be set up to cover a broad range of healthcare expenditures, or it can be limited to cover a narrow subset of medical services and pharmacy benefits. Accruals, rollovers and fund ceilings can be defined. The account can be set up to receive notional interest, or notional investments. The account can be set up to forfeit at termination, to pay for COBRA or to accumulate as a retirement health benefit. At SHPS, we have set up HRAs for retiree medical plans, pharmacy-only benefits and a wide range of different applications. There are a couple things an HRA cannot do: employees cannot make contributions and funds cannot be used for any purpose outside of healthcare. There are no limits on how an employer designs a health plan to work alongside an HRA. The strength of the HRA is the level of flexibility and control that an employer can exercise. The exact same trait, however, makes them less desirable to an employee.

HSAs, on the other hand, have been dubbed "the most tax-advantaged account ever created." Essentially, employee and employer contributions placed in an HSA are shielded from FICA and income taxes forever, as are all investment earnings, provided the funds are used for healthcare or other approved uses like long-term care insurance.

However, the employee must be enrolled in a high deductible health plan under very rigid guidelines established by legislation. These rules specify minimum deductibles, contribution limits, definitions of preventive coverage, and do not permit the coordination with any other health plan or with a traditional FSA. Rules around the use of incentives are fairly strict, and funds are available only to the limit of actual contribution.

Health Reimbursement Arrangement	Health Savings Account
• Employer control – eligible expenses can be limited and must be substantiated • Option to fully fund at beginning of plan year, however funds don't have to be contributed until expense is incurred • Can work in conjunction with health plan or no plan at all • Coordinates with a standard FSA and has the flexibility to determine which account pays first • Can be funded with incentives – payments for participation in health and wellness programs • Balances can accumulate to build a retirement health savings plan • Employees forfeit unused funds upon termination or at employer's discretion, may be used for COBRA payments	• Employee control – determines how much to contribute, how to invest and how to spend • Employee owns the account for life – no forfeiture of funds • Tax-free contributions, investment earnings and spending when used for healthcare services – very appealing to employees • Rigid definition of preventive care and plan structure specified by legislation (can only be used in conjunction with high deductible health plans) • Competes with 401(k) for retirement savings • Substantiation is not permitted, which limits employer control, making employer-funded plans unattractive • Not well-suited as mechanism for providing incentives and paying for preventive care

Fig. 8: Comparison between an HRA and an HSA.

From an employer's point of view, the most significant features of the HSA are:

- Employer contributions involve a true transfer of ownership of funds to the employee. The employee immediately has control over those funds; and
- According to IRS guidelines, employer substantiation of HSA funds is not permitted. Employees are free to withdraw funds for any purpose, though if it is not for medical reasons they are required to report the withdrawals on their yearly federal tax returns and pay income tax and a 10 percent penalty.

However, employers may not trust their particular workforce to spend their money wisely without some kind of substantiation. As a result, many employers have chosen not to use the HSA or, if they do offer it, choose not to make contributions. As a result, the HSA is much less common with large employers than HRAs.

On the other hand, the HSA, with its significant tax advantages, is very attractive to executives and high-income professionals, as well as the self-employed, the young and healthy. Figure 8 provides a brief comparison of each spending account.

An additional consideration is the positioning of the FSA. In conjunction with a high deductible health plan, the FSA provides employees with an additional opportunity to put money aside pre-tax for healthcare, providing it is used in the current plan year. This may be helpful to an employee who anticipates that their health spending will exceed the limit of money in an HRA or HSA, but prior to reaching the deductible. In the case of the HRA, some plan designs allow the FSA to be consumed first, permitting a rollover accumulation of the HRA. In the case of the HSA, the FSA must be a special type – the limited FSA – that cannot provide redundant coverage to the HSA.

Historically, employers have treated FSAs as an ancillary benefit of little strategic value. They were regarded as a cost-neutral benefit that had little, if any, impact on the healthcare bottom line. And despite the tax advantages, large numbers of employees don't avail themselves to using an FSA, primarily because employees:

- Don't understand how FSAs work;
- Fear leaving money on the table (use-it-or-lose-it);
- Cannot manage the cash flow impact; and
- Are unable, or unwilling, to accurately estimate uncovered healthcare expenses in a calendar year.

Several recent developments have eased some of these barriers. They include the introduction of debit cards, which simplifies usage and eases cash flow concerns; the government's two and a half month grace period, which gives participants 75 additional days beyond the plan year to incur eligible health expenses; and the eligibility for reimbursement of over-the-counter medicines not covered under a standard insurance plan.

HSAs, HRAs and FSAs, when combined to the extent allowable by law and strategically integrated into your program design, can become a key component of your overall healthcare consumerism strategy and create a mechanism that helps incent individuals to make better healthcare choices. Employees can take the money they save from paying lower premiums associated with a high deductible health plan and put those savings into an FSA and the FSA will help pay for healthcare services below the deductible. Twenty-nine percent of employers now offer a high-deductible plan with a reimbursement arrangement, and 33 percent plan to add one for 2007.[4]

Your health spending accounts need to be designed to support the goals of your overall health strategy with the following in mind:

- Its behavioral impact;
- The cost to administer;
- Fit with traditional plan coverage; and
- Employee acceptance and satisfaction.

Which spending account(s) you implement and how you combine them with the other elements of your program is dependent on your workforce demographics and your workforce's comfort level with the consumerism concept. Small employers, the self-employed and employers with large professional workforces, like law firms, investment banks and engineering firms, tend to favor HSAs. Many large employers are hesitant to offer funded HSAs to their hourly workforce, since the money can be used for non-healthcare purposes. Instead, they favor the HRA for its

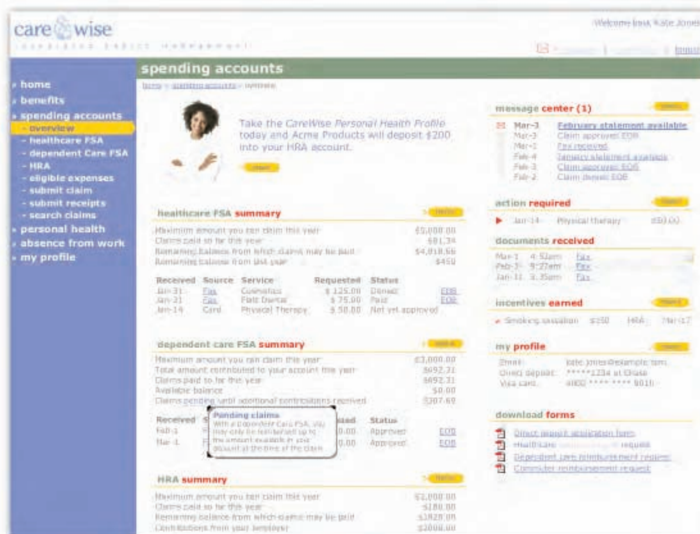


Fig. 9: A health portal can provide employees information to monitor spending account balances, and can be a feedback mechanism to monitor spending account activity, incentives and progress in health and wellness programs.

flexibility and control. A $500 contribution to an HRA is actuarially equivalent to a $400 contribution to an HSA – a 20 percent difference. The HRAs downside is that the restrictions may give employees less of a sense of financial responsibility. How to design your spending account strategy is discussed in further detail in Chapter Four.

Finally, spending accounts should be included as part of the employee's integrated experience with your entire benefit program (see figure 9). Using a web-based portal provides an important feedback loop that allows employees to track, measure and truly understand:

- Funds contributed by their employer or themselves;
- Tax savings (if self-contributing);
- Incentives earned through employer-sponsored programs; and
- Personal healthcare expenses.

[4] 11th Annual National Business Group on Health/Watson Wyatt Survey Report 2006

Personal Health: How Do You Tell Your Workforce They're Unhealthy?

Reduction in the rising healthcare trend is not possible without better management of chronic conditions. The nation's population is obese. There is an epidemic of diabetes on the horizon, and clinical data proves that diabetes is linked to kidney disease, heart disease and other associated conditions. Empowering employees with information and tools to address their chronic conditions, providing the necessary coaching and clinical support, motivating change in their unhealthy behaviors, and rewarding healthy ones, is the very core of healthcare consumerism. The challenge for employers is creating a genuine culture of health within their organization that permeates all aspects of behavior.

Care management programs help you create a culture of health with:

- Health screenings and health risk assessments to determine behavioral and clinical risks;
- Health and wellness programs such as smoking cessation, weight loss management, nutrition and exercise programs to manage modifiable risks;
- Condition management programs that include disease and case management;
- Nurse advocacy services to navigate the complex healthcare system and provide expert decision support; and
- Frequent, personally-relevant communications around health conditions and healthy behavior, tailored to an individual's current health status and readiness to change.

For care management to have both immediate and long-term impact on health behaviors, it must utilize a comprehensive set of interventions working together in close coordination. The following page explains the essential competencies required to deliver integrated care management programs.

Components of an Integrated Care Management Model

Data Integration

Holistic, person-centric view of information

- Aggregation, standardization and integration of diverse data sets such as eligibility and enrollment data, medical and pharmaceutical claims, laboratory results, health risk assessment results, program participation history, and medication to derive a personal record
- Integrated quality processes to acquire data, standardize and validate data, manage quality thresholds and manage close-looped reconciliation processes to ensure high degree of data integrity
- Ability to securely share a holistic view of a participant with multiple members of the care team to foster seamless coordination of interventions

Identification & Stratification

Predictive modeling & risk management metrics

- Rules founded on evidence-based medicine to profile retrospective and prospective health risk using data from the personal health record
- Sophisticated predictive modeling tools to generate clinical risk scores
- Ability to generate “total health risk” as a function of individual risk scores at a point in time and pattern of risk migration over periods of time
- Stratification based on risk scores with defined interventions based on exceptions to care
- Rules-based lead generation system to route a participant’s case for appropriate interventions

Enrollment

Targeted recruitment to increase participation

- Sophisticated recruitment campaigns combine highly trained enrollment specialists and state-of-the-art integrated call center technology with direct mail techniques
- Calibrated psycho-demographic market segmentation and messaging
- Prioritized enrollment using stratified scoring
- Dynamic rules to adapt recruitment to appropriate programs based on member’s readiness to participate

Engagement

Interventions to improve health of all employees

- Standardized assessment tools based on clinical guidelines to rapidly determine health status/issues and highlight opportunities for care plan
- Data and criteria-driven calls, interventions and participant goal setting
- Individualized care plans to address personal priorities, readiness to change and gaps in care
- Clinical and educational interventions address risky behavior and drive positive outcomes
- Scheduled monitoring of participants to ensure ongoing maintenance of health status and re-enrollment into program upon regression of risk

Reporting, Analytics & Forecasting

Actuarially validated, statistically significant results

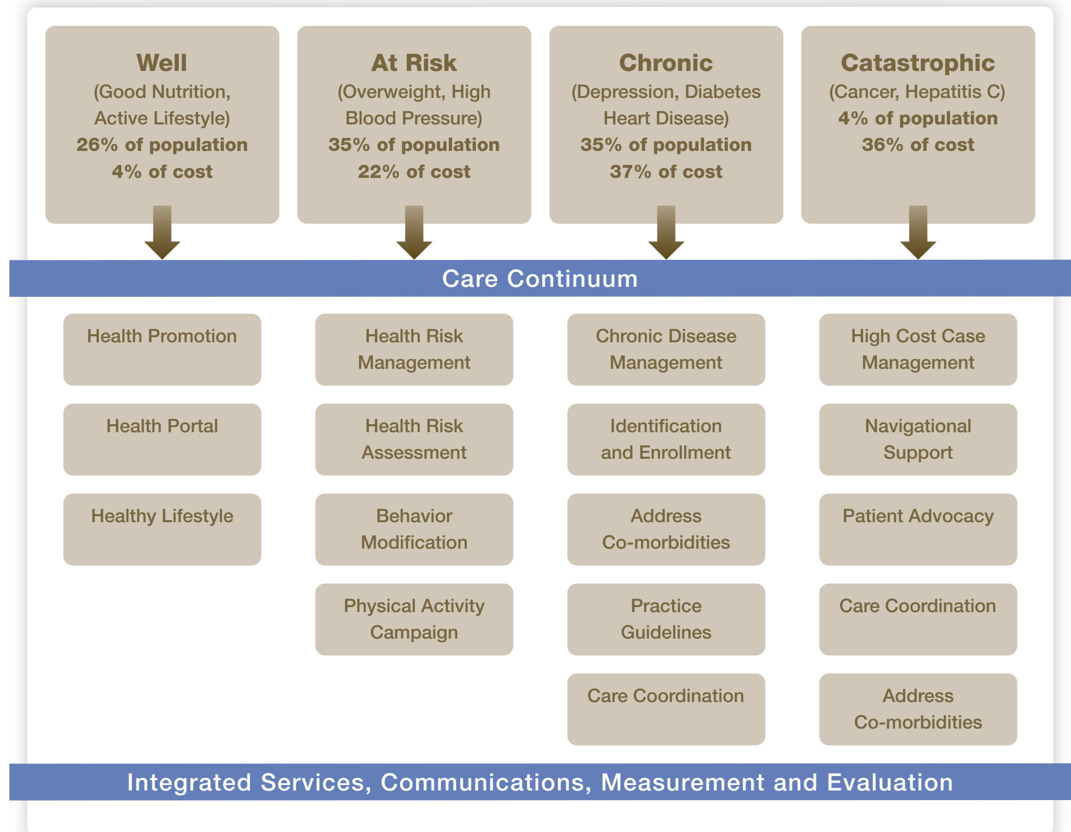
- Analytics based on actionable information on the care continuum, lifestyle risk and clinical intervention and future health utilization
- Comprehensive reports, including an executive dashboard focus on operational metrics, humanistic results, delivery of evidence-based medicine and net savings
- Actuarial validation of historical performance and actuarial forecasts of healthcare cost trend reduction

Communications

Messages that drive behavior change

- Comprehensive set of participant communications materials which encourage desired behaviors
- Scientific behavioral techniques used to drive enrollment and active participation with clinical care plan
- Consistent participant experience across all interventions
- Ability to customize program branding to be consistent with employer’s overall health strategy

Fig. 10: The goal of care management is to keep individuals on the well and at-risk side of the care continuum.



For healthcare consumerism to be effective, it must address your entire workforce, regardless of health status. The goal of care management is to keep individuals on the "well" and "at-risk" side of the care continuum (see figure 10) and to improve health and reduce spending for those who are chronic or catastrophic.

The overall outcome of care management is a happy, healthy, and more productive employee. Nurse lines provide employees the ability to call in 24/7 and ask healthcare professionals questions about specific health issues. Nearly two-thirds of all employers will offer disease management benefits by the end of 2006 to help them effect behavioral change within their chronically ill population.[5] Disease and case management programs coach individuals to manage their chronic or acute condition in tandem with their doctor in a way that decreases missed work days, prevents further complications of their condition, provides standard of care treatment and ultimately decreases the organization's total medical spending. The result is a more productive employee spending less time at the doctor or at home sick.

Additionally, an increasing number of health and wellness programs are being introduced by employers and blended with condition management programs. A health and wellness program will typically include the following components:

[5] Forrester Research; "2005 Benefits Strategy and Technology Study", December 2005

- Weight management
- Blood pressure
- Cholesterol
- Stress reduction
- Nutrition
- Exercise

In the future, employers will need to focus on rapid identification and treatment of chronic conditions. Laboratory data is the only conclusive way to quickly and accurately identify chronic conditions since many people may not even be aware of the presence of a condition. For example, an estimated 14.6 million Americans have been diagnosed with diabetes. Unfortunately, the American Diabetes Association estimates an additional 6.2 million people (or nearly one-third) are unaware that they have the disease.

Laboratory results data also permits a framework for providing incentives based upon health improvements. Similarly, pharmacy benefit manager (PBM) data can provide almost real-time notice of the presence of a condition. In addition, PBM data provides evidence of medication compliance, which is not possible with utilization data and medical claims from health providers. We recommend to most employers that they incorporate diagnostic testing and financial incentives into their overall health program so that laboratory data is readily available.

A review of SHPS' clients shows companies utilizing an integrated care management program typically achieve the following results:

- Return-on-investment ratio of 2.5 to 1;
- 25 percent increase in employee compliance with evidence-based medicine guidelines;
- 55 percent participation consent rate for chronic and at-risk members; and
- Employee satisfaction rating greater than 90 percent for care management programs.

Encouraging behavior change through personally-relevant communications

Informing employees about change may be fairly easy, but getting them to embrace it and adopt new behavior is much more difficult. Behavior modification is crucial to the success of any consumerism program. Employees are being asked to change habits that some have held onto their entire life. It's much easier to recognize healthy habits than to actually implement them into your daily life. That's where behavior modification strategies come into play. They encourage and motivate people to enroll in programs and sustain lifestyle improvements.

Best Practices:

It is SHPS' experience that health and wellness programs perform best when the following concepts are exhibited:

- Real-time laboratory results data is synchronized with self-reported behaviors;
- There is integrated identification, with interventions ranging from low touch to high touch, to meet the needs of diverse workforce populations;
- There is an integrated, behavioral point-of-view around how health is prioritized and communicated in the company;
- The program has incentives for enrolling in health programs and reaching clinical goals;
- The program communications overcome any cultural bias within the organization relative to the different workforce populations;
- The health and wellness program is aligned with other activities in the organization; and
- Executive support for health and wellness exists.

SHPS suggest employers utilize three distinct techniques of psychology to drive behavioral change. These are:

- Motivational Interviewing – a gestalt technique favored by family health practitioners and nurse/coaches to help individuals change personal thought patterns to influence behavior;
- Social Psychology – our experience suggests that many of the strongest motivators for change are in fact social and extrinsic, rather than personal and intrinsic (see "Principles of Influence");
- Stages of Change – a model that helps to build awareness, reinforcement and commitment for personal behavioral change based on an individual's readiness to change those behaviors.

By incorporating these techniques into all communication and change management efforts, one can begin to change employee behavior by appealing to deep-rooted, psychological motivators. Consumer marketers have been doing this for years. In the healthcare arena, pharmaceutical companies have mastered this approach by showing healthy people who also suffer from a certain medical condition and encouraging employees to ask their physician about a certain drug.

Even when people realize that change is needed, lifestyle improvements come in stages rather than one major life change. Changes in behavior are often temporary, lasting minutes or days. Activating long-term behavioral change requires a step-by-step approach. People move gradually from being uninterested in change, to considering change, and finally to committing to and making changes. Sometimes the change is successful, other times it fails to take hold. Effective employee communications reinforces the reasons for making behavioral change in the first place and lays out a plan of action. It provides personalized support for an employee based on their readiness to change and offers tools, information and resources to move them to the next stage.

Principles of Influence:

Dr. Robert Cialdini, professor of psychology at Arizona State University, developed the principles of influence theory based on social psychology and anthropology. He lays out the following six principles:

Authority – we intrinsically trust those in authority; therefore referencing specific sources of recommendations and statistics is important.

Liking – pointing out similarities, giving compliments and praise and offering cooperation is important when asking someone to make difficult, yet important, lifestyle changes.

Consensus – this is the "everybody else is doing it" principle; people naturally follow what others like them are doing; if many people have done it, they must be doing something right.

Consistency – start small and build; this is an important way of achieving positive lifestyle changes. Draconian measures often don't work.

Reciprocity – when someone offers us something, we feel the need to repay in kind.

Scarcity – exclusivity of information or rivalry for scarce items. When demand is higher than availability, people are more likely to act quickly.

Source: Robert B. Cialdini, *Influence Science and Practice*, 2001

As one might expect, health information tailored to meet individuals' unique needs is more effective at promoting risk-reducing behavior changes than generic information. To explore mechanisms underlying tailoring's effectiveness, a study randomly assigned 198 overweight adults to receive weight-loss materials that were (a) tailored to the individual, (b) in an American Heart Association (AHA) brochure, or (c) AHA-content formatted to look like tailored materials.[6] Participants who received tailored materials had more positive thoughts about the materials, positive personal connections to the materials, positive self-assessment thoughts and positive thoughts indicating behavioral intention than those who received either of the untailored materials. The tailoring of health information can significantly improve the chances the information will be thoughtfully considered and can stimulate pre-behavioral changes such as self-assessment and intention.[6]

Incentives

Incorporated with these services is another piece critical to the success of your consumerism strategy. Incentives should be designed to engage employees in appropriate behavior modification programs and should be tightly linked to desired behaviors such as completion of a wellness program, enrolling in a disease management program or achieving a specific health goal. There are several ways to promote incentives (see figure 11) and tie them into your consumerism strategy:

- Contribution to a spending account;
- Provide program "points" (toward merchandise rewards);
- Discount insurance premiums; and
- Offer free generic drugs.

We believe that the most effective approach is to implement incentives as a contribution to a spending account. Specifically, the use of an HRA for incentives provides both a positive and a negative reinforcement mechanism (i.e., employee earns extra healthcare money or employee loses extra healthcare money). Additionally, evidence shows the existence of such accounts promotes an individual's ownership of their healthcare (see page 21).

Many employers choose to tie incentives to the employee's participation in a desired program, such as completion of a health risk assessment or enrollment in a disease management or weight loss program. A more aggressive approach for incentives is to tie them to specific health outcomes, which could include a certain body mass index (BMI), cholesterol level or blood pressure. While tempting, we recommend you consult with your legal counsel before pursuing these incentives. Requiring a specific health outcome may be considered discriminatory in light of the Americans with Disabilities Act (ADA). An alternative to outcome-based incentives is progress-based incentives, meaning employees are rewarded for showing improvement in their health status. This type of incentive could be earned when BMI is lowered by a point or a percentage reduction in cholesterol is achieved.

Incentives will likely require coordination with multiple parties or platforms. Depending on your incentive, you may need to send data files to your PBM or your health and wellness provider; or both may need to interact with your payroll and eligibility and enrollment providers. One of the biggest challenges surrounding healthcare consumerism is the integration required across every employee touch point. You can not have an effective consumerism strategy by implementing standalone programs incapable of "speaking" to each other in an integrated system.

[6] Health Psychology, "Understanding how people process health information: a comparison of tailored and non-tailored weight-loss materials", September 18, 1999.

Fig. 11: Types of Incentive Programs

Incentive Types (n=)	Definitions	Value Range (average)	Target Behavior	Outcomes
Financial (14)	• Cash	$50 – $625 ($348)	Participation and/or completion of: • Health Risk Assessment • Screening • Preventive care • Healthy Behaviors and Programs	• 52% – 99.7% Health Risk Assessment completion • 65% wellness program participation • 3.5:1 ROI (over 10 years) • Program participants had 49% fewer sick days (over 10 years)
Benefits (22)	• Reduced deductibles • Deposit to Flexible Spending Account • Lower out-of-pocket max and co-pay • Reduced health insurance contribution • Lower ER co-pay • Waived deductible and co-insurance • Additional paid time off	$96 – $2,000 ($476)	Participation and/or completion of: • Health Risk Assessment • Preventive care • Disease Management • Wellness class • Healthy Behaviors and Programs	• 40% – 90% Health Risk Assesment completion • Reduced inpatient utilization • 99% compliance with Wellness criteria • Decrease in stop-loss insurance premiums • Program participants had 20% fewer days lost
Goods (8)	• Gift certificates • Clothes • Trinkets • Athletic bags • Raffles	$10 – $25 ($20)	Participation and/or completion of: • Health Risk Assessment • Screenings • Exercise program • Wellness website registration	• 7% – 30% Health Risk Assesment completion
Combination (5)	• Participation in the company insurance • Gift certificates • Cash • Reduced health insurance cost	$125 – $800 ($383)	Participation and/or completion of: • Health Risk Assessment • Behavior Change programs • Disease Management • Maternity class • Healthy behaviors	• > 80% wellness program participation • 70% Health Risk Assesment completion • 12% decline in Health Risk Assesment participant cardiac conditions • Health Risk Assesment participants were half as likely to become disabled

(n) = # of companies reviewed

Source: Employer Incentives for Promoting Healthy Behaviors Benchmarking Study summary provided by Janet Edmunson at BCBSMA; Chapman, L. Getting the most out of incentives: HRA completion, program participation and wellness achievements. Summex Corporation. 2004., (Compiled by Motorola Wellness Staff, 2004); StayWell book-of-business data; and Brown, S. Incentive for health: Bank gives lifestyle credits. Employee Benefit News. 2004.

Fig. 12: Examples of Employer Incentives

Company	Program Structure	Dollars	Results
Diversified Technology Fortune 100	20% reduction in premium for completion of Health Risk Assesment during open enrollment.	20% off premium resulting in approximately $200 for individual and $600 for family coverage.	Health Risk Assesment participation during open enrollment was 83%.
Healthcare & Pharmaceutical Fortune 20	Annual reduction in premium if employee completes Health Risk Assesment and participates in subsequent selected risk reduction program.	$500 per employee.	Four-year study of incentive program demonstrated $225/PEPY savings. Estimated $8.5 million in annual savings since wellness program was implemented 9 years ago.
Regional Bank	Raised employee deductible by $2,000 with an opportunity to mitigate the entire increase by following lifestyle-related criteria.	$500 towards deductible for each of the following: specified BMI, cholesterol and blood pressure as well as not smoking.	Specific ROI not available. 99% program participation. Decrease in stop-loss premium.
Major Medical Facility	Reward for meeting 8 out of 10 wellness criteria; reward increases each year as individual meets the Wellness Challenge.	$250–$375 per individual in the first year ($25–$50 increments each year an individual meets the challenge).	10 year ROI approximately 3.5 to 1 and 10-year cost savings estimated at $2 million.

Source: S. Brown, "Incentive for health: Bank gives lifestyle credits". Employee Benefit News. 2004.

Incentive Criteria: Guiding Principles for Employees

- Keep it simple – incentives should not cause confusion
- Make incentives "actionable" – encourage participation to reduce health risks, improve health status and result in meaningful behavioral change
- Reward desired behaviors immediately – immediate action will maximize participation
- Include everyone – reward healthy people for remaining healthy
- Communicate the details – make sure everyone understands what they have to do to earn the incentive and by when (deadline)

Incentive Criteria: Guiding Principles for Employers

- Should be designed to drive desired outcomes – the reward should be relevant to the goal
- Assure ability to track and administer – incentives are useless if they aren't received
- ROI – must provide positive return on investment over three years
- Consider the use of an HRA as a mechanism for providing incentives

Information Transparency and Consumer Advocacy: Knowledge is Empowerment

"…what I worry about most is what happens when our employees sit down with the doctor in the examining room, and they fail to ask the right questions. More than anything else, we'd like to improve the doctor-patient interaction. What we truly need for our employees is an angel on their shoulder who provides advice in their time of crisis."

—VP of Human Resources, University Medical Center, participating in a SHPS Client Advisory Council meeting

Healthcare consumerism is about creating better healthcare consumers. However, healthcare is not consumed like cars or groceries. On the contrary, health is personal, interactive, urgent, dynamic and often consumed in times of personal crisis. Under such circumstances, the individual's ability to effectively assimilate new information and act on it with dispassionate rationality is rarely possible. Sometimes, managing a personal health condition involves learning about, and mastering, complex medical information.

For this reason, information transparency "services" occur at different levels of intensity, and employers need to consider the extent to which each of these services should be made available:

- Self-help services: these are essentially reference tools that allow a competent, primarily healthy employee population to self-navigate through the healthcare system, identify high quality providers, and gain insight into the cost of their personal healthcare.
- Personal advocacy services: these are a source of one-to-one healthcare support provided by specially trained health or consumer advocates.
    - Administrative – this reflects the types of advocacy services employees are familiar with today. Counselors help employees understand their benefits, what plans they are eligible for, offer advice for participating in spending accounts and resolve issues and concerns.
    - Clinical – in times of crisis, an individual may wish to speak to a health advocate about whether they should use emergency services or where to find the best hospital for an unusual condition. Additionally, health advocates help individuals better understand their care plan.
    - Financial – addresses the transparency issue with regards to cost of care. Specially trained advocates in provider billing help individuals understand what they are charged for and challenge the billing, if necessary and appropriate.

These services can be provided through a range of modalities, including an interactive health portal, telephonic and face-to-face counseling. Interestingly, as health portal technology becomes increasingly sophisticated, the ability to allow individuals to collaborate with a physician and care team creates the possibility of lower-cost delivery models that combine technology with personal intervention.

Self-help services are the least expensive and are commonly offered as add-on services to a web-based health benefit application or other source. These tools might include:

- Estimates of cost of treatment;
- Physician-finder guides that allow review of quality and/or other criteria;
- Hospital selection guides to identify centers of excellence for particular specialties;
- Self-help health support and condition-specific information look-up;

- Tracking tools to monitor personal health and program compliance;
- Financial and medical-billing tools that show the costs for all medical treatments, including both covered and out-of-pocket expenses;
- Benefit selection tools to assist in the selection of a health plan or determine the level of funding to place in a spending account; and
- Prescription drug database, showing generic substitutes, potential interactive risks, etc.

Unfortunately, credible information about costs, provider quality, various treatment options and medications is often not available at all; or exists amongst thousands of web pages and commercial health sites.

The relative effectiveness of these tools is not entirely clear, though intuitively their value seems to make sense. The assumption around these tools, however, is that the impacted individuals are emotionally competent to make decisions, self-motivated to conduct their own research and have sufficient education to grasp the implications of any health information they are viewing.

In times of crisis, however, or where a population has special needs, transparency and support tools usually comes in the form of ad hoc or personalized advocacy, in which emotional and decision support are provided along with information. Under these circumstances, the health advocates must have:

- Accurate reliable health data on hand and research protocols on hand;
- Employees need to be aware how to access these services;

The Need for Consumer Advocacy

During a routine exam, a mother casually mentioned to the pediatrician that her four year-old daughter wasn't sleeping through the night and wakes up with little "twitches." While the pediatrician said it probably wasn't serious, he recommended that the daughter be tested by a pediatric neurologist to rule out epilepsy. The parents, instinctively protective, immediately schedule the test. Their daughter endured a sleep-deprived EEG, an unpleasant procedure for parent and child alike.

Final result: One parent missed a day of work, the test proved negative and an unintelligible medical bill for over $1,200 arrived two weeks later. The parents were relieved, but wondered if the whole exercise was necessary.

- How do the parents know if they did the right thing?
- Would the referring doctor have made the same recommendations to a family without health coverage?
- Is it realistic for non-clinical people to challenge the doctor's recommendation? What information or tools are needed to do so?
- Is there a way to help the parents decipher a cryptic medical bill that they will pay out-of-pocket under their high deductible health plan?
- In any city in the US, there may be only a handful of pediatric neurologists capable of accurately analyzing a child's EEG. How do parents know they selected the right specialist?
- If parents will seek reimbursement from their spending account, do they pay the provider at the point-of-service, or later, after the bill is adjusted for network discounts?

Consumer advocacy could help resolve these issues and result in a better-informed decision regarding treatment and spending options.

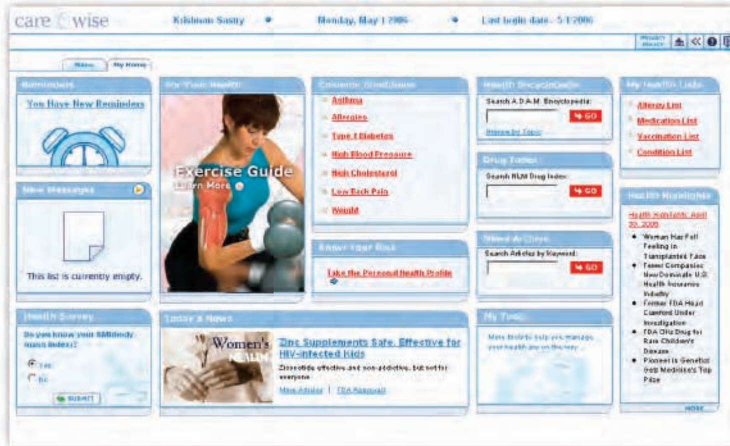


Fig. 13: A health portal should deliver meaningful information to support well-informed decisions, collaboration between employees and health experts and self-service tools to encourage personal health management.

- The advocate may need to provide emotional support in times of crisis to assist the employee in rational decision making around their healthcare; and
- The advocate may need to speak to, or coordinate with, a care team serving a specific employee.

In the future, one of the biggest challenges will likely be providing high-quality, transparent health information for Medicare and Medicaid participants. In these populations, there may be significant co-morbidity of conditions, and poor coordination between specialty doctors. As a result, a personal health advocate may be required simply to coordinate care and billing across several physicians, obtain second opinions, and keep the individual informed of their condition.

At the end of the day, however, the communication between the doctor and the patient remains one of the weakest links in the system of information transparency. The doctor spends five minutes on average with a patient and may not be practicing evidenced-based medicine or providing clear pricing at the point of sale. Arming patients with the right tools, questions and materials in advance of a doctor-patient encounter is critical. So too is asking patients to have greater confidence to ask difficult questions at a time when they may be feeling vulnerable.

How Accurate are Medical Bills?

More than 90 percent of all hospital bills processed contain errors – an estimated two-thirds of those errors result in the patient being overcharged for the services provided. The average error rate is four to six percent of the total medical bill. An average inpatient bill is $55,000. Therefore, using an median error rate of five percent, the bill would be reduced to $52,250, a savings of $2,750.

Source: SHPS Cost Management Systems, 2005.

Internet Used as a Health Resource

The number of health-related Web pages in a simple Google search using the keyword "health" netted nearly 250 million Web pages.

The Internet is used by a variety of populations. For example, more than 20 percent of people over the age of 65 have reported using the Internet, with two out of three having used the Internet to seek health information. Populations typically perceived to be hard to reach, such as lower-income populations, are also using the Internet. In a recent study, nearly 60 percent of lower-income participants accessed an Internet-based behavior change program from their own homes.

Source: Bensley RJ, Mercer N, Brusk JJ, Underhile R, Rivas J, Anderson J, et al., "The ehealth behavior management model: a stage-based approach to behavior change and management." Prev Chronic Dis [serial online] 2004 Oct.

Benefits Administration:
Healthcare Consumerism's Foundation

Benefits administration includes eligibility and enrollment, COBRA/HIPAA, individual billing, carrier exchange and program reporting. It is perhaps the least glamorous component of consumerism, consisting of services traditionally treated as a commodity by employers. Nevertheless, when included into the consumerism framework, benefits administration is the foundation that enables the rest of consumerism's services to function.

The eligibility and enrollment value proposition is based on performing a tremendously complex task accurately 100 percent of the time. But it also has critical strategic implications because employee data provides keen insight into important life event status changes, such as marriage, pregnancy, new dependents, promotions at work, salary changes, moving into a different home, etc. Life events provide an important opportunity to leverage personally relevant communications to drive desired behaviors.

Decision-support tools at the point of benefit selection are critical to helping employees fully understand their health needs, their plan choices and even their roles and responsibilities.

Currently, employees would be hard-pressed to evaluate their utilization of care and determine that a higher premium plan might actually provide more care coverage. Providing an enrollment resource that allows an individual to enter personal preferences, anticipated usage of healthcare and gives applicable cost and services information in a self-service environment is necessary to help your employees embrace the consumerism concept.

COBRA and HIPAA compliance must always be accounted for in any health benefits program. Some employers have even extended certain consumerism programs, such as care management, to COBRA participants in recognition of the fact that these former employees also drive healthcare costs. And the ability to bill individuals directly becomes increasingly important in a future consumerism world.

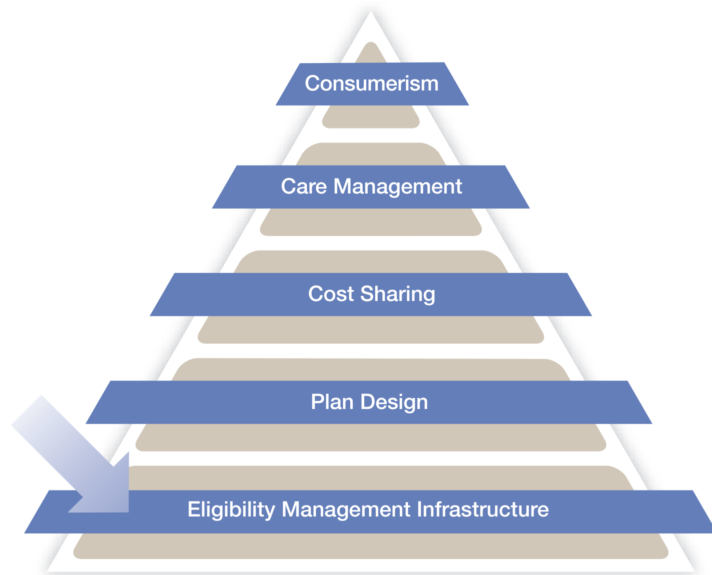


Fig. 14: Accurate management of eligibility data is the foundation of an effective health strategy.

The Importance of Cost-Effective Carrier Exchange

If you're paying for health benefits your employees aren't entitled to, then you will never optimize your results, no matter what type of program you implement. Data management is not an employee-facing component of the healthcare consumerism model, yet it certainly can have a huge impact on your ability to deliver accurate, cost-efficient benefit programs. Leakage is the accumulation of over-enrolled participants resulting from failure to promptly terminate coverage. It's estimated that 10 percent of employees have an ineligible dependent on the company's health plan. SHPS experience shows that leakage always exists and is as much as five percent of the enrolled population. Overpaid claims, premiums, and administrative services only (ASO) fees related to leakage can cost even moderate-sized employers millions annually.

Consumerism and choice brings complexity, so executing high quality data interfaces between human resources, eligibility and enrollment platforms and carrier administrative systems is vital. Building a solid eligibility management infrastructure allows you to implement more choice into your benefits program with minimal waste or overpayment. This includes multiple health plans, care management programs and other elements that support consumerism and behavioral change, such as linked spending accounts, incentives and rewards, real-time laboratory and clinical data, pharmacy data and self-reported health risk assessment information.

Effectively managing data goes far beyond simple claims administration and provides valuable knowledge about your population's workforce characteristics. Data mining can provide insight into driving the appropriate level of clinical intervention for care management programs; help drive a tailored communications campaign to promote FSA participation; or help determine the appropriate level of incentive or reward for participating in a health risk assessment.

Annual enrollment is the one time each year that you have your employees' undivided attention. This an excellent time to raise awareness of health issues, launch new programs, encourage completion of a health risk assessment and gather consumer feedback.

Leveraging the vast amounts of data from your population is where using metrics can help affect positive cost trends. The 80-20 rule is almost universally accepted, and there is not a lot you can do to mitigate some of that 20 percent. However, if you consider 30 percent of your population has a manageable disease that drives 60 percent of your healthcare cost (and often trends at an annual rate in excess of 20 percent if left unmanaged), it becomes clear there remains a huge opportunity to affect the healthcare cost trend by focusing on the portion of the population that can effectively self-manage themselves.

Auditing your carrier data exchanges and reconciling premium payments can result in significant cost savings. Services performed for three SHPS clients resulted in the following cost savings:

- Client A: 64,000 eligible employees
  - Reduction of over-enrollment error rate by 14.15%
  - Annual savings (ASO fees, premiums, claims): $3.8 Million
- Client B: 3,000 eligible employees
  - Eliminated 1,498 inappropriate member coverage records from six carriers (Two medical, pharmacy, two vision, life)
  - Annual savings: $2.9 Million
- Client C: 11,400 eligible employees
  - Identified over 2,000 member-months of inappropriate coverage among four medical plans
  - Annual claims savings: $1.1 Million

A study by Watson Wyatt shows that employers with the best healthcare consumerism programs focus on the "evidence".[7] This includes:

- Basing decisions on claims analysis;
- Implementing a data warehouse;
- Using hard dollar ROI calculations;
- Measuring health outcomes; and
- Using clinical risk adjustments in plan selection and/or pricing.

It is critical to understand your data before you begin to develop your program and consistently review your evidence to identify gaps or concerns in your program ongoing.

Managing these complex data exchanges and analyzing your programs' metrics, however, is formidable. Large employers with robust offerings and multiple interfaces should consider using a data aggregator to help manage integrated delivery, reporting and analytics, particularly as you build more complexity into your consumerism program.

[7] National Business Group on Health and Watson Wyatt, "Delivering on Health Care Consumerism: Strategies for Employer Success," 11th Annual Survey Report, 2006.

Integration: Making Consumerism Meaningful for Employers and Employees

SHPS believes that healthcare consumerism is driving the emergence of a new delivery model distinct from the health carrier – a program integrator. The program integrator provides a single point of access for all participant-facing services and allows an employer to deploy a single health strategy and program design across its entire workforce. This type of arrangement permits companies to create a single consumer program, while working with multiple health networks and/or carriers. This allows the employer to change carrier or network vendors to obtain the best discounts and access high performance providers, without putting program continuity at risk. The program integrator model makes sense for employers who acheive sufficient size and scale:

- Have 3000 or more employees;
- Are self-insured;
- Possess a geographically distributed workforce; and
- Desire on-going competitive bidding between health networks; or need to employ multiple local networks to achieve optimal discounts.

It is SHPS' experience that a program integrator can bring at least a two or three percent increase in the healthcare cost trend reduction over companies that carve-out their programs separately. Figure 15 illustrates how the program integrator and health plan roles split out in this scenario.

Now that we've laid the foundation, we turn our attention to the practical considerations required in implementing a healthcare consumerism strategy, including your workforce demographics, culture, tolerance for change, benefits literacy and other employee considerations. As you will see in the next chapter, one size does not fit all in the world of healthcare consumerism.

Program Integrator	Health Plan
• Manages a consistent and positive participant experience across multiple health plans • Orchestrates the solution design and integration of services from multiple vendors to provide a meaningful participant experience • Assures program stability and continuity of program services (spending accounts, care management, incentive structure) • Integrates reporting and analytics across the full health and productivity solution • Allows employers to negotiate and switch carriers to preserve the price and quality of their health networks	• Networks with good provider access, coverage and discounts • Fast and accurate claims adjudication and member support for all questions about coverage, claims and access • Transparency at the point-of-service with respect to provider price and quality • Provides integrated, but generic programs to the participant

Fig. 15: Comparing the roles of a program integrator to a health plan.

Chapter 4: Strategies for Developing and Executing a Program

"I have been working in the benefits area of my company for the last 20 years. Implementing consumer-directed healthcare is the most critical, visible project that I have ever worked on. The stakes could not be higher. I want everyone in this room to know that my entire career is on the line. This has visibility all the way up to our CEO, and 60,000 employees are watching."

—Director of Benefits,
Fortune 50 Company Client Meeting

In the prior section, we introduced the general framework for designing a healthcare consumerism strategy, and we introduced a catalog of tools that can be used together to drive behavioral change, better health, and lower costs. But theory and practice are very different. There is no single healthcare consumerism model that meets the needs of every employer.

On the contrary, the business model, financial objectives, workforce requirements, and relative access to labor may lead employers to select dramatically different consumerism models – even where two firms are direct competitors. The worst thing a firm can do is to look at their business neighbors' health strategy and assume it will work for them. In this section, we will explain why this is so and provide practical guidance for developing a consumerism program that will work for your business.

Essentially, there are four elements to constructing an effective healthcare consumerism program:

I. Structuring for Success: Traditionally health benefit programs are run in vertical silos with separate project managers. A consumerism approach needs executive-level sponsorship with overall accountability for the success of the entire health program.

II. Designing Your Comprehensive Health Program: The program design should specify the specific elements – plan design, incentives, deductibles, coverages, premium structure, care management services, decision support tools, etc. and the three to five year sequence in which these programs are deployed.

III. Executing Program Rollout and Change Management: The program rollout specifies communications and change management techniques, timeframes and methods for engaging employees. Consumerism demands extensive integration of services that have historically been delivered as siloed products. All employee touch points need to be consistent, synchronized and personalized to individual life events.

IV. Reevaluating the Healthcare Supply / Value Chain: The reevaluation of vendors and health networks needed to deliver the program and assess the components based on value needs to be specified as well. Employers often make the mistake of assuming that the health network/claims processor has to be bundled together with other services. On the contrary, network selection is a decision that should be made separately from program design, because poor network choices can overwhelm the savings from a well designed program. Moreover, employee satisfaction is closely aligned with cost and quality of service and network discounts. Employers should move beyond traditional networks to customized networks based on treatment of chronic disease states that addresses the majority of healthcare spending in a given year.

Step I: Structuring for Success

"I have been working in the benefits area of my company for the last 20 years. Implementing consumer-directed healthcare is the most critical, visible project that I have ever worked on. The stakes could not be higher. I want everyone in this room to know that my entire career is on the line. This has visibility all the way up to our CEO, and 60,000 employees are watching."

—Director of Benefits,
Fortune 50 Company Client Meeting

The traditional benefits organization and benefits delivery model is obsolete.
Historically, health benefit services like spending accounts, health & wellness, disease management, and enrollment and eligibility were managed as separate, stand-alone services. In larger organizations, each element might have its own program manager, and performance of each component was assessed separately. Our recommendation is that all matters related to health benefits be integrated into a single program.

Employers routinely send RFPs for standalone services issued by separate parts of the same organization. For example, care management services may be handled by a health manager, plan selection by a benefits strategist, enrollment by benefits administration, and general benefit communications is handled by an employee communicator.

This approach is partly driven by the fact that healthcare management has two opposing characteristics that create extraordinary challenges for the health benefits professional. First, healthcare is an exercise of numbers: numbers that describe health outcomes, actuarial trends, characterization of risk, and overall costs. Best practices and evidence-based medicine come from the statistical review of thousands of outcomes. Thus, a core part of the employer's consumer strategy starts with the definition of the specific financial and health outcomes they seek to achieve across their entire covered population.

Belying these numbers, however, healthcare is also a profoundly personal and individual matter. Every individual has unique health needs, a unique financial profile, and a unique tolerance for risk. Individuals rarely behave rationally when their own health, or the health of a loved one, is at risk. During times of stress and personal uncertainty, most people predictably take the course of action that offers the most certainty of outcome, regardless of whether it is rational and cost effective to do so—a key factor in the over-utilization of hospital and clinical tests.

So while the overall goals of the health benefits professional are quantitative outcomes, the tactics needed to achieve these outcomes will depend upon a combination of carefully designed incentives, communications, program design, and behavioral tactics to engage individual employees. These tactics may be highly unique to the situation of a specific employer and need to account for things like:

- Socio-economic status of the target audience(s);
- Work environment and culture;
- Differences in gender attitudes and behavior; and
- Innate personality preferences.

A single employer with highly diverse workforce segments may need to employ multiple "marketing" strategies that address each segment.

Moreover, to drive true behavioral change, the program elements – medical plan, spending accounts, care management services, incentives, communications, health portal, enrollment and eligibility, decision tools and program metrics – need to be aligned with the program objectives.

In our opinion, it is critical for organizations to:

- Integrate the entire Health & Productivity function including benefits administration into a single program;
- Assign a single executive with complete accountability for all aspects of the healthcare consumerism program, including: design, vendor selection, behavioral tactics, metrics, and continuous improvement;
- Create a benefits team that combines clinical, actuarial, communications, administration and measurement functions; and
- Redesign the vendor selection process to assess vendor fit with the overall health consumerism model and identify program integrators.

Step II: Designing Your Comprehensive Health Program

Program design is crucial yet complex for many employers. How do you actually design and rollout a healthcare consumerism program that is right for your organization when there are thousands of permutations? SHPS has worked closely with many clients to develop consumerism strategies to help answer this question. While it is true that every employer has unique variables, we have also learned from experience that it is possible to streamline the decision making process.

Depending upon which category a company falls into, the choice of program design can vary significantly. The overall goal of consumerism–behavioral change–is the same, but critical tactics differ. For example, how quickly should companies introduce a high deductible health plan? How high should the deductible be set–$1,000 or $5,000 for single coverage? Should organizations offer an HSA or HRA? Should the employer fund the HSA? What about retiree access for the HRA? How aggressive should incentives be, and what should they be tied to? How extensive should care management and decision support tools be?

While every employer has unique financial and workforce considerations, we have found that most employers fall into one of three general strategy categories as a purchaser of healthcare. These categories are:

Cost Managers: These are companies whose primary concern is strictly the cost of healthcare. Often operationally focused and with narrow margins, they provide health benefits out of competitive necessity, and may be at immediate competitive risk if they fail to get costs under control. Their expected return on investment in consumerism is short term. With a larger proportion of non-exempt, high-turnover personnel, opportunities for long term health improvement may be limited. The programs need to drive instant results.

Value Drivers: These are companies who are concerned about healthcare costs, but also need to retain critical employees and improve overall health and productivity. Value drivers may have a mixed workforce of hourly and professional workers, or employees with jobs where tenure is valuable to their contribution. Value drivers may be willing to trade short-term increases of healthcare cost trends to achieve one to three year returns on investment.

Health Advocates: These are companies that see the overall health of their workforce as a potential competitive advantage, and are willing to make extraordinary investments to build a healthy, world class workforce. Such companies are typically high-margin businesses, with a preponderance of professional long-tenure employees and high profitability per employee. Such companies often talk about creating "a culture of health," view their employees as athletes, focus on performance and seek to achieve three to five year returns on investment.

How do you know which category your firm falls into? To provide more insight into the descriptions above, we ask some specific questions to give evidence to design considerations and have developed a simple questionnaire that provides some of the logic and reasoning behind each approach in order to help companies better understand their health priorities.

Employer Considerations

Question 1: Why do you offer healthcare coverage?

Group health coverage has never been offered as an exercise in altruism. Businesses have specific, practical reasons for offering healthcare benefits. Some offer it because it's a requirement to attract the people they need. Other organizations see their health strategy as an opportunity to create competitive advantage. Depending upon corporate circumstance, both points of view are correct. Companies for whom healthcare is a requirement are more likely to prioritize high deductible plan designs and targeted disease management programs that drive immediate savings and achieve the shortest payback of invested dollars. Plan designs are often more restrictive and prescriptive, with potentially severe financial penalties (in the form of higher premiums or a large deductible gap) for non-compliance with specific health & wellness, and condition management programs.

In extreme cases at the low end, some employers have chosen to offer catastrophic only coverage to their employees (e.g. a high deductible health plan with an unfunded HSA). This type of coverage provides value primarily to healthy people who would access healthcare in an emergency, while creating a disincentive to potential employees who are shopping the labor market for the best health plan.

Companies focused on achieving competitive advantage often take a longer view, placing emphasis around integrated health management programs that provide comprehensive decision support for acute needs, health & wellness, disease and case management for the entire population. Extensive communications, financial incentives and internally branded programs may make more sense as opening approaches in year one, with the introduction of a high deductible health plan in either year two or year three of the strategy. This type of strategy requires greater commitment of resources, but achieves the best overall health and productivity outcomes.

Question 2: What are your financial priorities?

In many respects, consumerism can be viewed as an investment project with an expected payback through a reduced healthcare cost trend and the avoidance of future costs. A key decision that firms need to make early on is their expectation for payback. Thus, this factor drives a firm's willingness to make short term investments in health programs that will result in a longer term ROI through better health and reduced claims in the years to come.

In our experience, the firms with the lowest healthcare costs have approached healthcare with a longer term investment horizon. The element of time allows for adjustments to program design, and allows employees to become more effective in utilizing health programs. However, financially strapped firms may not have this option.

Question 3: What are your spending trends?

High recent spending trends may force employers to raise premiums substantially, while simultaneously introducing new programs and plan designs. In this case, employers may be justified in taking extreme steps, such as tying plan premiums and deductibles to specific biometric outcomes like body mass index, blood pressure, and cholesterol.

Question 4: What is your principle workforce strategy?

The benefit plan can be used as an incentive or disincentive to retain employees. But health plans have a direct overall impact on cost per employee.

Some employers have workforce needs where there are large numbers of interchangeable positions, performing repetitive work. Such firms often have low revenues and profit margins per employee, and benefit cost per employee becomes a critical factor.

Other firms may rely on high performance teams of knowledge workers to create extraordinary value, and achieve high margins per employee. These firms may choose to invest significantly in health benefits to attract a world class work force.

In reality, many employers have both high value and commodity employees in their workforce. The biggest challenge for these employers is to come up with a program that meets the needs of the diversified workforce. These employers are potentially at greatest risk of employee dissatisfaction because a compromise design may end up frustrating both portions of the workforce. These employers may have to offer plan choices that vary premium, deductible and choice of spending account to meet distinct needs.

Question 5: What is your workforce turnover?

Workforce turnover is a mixed blessing for employers. Too much turnover drives high hiring and training costs, and can lead to breakdowns in quality and productivity. Too little turnover can create an inflationary wage trend and a sedentary, complacent workforce. The "targeted" turnover level for a workforce routinely varies from five to 80 percent annually, depending upon the business model and type of work.

From a health management standpoint, however, turnover reduces the time and opportunity to drive behavioral change. Disease management programs in particular require significant first year investment to achieve a payback based upon avoidance of future health claims in subsequent years. High turnover makes it difficult to achieve this payback. Health behavioral interventions in a high turnover population must be designed for immediate behavioral impact, hence, greater reliance on strong financial/behavioral incentives tied to clear health outcomes.

Turnover levels and retention strategy also impact plan design. HRAs set up for forfeiture upon termination are favored in high turnover environments, as both a retention incentive and means of cost savings. In competitive hourly labor environments, some companies have chosen to offer a more generous health plan in lieu of higher pay to attract and retain employees. This strategy, however, can backfire, through a perverse form of adverse selection—that is, a company may inadvertently become the employer of choice for those with pre-existing conditions, while healthier employees choose the company down the street with higher pay and less coverage. In labor markets characterized by high mobility and opportunity, this is a real issue. Government and not-for-profit employers often serve as examples of this principle at work.

Question 6: What is the health status of your workforce?

Every workforce has its unique health challenges, depending upon gender, socio-economic, geographic and age distributions. The prevalence of smoking and obesity is potentially doubled in some locales, while active lifestyles are common in others. Low back pain is often seen in manufacturing and transportation environments. Older female workforces may be unaware of the risk for heart disease, consistent with the common, but incorrect, notion that heart disease is primarily a problem for males. Because every workforce is different SHPS strongly recommends organizations perform a two to three year retrospective claims analysis on their population to understand the health risks—especially the drivers of chronic disease, their employees' compliance with evidence-based medicine and utilization patterns. Depending upon findings, plan design and care management tactics may be greatly altered:

- Focus on condition management versus general health & wellness;
- Intensity of incentives to engage employees in health programs;
- Use of on-site health fairs and diagnostic testing; and
- Adjustments to plan design to encourage greater use of drugs to manage specific chronic conditions and encourage use of medications.

Fig. 16: Strategy Survey

1 Answer each question by circling the score that best fits your company.

Why Does Your Company Choose to Offer Health Benefits?

Necessity	1	2	3	4	5	6	7	8	9	10	Competitive Advantage

- Required by law
- Needed to stay current with the employer down the street
- Manage turnover of key workforce groups
- Large proportion of workforce represent commodity positions, fungible jobs
- Poor health associated with productivity/service issues
- Bargaining units

- Quality of workforce provides significant competitive advantage
- Attract / retain the best and brightest
- Poor health associated with failure of critical projects / products / relationships
- Create a culture of health
- Focus on building a world class competitive workforce

What are Your Firm's Financial Priorities?

Cost Reduction	1	2	3	4	5	6	7	8	9	10	Employee Investment

- Cost reduction must be achieved regardless of consequence
- Failure to halt healthcare spending imperils the organization's existence

- There are sufficient profit margins to cover short term increases in cost that may lead to greater savings in the long run
- Want to save money, but employee retention is also important

What are Your Benefit Spending Trends?

Above National Average	1	2	3	4	5	6	7	8	9	10	Below National Average

- Benefit trends have been unacceptably high. We look for a dramatic change in healthcare cost trend

- Benefit spending trends are under control and consumerism is a way to keep them under control

What is Your Workforce Strategy?

Commodity 1 2 3 4 5 6 7 8 9 10 Strategic

Commodity	Strategic
• Primary value delivered by a relatively unskilled low wage workforce • High turnover • Low cost to replace one employee with another • Low revenue / margin per employee	• Primary value delivered by high performance teams and individual contributors • Loss of the wrong employee imperils business goals • High revenue / margin per employee

What is Your Workforce Turnover?

High Turnover 1 2 3 4 5 6 7 8 9 10 High Retention

High Turnover	High Retention
• Significant turnover of key covered populations	• Stable populations • Long term employees

What is Your Company's Relative Health Status?

Poor Health 1 2 3 4 5 6 7 8 9 10 Well

Poor Health	Well
• High incidence of chronic diseases like diabetes, heart disease and COPD • High incidence of smoking and obesity • Lower income and education levels	• Younger, fitter populations • High education and income levels

2 Add your scores: ___________ Total Score

3 Divide by 6: ___________ Average Score

In general, employers who average a score of 1–3 are well-characterized as cost managers. Employers who average between 4–6 are value drivers, and employers with an average score of 7 or above are health advocates. This questionnaire is a simple aid to help employers identify their true priorities. Additionally, the chart on pages 50 and 51 compares the program elements between cost managers, value drivers and health advocates.

Employee Considerations in Plan Design

Employee benefit surveys administered by employers reveal that the healthcare benefit is valued more than any other employer-sponsored benefit by a two-to-one margin. While access to high quality healthcare is a primary reason employees seek health benefits, so is protection from the financial risks of poor health. A study published in 2004 reported that nearly 20 million American families during 2003 had trouble paying medical bills, with nearly two-thirds of those families saying the medical bills made it difficult to pay for other basic necessities.[8] In our modern society, there is no other factor besides health that can so quickly lead to the financial ruin of an otherwise prosperous family. Families that have achieved a certain level of prosperity will invariably demand health coverage as a fundamental condition of employment, regardless of personal health status.

Not surprisingly, income and education levels are strong predictors of risk tolerance, both qualitatively and quantitatively. For example, high income individuals with free cash flow may be extremely comfortable with plan designs that require steep high deductibles, but are more likely to insist upon uncapped catastrophic coverage. Their focus is upon wealth preservation. At the other extreme, low income employees may be debt constrained. That is, they have no ability to borrow money even at high rates of interest and their primary concern is choosing between food, rent or needed healthcare. They will likely trade uncapped health coverage for a plan with a lower deductible or provisions and services that protect cash flow. An employer considering an HRA versus an HSA may favor the HRA for lower income populations because it is strictly limited to healthcare, whereas the employee can access their HSA for any purpose, although penalties and taxes apply for non-health expenditures. However, an employee with significant credit card debt at 30 percent interest is arguably better off paying down that debt with HSA funds, in spite of penalties.

Similarly, income and education levels are also correlated with higher incidence of chronic disease, with a greater likelihood of non-compliance with best practices around condition management. As a result, plan designs targeted at hourly and lower income populations are more likely to be focused on program compliance, with greater restrictiveness around the use of healthcare spending accounts.

Another consideration relates to populations where one gender predominates in the workforce. In married households, women are more likely to make primary benefits and healthcare decisions. A primarily male population may require significant secondary communications to the household.

Figure 17 summarizes our discussion graphically. In this figure, we've broken out income versus health status. Broadly speaking, plan designs under consumerism can vary broadly from highly behavioral and restrictive (lower left hand corner) to permissive and market driven (right hand corner). The average income, education level, tenure and workforce culture are all primary considerations. Note that the employer-funded (or partially-funded) HSA exists at the top of the market. Its market-based incentives make sense for executive populations who, from an actuarial point of view, are aggressive consumers of preventive healthcare, highly purposeful, and more likely to enjoy better health overall. At the very low end, the un-funded HSA is a last ditch effort by employers to preserve a health benefit – particularly for smaller employers. The broad middle ground is primarily occupied by companies with some form of HRA. Many companies like the flexibility, continuity and control of the HRA, because they can keep their existing coverage

[8] Medical bills figure in personal bankruptcy, Friday, August 06, 2004 By Christopher Snowbeck, Pittsburgh *Post-Gazette*

schedules but raise deductibles and add the health account. With the HSA, redesign of coverage may be necessary and plan design is legislated.

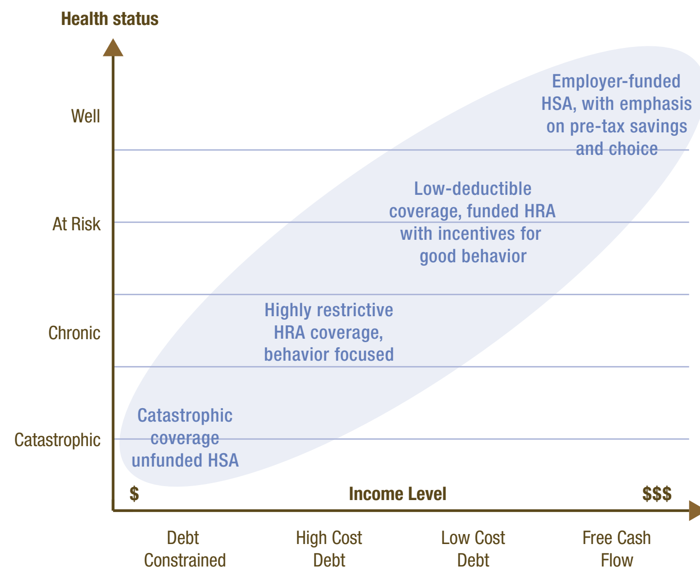
Historically, SHPS clients with the health advocate mindset have achieved the lowest long term healthcare cost trend numbers – often between two and five percent. There are a variety of systemic reasons why this might be the case that go beyond the issue of program design itself. Companies who could be characterized as health advocates may employ a higher proportion of well-educated, high income professionals so direct comparisons of healthcare cost trend without an actuarial adjustment would not be appropriate.

In addition, there is a greater ability to invest in health management programs that will provide an effective return over a three to five year time frame. These opportunities may not be available to employers who employ primarily an hourly workforce with high turnover. Particularly problematic are employers who have mixed populations of hourly workers, which include segments of high tenure employees, alongside a short tenure workforce.

The cost manager needs to focus on interventions that have a short term payback for the least dollars. A low income and more transient population, almost by definition, will have significantly higher health risks. Lifestyle issues, like poor nutrition, smoking, obesity, lack of exercise, stress, lack of sleep (for example, due to holding down two jobs), substance abuse, and inability to manage personal health conditions are endemic. In addition, aggressive care management programs (laboratory diagnostics, wellness, and disease management) often increase short term health costs, as undiagnosed conditions are surfaced for treatment.

Most small companies operate in the cost manager category as a matter of necessity. Due to size, they may lack the ability to leverage care management services over a smaller covered population, may not have access to population health metrics other than what is provided by their health plan, and may lack the purchasing economies of scale to get good discounts. For all of these reasons, catastrophic coverage with employee-only funding of the HSA is rapidly becoming the most popular strategy for small businesses.

Fig. 17: Health, Wealth and Plan Design



Program Elements	Cost Managers	Value Drivers	Health Advocates
Objective	Immediate short term reductions in healthcare cost trend and costs to preserve a health benefit	Short term reductions in healthcare cost trend, balanced with targeted investments to achieve improved long term health outcomes	Create competitive advantage by creating a culture of health that maximizes workforce performance
Overall Strategy	• Immediate shift to high deductible health plan • Emphasis on financials of plan design • Financial penalties for non-compliance • Strong behavioral focus • Cost-shifting to at-risk and chronic populations, especially if non-compliant	• Gradual shift to high deductible health plan • Emphasis on employee engagement • Investment in broad care management • Financial rewards for participation in H&W and disease programs if appropriate • Implement integrated metrics	• Early establishment of integrated health metrics • Early introduction of a $0 balance HRA as a vehicle for health incentives to accompany current plan designs • Introduction of high deductible health plan in year 3 or 4 of strategy • Aggressive investment in Total Population Health Management from an integrated provider • Combination of behavioral and market based financial incentives • Corporate branded, 3 – 5 year health outreach program to cover all aspects of consumer healthcare
Plan Design	• Limited plan options • Restrictive high deductible health plan with an HRA or an unfunded HSA (extreme case) • Deductible gaps of $1,000 or greater (individual coverage) • High out-of-network co-insurance • Aggressive formulary incents generics, mail order and in-network purchase of specialty drugs • May cap out-of-pocket maximums	• Medium deductible HRA (e.g. $1,000 deductible for single coverage, deductible gap of $500 or less) phased in by partial replacement • Broad definition of preventive healthcare and provisions for treatment of mental health • Traditional and high deductible health plans offered side-by-side • Discounted premium on high deductible health plan facilitates 3 year migration to high deductible health plan	• $0 balance HRA to accompany existing health plans • Gradual migration to medium deductible HRA plan over 3 years • Broad definition of preventive healthcare, and provisions for treatment of mental health • High deductible health plan with funded HSA offered as an alternative for executives
Type of Spending Account Used	• Restricted HRA (rollover limits, forfeiture at termination, health coverage only) • HRA deduction first, then FSA; or • (Extreme case) Un-funded HSA, option for limited FSA	• Primarily HRA/FSA • HRA may permit unlimited accumulation, access at retirement, coverage of COBRA payments • HRA may be designed to cover all IRS eligible expenses, with an FSA pay-first model • Multi-purse debit card facilitates use of HRA with FSA to cover deductible gap	• Primarily HRA/FSA but may include an HSA option with an employer contribution • Unusual: HRA/HSA combination (Example: The HSA covers the first $1,000 and is employee-only contribution; the HRA covers amounts above the $1,000 deductible)

Fig. 18

Program Elements	Cost Managers	Value Drivers	Health Advocates
Incentives	• Aggressive incentives for outcomes: -Body Mass Index -Non-smoker -Blood Pressure -Premium reduction or employer contributions to HRA -Failure to comply with protocols costly	• Incentives for actions: -Health Risk Assessment -Participation in Disease Management -Health fair/lab tests	• Behavioral incentives for actions: -Health Risk Assessment -Participation in Disease Management -Health fair/lab tests -Achievement of specific wellness outcomes • Positive market incentives -HSA contribution or HRA with retirement or post-termination value
Care Management Framework	• Targeted Case and Disease Management for population specific and catastrophic conditions • Generic on-line health and wellness • Services often bundled into the health plan	• Care Management carved out from health plan solution • Health Risk Assessment and on-site lab screening • Personalized health report • Total Population Health Management -Health Portal -Full Spectrum Disease Management -Case Management	• Health Risk Assessment and on-site lab screening • Personalized health report • Total Population Health Management -Health Portal with ability to customize content by condition -Employee health record -Input from third parties -Supports HIPAA compliant personal messaging -Full spectrum Disease Management -Case Management • Extensive health & wellness including on-site exercise and clinical facilities.
Advocacy and Decision Support Tools	• 24 hour nurse line • On-line price/quality tools	• 24 hour nurse line • May include 2nd opinion services • On-line price/quality tools	• 24 hour nurse line • May include 2nd opinion services • On-line price/quality tools • May include personal health bill audit service
Program Sequence	• Full replacement high deductible health plan in year 1 or 2, along with decision tools • Disease / Case may be introduced with or subsequent to high deductible health plan • Incentives focus on HRA and mandatory on-site lab screening in year 1 • Additional incentives added for Disease Management compliance in year 2 or 3	• Introduction of partial replacement high deductible health plan with HRA • Integrated health metrics • Case and Disease Management • Move to full replacement with high deductible health plan and introduce financial incentives • Move to total population health management with advanced health & wellness offerings	• First priority: Total Population Health Management and implementation of integrated health metrics • Communications blitz focused on personal health • Introduction of $0 balance account and incentives • Partial replacement high deductible • Full replacement to high deductible • Offer choice of HRA or HSA

Step III: Executing Program Rollout and Change Management

"I work as a Team Leader amongst mostly single women with children. They earn an average of $10.50 per hour. Due to the rising cost of gasoline, they are paying at least $50 more a month. In the summertime, they must pay another $50 a week more with daycare. To think they can share in paying higher healthcare premiums is outrageous. Maybe we should look at the cost sharing as the employees who make more money will pay higher premiums than the employees at the lower income level."

—Employee of a mid-sized employer

Balancing rising healthcare costs with the emotional reaction of employees is a key challenge in program rollout and change management. Employers will find that rolling out a successful consumerism program is radically different from ordinary benefit communications. What's different?

- Total behavior focus;
- Intensity, consistency and scope of communications;
- Integrated programatics – all aspects of the health experience, from benefit, to enrollment, to incentives and care management have to be treated as a single program.

Employers cannot rely on classic annual enrollment communications to deliver the employers' point of view. Instead, what's needed is an understanding of consumer marketing and healthcare to create an open, ongoing dialogue with employees.

Many employees already think they are effective healthcare consumers and so may not see the need to change their behavior. Employers don't believe employees are doing enough to control healthcare costs. Change management should resolve this disconnect by defining what it means to be a "good healthcare consumer."

Need For Better Communications

Unfortunately, companies have little to brag about when it comes to their current employee communication practices. A 2004 Towers Perrin survey of 1,000 employees shows that only 51 percent of employees believe their company generally tells them the truth. On average, employees gave their company a rating of 69 (on a scale of 1 – 100) when it comes to overall communication effectiveness. 60 percent say they receive the information they need to do their job well. Fifty-seven percent say communication from corporate headquarters is clear and understandable.

In another study conducted by MetLife, employees voiced a strong need for benefits education and advice. Only 40 percent of employees understand which benefit options best meet their needs and only 31 percent of employees give their companies' benefits communications high marks.

Fig. 19: Effective change management requires a well-orchestrated effort involving many components, including participant communications.

Consistent Themes Across Communication Programs

- Employees should understand that change is inevitable in today's environment and that if employers are to continue to offer benefits, change must be embraced;
- Cost and quality issues must be transparent to the employee; if the employee is to become a healthcare consumer, they must be presented with all of the facts and know exactly what is expected of them;
- Employees must be empowered with the tools and resources they need to make smart purchasing decisions – and know where to find and how to use these tools and resources;
- The communication strategy must be targeted and measured;
- The strategy necessitates a long-term communications initiative around behavioral change; this is much more than rolling out a campaign during open enrollment, this is a commitment on behalf of the organization to partner with the employee to create a health-minded culture;
- Consistent, actionable messaging; and
- Behaviors and actions required must be clearly communicated.

Designing an Effective Rollout Plan for Your Consumerism Initiative

As with program design, every employer will have unique challenges for program rollout. Before devising a rollout plan, SHPS recommends that employers explore a range of critical questions:

- What is your workforce's tolerance for health-related financial risk?
- What is the relative benefits literacy and sophistication of your workforce?
- What are your employee expectations for benefits?
- How would you characterize your workforce culture?
- Do your employees have ready access to technology?
- What resources do you have available for rollout?

Step IV: Reevaluating the Healthcare Supply / Value Chain

In previous chapters, we defined a framework and strategies that take an outside-in approach to driving consumerism. The right "demand side" program integrator may not be the best "supply side" network and visa versa. The right program integrator will not only redefine demand but also help create and manage a consumer-centric program that will build and select the best supply sources (i.e. networks) to stratify risk and drive specialty discounts to serve your population needs. The right suppliers will be able to create provider networks that serve your well and chronic populations.

Selecting the right program integrator

Healthcare consumerism changes the current playing field for the traditional health benefits delivery chain. A question we are often asked is whether it's better to assemble individual "best of breed" components or to go with integrated solutions. SHPS' findings are two-fold. No one vendor can do everything. At the same time, the definition of "best of breed" is changing. Vendors who have not built an integration framework to work seamlessly with other administrators cannot meet the demands of consumerism, regardless of the quality of their individual solutions. Thus, we've taken a dual approach – in many cases we have best of breed products; in the cases where we don't, we're working diligently to take the final step toward that goal. More significantly, we've taken great strides to become the best integrator in the market – and our results speak for themselves.

Why is network selection so important? And why should it be separate from other vendor decisions?

Choosing the right healthcare networks is one of the most important decisions an employer can make. The impact on cost, quality, and client satisfaction is enormous. Yet employers often choose to purchase their health network services from the same firm that administers their consumerism programs. For small and mid-size employers, this may be the only practical choice. However, for large self-insured firms who employ multiple networks today to get the best discounts, we strongly recommend that employers keep their health networks separate from their health-care consumerism programs to ensure that they can continually bargain for the best services and discounts without impacting the continuity of their overall health program.

> Large, self-insured, geographically dispersed workforces often require the support of an independent program integrator for all aspects of the development, implementation and monitoring of a consumerism program. Smaller and centralized workforces that are not part of buying coalitions are more likely to benefit by combining the program integrator and network functions within a single carrier. Thus, workforce size and distribution can be a significant driver of the overall vendor selection and program implementation strategies.

Network impact on cost comes in several forms:

- Provider discounts;
- Quality of care and level of health outcomes; and
- Ability to provide value-added support for condition management.

For employers with broadly distributed workforces, there may be advantages to continuing to work with highly discounted local networks rather than a single nationwide network. Quality and cost can be compared, with the potential for renegotiation of discounts.

A New Model For Healthcare Delivery

- Employees select primary care providers (general practitioners, gynecologists, pediatricians), which they pay with HRAs and HSAs based on discounts applied at the point of sale;
- If through laboratory tests or other identification employees are diagnosed with chronic ailments, they are registered in care advocacy programs by the primary care provider; and
- Care advocacy provider and physician collaborate to find the specialty network (including specialists, in-patient facilities, and drugs) and provide coordinated care to the employee.

In addition, SHPS advocates the use of specialty or pay-for-performance networks, wherever feasible, to better manage chronic conditions that may be present in the workforce population and drive the majority of health costs. We believe that these networks will become an increasingly powerful tool for employers to drive better health outcomes. Specialty networks will help create focused and efficient service delivery around the 73 percent of healthcare spending driven by 39 percent of the people with chronic diseases.

Interestingly, however, our early client experiences with consumerism also reveal that networks will likely drive the greatest areas of employee satisfaction (or dissatisfaction) through the behavior of providers at the point of checkout–areas that cannot be controlled by program design but can be controlled by selecting the most competitive networks and building leverage to drive provider change. Employees have been conditioned to expect modest co-pays. While employees may have chafed from lack of provider choice under managed care, they appreciated the complete elimination of most paperwork.

Placing some financial responsibility on the employee reveals major structural flaws in the current health system, such as:

• No ability to distinguish quality of care: A review of SHPS client's health claims and medical records consistently demonstrate that doctor's comply with medical protocols for evidence-based treatment in only 52 percent of cases. These statistics suggest that 48 out of every 100 employees should be shopping for a new doctor or learning how to ask better questions in the doctor's office. However, most employees have little awareness of the quality of care they receive, and no trusted source for identifying qualified providers for their specific needs.

• Complexity and inconsistency of medical billing: For the past two decades, providers and payors have been engaged in a costly game – the provider seeks to maximize reimbursement by breaking out services into minute details to maximize reimbursement – the health network / payor creates new rules, discount schedules and audit procedures to hold reimbursements in abeyance. The discount structure is normally kept confidential by law. Two decades of bureaucratic evolution has created a payment system where 30 percent of every healthcare dollar goes to administrative cost. To correctly analyze and understand medical bills takes years of experience and an advanced degree. Within a hospital or large practice, it is not uncommon for the most experienced senior nurses to work exclusively on medical coding and bill submission, along with experienced staff. In the past, employees were shielded from this complexity as long as they had health coverage. Employees could rarely identify how much money was spent on their behalf for their healthcare, and had no means to verify they were charged correctly. Under consumerism, individuals need to receive accurate estimates of cost in advance of proposed treatment, understand alternative treatment options and costs and be able to verify that they were charged fairly and correctly afterwards.

• Provider response to late payment concerns: From the provider perspective, consumerism introduces the risk of late payment. Under the old system, providers collected co-pays for physician visits or other specified events, and the provider would submit a bill for services to the carrier. The payor covered most of the remainder, and post-treatment collection from the employee was a manageably small percentage of the total bill. Under a high deductible plan, the entire bill may go back to the employee for payment after a claim is filed until a deductible requirement is met, potentially adding one to three months to the collection cycle. In response, many providers have developed new point of sales procedures, often in violation of network rules. For example, the Director of Benefits for an organization with 28,000 covered lives surveyed point-of-sale collection procedures for five major in-network providers in a single metropolitan area after the firm had launched a new high deductible health plan. He found that each provider had developed its own unique collection procedure, and none were consistent. The greatest challenge from an employee relationship standpoint, however, was the tactic enlisted by a

prominent local pediatrics practice. This practice, which served nearly 1,000 dependents from corporate headquarters, demanded payment in full at the time of treatment, even estimating discounts before the claim was filed for reimbursement.

As healthcare consumerism grows, the entire health network system is potentially in crisis. At SHPS, we already see some evidence of this through the early experiences of our clients and the frustration of their participants. Employees can't take responsibility for spending if they don't know, with some level of accuracy, what an episode of treatment will cost in advance. The health networks that grow and thrive in this new environment will rapidly provide price and quality transparency and a friendly, consistent experience from appointment through final payment.

Until health networks become more responsive, however, we believe it is critical for employers to select and manage their network provider(s) separate and independent from the organizations they use to administer their consumerism solutions. The ability to swap out provider networks to maintain competitive levels of price and quality is critical while simultaneously preserving the continuity of their overall consumer-based health initiatives.

A "Vision" of Consumerism

The vision industry provides an excellent example of how healthcare might evolve when consumers become responsible for routine care. Unlike healthcare, many eye care services are branded. Companies like LensCrafters, Pearle Vision, For Eyes and others offer consumers standard services, clear pricing, and convenient, attractive settings. While the optometrists are screening for serious complications, they have no financial incentive for unnecessary referrals to specialists.

If most consumers were responsible for the first $1,000 in healthcare spending and could keep the money they didn't spend for a rainy day, where would they go for preventive care and what kind of experience would they be looking for? We can only speculate on the details, but it is fair to say that it would not look much like the typical doctor's office of today, which engenders long waits for appointments, generates confusing bills and has only a 52 percent probability of providing medical care that conforms to evidence-based treatment.

Imagine the opportunity to go to a branded health franchise that packaged routine tests, care management services and condition specialty centers in a comfortable setting, and allowed consumers to manage an on-line healthcare record – an experience that was standardized across the country – and monitored to ensure evidence-based medicine. Imagine being able to pull together a set of health questions to submit for response by end of the following day. While these developments are currently in their infancy, the experience in the eye care industry suggests that all healthcare provided below the deductible could evolve into radically new models of delivery that are far more consumer friendly – and cost effective.

Characteristics of the Ideal Consumer-Friendly Healthcare Delivery:

- Convenient access and scheduling for primary care and specialty care;
- Clear, well-understood pricing for services, including bundled episodes of treatment;
- Peer-reviewed compliance with evidence-based medicine;
- Personal assistance and education to help individuals understand and manage their chronic conditions including provision of second opinions from experts;
- Collaboration among primary care provider, consumer advocate, disease experts and specialty networks;
- On-line portal that provides access to a personal health record, tracks personal wellness, permits appointment scheduling and offers a mail-order pharmacy;
- Full discussion of all prescription choices and costs with the doctor;
- Ability of the doctor to write an electronic prescription on the spot for transmission to retail or mail-order pharmacy;
- Incorporates fitness testing and total lifestyle coaching personalized for an individual's needs;
- Permits submission of medical questions in advance of the appointment that are incorporated into the physician visit, or that can be answered on-line by a doctor or nurse practitioner;
- More time with the doctor and less total time on-site in the medical facility; and
- Payment/discounts/deductions from personal health accounts occur at the point-of-sale.

Chapter 5: Integrated Health Metrics – How to Make the Business Case and Measure Results

Explaining to a CFO that you want to spend a million dollars to change people's behavior is a tough sell unless you have credible metrics.

One of the challenges facing proponents of consumerism and health management programs is quantifying the value proposition to the chief financial officer.

It's imperative that employers determine the right program metrics to identify which program components are most effective, and which programs need improvement. In developing your strategy for measuring results, keep the following in mind with regards to metrics:

- They must be integrated so they measure the entire program;
- They must be tied to overall financial outcomes. The CFO must recognize the programs value;
- Individual vendors must be assessed based on their contribution to the entire program, not just the standalone service they offer;
- Must be actuarially validated; and
- They must provide real-time insight into opportunities for interventions on an ongoing basis.

Health and wellness management programs have been greeted with considerable doubt since their inception. Skeptics often assert, quite correctly, that the evidence demonstrating the programs' economic value has been scant and at times conflicting. A frequent criticism of wellness programs, for instance, has been that it is primarily healthy people who participate – and they are not driving cost.

Clearly, there are some inherent difficulties in measuring the economic value of behavior change. It is certainly easier to measure the savings for shifting an actual claim than it is to measure a claim that never occurred. Yet, prevention and more prudent usage of healthcare services is the intended outcome of a more engaged employee.

Measurement is further complicated by the fragmented, dynamic nature of healthcare and the resultant "noise" within the data of a typical health plan. In practice, it is nearly impossible to neutralize all of the factors influencing the consumption of healthcare and isolate cause-and-effect for a specific health management initiative. Changes in plan design, enrollment, provider reimbursement levels as well as statistical anomalies can all muddy the waters when it comes to recognizing and understanding utilization patterns. Consequently, sound actuarial methodologies and statistical principles are critically important when it comes to quantifying the impact of health management and consumerism initiatives.

Human resource and benefits professionals need to make a persuasive case to senior management that investing in a culture of health will ultimately improve bottom-line results. In the final analysis, the success of any organizational strategy depends on a sound business case supported by hard data and a clear, positive return on investment. In developing and implementing a consumerism strategy, every employer should consider the steps outlined on page 62.

Return on Investment versus Net Savings

How should an employer gauge their level of investment in care management programs like disease, case, wellness coaching, and 24 hour nurse line? Explaining to a CFO that you want to spend a million dollars to change people's behavior is a tough sell unless you have credible metrics.

"Return on Investment" is the most commonly used and misunderstood metric in the field of healthcare. Care management vendors, in particular, use ROI to demonstrate the value of their services to skeptical financial executives. While this comfortably familiar term promises quantitative rigor, there are no standard, generally accepted methodologies for calculation of ROI and thus no easy way to compare different vendor offerings. In cases where clients have used multiple specialty vendors, each vendor's ROI calculation may take credit for savings achieved by others. Adding up the ROI's, one might conclude that the healthcare should be free! Sometimes an external advisor will provide the employer with a standardized method for calculating ROI and specify that vendors comply with this method for purposes of responding to an RFP.

So is a high ROI a good thing? Are companies who demonstrate higher ROIs more effective at service delivery? Not necessarily. ROI is closely tied to the potential health savings per episode of care. The highest return is generated by creating limited care management programs that touch a small portion of the population who are very sick – for example, case management of catastrophic illnesses like cancer. A 10 to 1 return on investment might result in $1,000,000 in net savings for a company.

That same employer might consider a program that touches not only the catastrophically ill, but all individuals with significant chronic conditions – perhaps 11 percent of the population. Proper condition management and the application of evidence-based medicine will also generate savings, but in smaller increments per intervention. The return on investment may come down substantially – say 2.5 to 1. However, by touching over 11 percent of the population, the company may achieve net savings of $5,000,000 off the total healthcare cost trend.

Another consideration is the payback period. While case management and utilization reviews can drive an immediate payback in year one, disease management and wellness interventions may increase costs in year one but drive three to five year savings by preventing future health claims. A typical disease management scenario may achieve a year one ROI of only 1.2 to 1, with an increase of 4 to 1 or 5 to 1 in year two, and flattening to around a 2 to 1 payback every year thereafter. For that reason, disease management is much less effective with high turnover populations, but is an excellent choice for employers with stable, long tenure workforces.

SHPS uses ROI calculations, as do other care management vendors, but also advocates the use of another measurement methodology: actuarially validated net savings. This type of calculation ties the results of all care management interventions – and in fact, program interventions – back to the actual health cost numbers reported to a CFO for generating financial statements. This method has several advantages:

- Transparency to financial statements;
- Looks at the entire health program, rather than individual interventions;
- Allows for analysis to identify the contribution to net savings from each individual program element; and
- Allows employers greater insight into how deeply to invest in health and wellness programs.

In essence, you continue building up your programs over a period of two to three years, until $1 in investment no longer yields more than a dollar in net annuals savings from trend.

Develop the business case: A compelling rationale is needed before embarking on fundamental changes in program design and benefits structure. Employers should use their own data to establish the baseline across their covered population. Key steps in the process are described below:

- Compare the disease burden, compliance with evidence-based medicine and utilization levels relative to benchmarks;
- Assess the opportunity to improve health and financial outcomes through behavior change;
- Measure the savings associated with a step change in health improvement and employee engagement;
- Compute the incremental costs involved in capturing these savings; and
- Calculate return on investment and net savings using an actuarially-sound methodology.

Establish and monitor key performance metrics: Employers should determine criteria for success and select metrics that will be used to measure performance. Fortunately, technological advances in business intelligence software have provided more robust data mining, risk scoring and predictive modeling tools to meet these new challenges. SHPS recommends using reports that measure and evaluate program effectiveness across population segments, including indicators for:

- Clinical health and lifestyle risk;
- Utilization of health services;
- Member engagement;
- Compliance with evidence-based medicine; and
- Net savings/return on investment.

In developing the ROI methodology, the application of actuarially validated principles, such as multivariate analysis, is essential to assure that savings from multiple programs are appropriately apportioned.

Create infrastructure for aggregated reporting: Employers that embrace a financially rigorous approach to performance measurement should create a centralized data repository. A centralized data warehouse can provide employers with a unified, global view that will offer a clear line-of-sight on the interplay of various factors influencing healthcare behavior and consumption.

Most data warehouses include enrollment and eligibility data as well as medical and pharmacy claims. Many employers include health risk assessments, which improve predictive accuracy leading to more effective clinical interventions. In order to measure the impact of health management on work force productivity, compensation and absenteeism data may be incorporated as well. In the future, mining of additional data sources (e.g., job classification, family history, laboratory data, program participation data, case data and employee behavior) may lead to further enhancements in predictive accuracy and ROI methodologies.

Fig. 20: An Executive Dashboard provides a high level overview of key performance metrics.

Summary of Key Statistics

	Baseline	Q1	Q2	Q3	Q4
Eligible Members					
Self-insured plans (EEs)	27,274	27,152	27,267	27,173	27,163
HRA Participants	51,821	51,589	51,807	51,629	51,610
Severity Level					
Well		21,151	21,242	21,174	21,170
At-Risk		12,897	12,953	12,914	12,912
Chronic Conditions		15,477	15,542	15,489	15,483
Catastrophic Conditions		2,064	2,070	2,052	2,045
Clinical Measures					
Diabetes - Average HbA1c Test Result	7.38	7.23	7.09	6.95	6.81
Cardiovascular - % Receiving Lipid Testing - Past 12 Months	74.0%	82.0%	90.2%	96.0%	99.0%
Cardiovascular - % Receiving ACE Inhibitor / ARBII	80.0%	86.0%	95.0%	96.0%	98.0%
Hyperlipidemia - % with Lipid Testing - Past 12 Months	26.0%	18.0%	24.0%	59.0%	86.0%
Clinical Health					
SHPS Clinical Risk Score	1,000	1,010	1,020	1,005	995
HRA Lifestyle Risk Score	1,060	1,030	1,020	1,010	1,010
Evidence Based Medicine (% compliant)	54%	55%	55%	56%	57%
Financial Measures					
PMPM Cost Trend		2.6%	3.2%	4.3%	5.2%
Net Savings		$0.53M	$0.63M	$0.55M	$0.61M
ROI		0.86 to 1	1.26 to 1	1.06 to 1	1.06 to 1

Administrative Measures

	Goal	Q1	Q2	Q3	Q4
Participation					
HRA	70%	65.0%	73.7%	78.0%	83.0%
HRA - Behavior Mod.	40%	38.5%	40.2%	42.7%	43.7%
Livingwise	50%	23.0%	45.0%	56.0%	78.0%
Nurse Helpline	50%	71.3%	74.0%	76.9%	77.5%
Disease Management	60%	57.0%	59.2%	61.5%	62.0%
Member Satisfaction					
HRA	95%	98%	99%	97%	98%
Behavior Modification	95%	80%	90%	95%	97%
Nurse Helpline	95%	100%	97%	94%	96%
Disease Management	95%	90%	96%	97%	98%

Return on Investment

	Q1	Q2	Q3	Q4	Total
Total Savings	$1.14M	$1.14M	$1.08M	$1.18M	$4.53M
SHPS Fees	$0.61M	$0.50M	$0.52M	$0.57M	$2.21M
Net Savings	$0.53M	$0.63M	$0.63M	$0.61M	$2.32M
Return on Investment	0.95 to 1	1.26 to 1	1.06 to 1	1.06 to 1	1.05 to 1

Utilization Measures

	Goal	Q1	Q2	Q3	Q4
Aggregate					
Admits/1,000	51	53	52	51	48
Bed Days/1,000	162	170	165	162	162
Average Length of Stay	3.2	3.2	3.2	3.2	3.4
ER Visits/1,000	145	146	143	146	142
IP Readmission %	2.9%	3.2%	3.0%	2.9%	2.8%
OP Surgery/1,000	121	126.0	124.3	121.5	120.9
Office Visits/1,000	2,940	2,999	2,993	2,939	2,937
Scripts/1,000	11.0	10.2	10.5	10.9	11.3
12 Disease States					
Admits/1,000	23	23	22	22	21
Bed Days/1,000	72	78	73	74	72
Average Length of Stay	3.2	3.5	3.4	3.2	3.2
ER Visits/1,000	52	53	52	52	51
IP Readmission %	3.4%	2.8%	3.3%	3.4%	3.2%
OP Surgery/1,000	53	55	54	53	53
Office Visits/1,000	1,220	1,228	1,225	1,216	1,202
Scripts/1,000	7.2	6.6	6.8	7.1	7.3

Key
- Exceeding or meeting target
- Close but not quite at target
- Needs more work

What should an employer measure before embarking on a consumerism strategy? You should focus on:

- Identifying the biggest burden on the population in terms of severity and breadth; and
- Finding out what is driving the illness and cost.

Benchmarking your population allows you to identify the population's bad habits, determine current status and estimate the migration possibilities from their existing status. The important measurement categories include:

- Lifestyle behavior;
- Clinical behavior/modification; and
- Ability to participate in programs designed to affect the above.

Key questions employers need to consider about their population, both in implementing a consumerism strategy and ongoing–since your program will require constant tweaking based on program reporting–include:

- Is my population in better compliance with evidence-based medicine?
- Are they making the right choices from a clinical standpoint?
- Are they doing the right things to reduce moderate to high risk factors?
- Are they using the decision support tools given to them?
- Ultimately, are they changing behavior?

Final Thoughts on Healthcare Consumerism

Without a fundamental structural change, our current healthcare system will collapse under its own weight – an ugly truth that will not go away, regardless of whether we pay for our health insurance through individual premiums, payroll deductions, or state or federal taxes. We believe that healthcare consumerism will be a permanent part of our country's changing healthcare landscape.

Final Thoughts on Healthcare Consumerism

Both employees and employers have become passionate and aggressive about controlling healthcare cost and quality. Some employees and health advocacy organizations have cynically accused employers of using consumerism as a euphemism for cost shifting and discrimination against the unwell. We understand the frustrations of employees, who have seen their healthcare costs rise by 10 percent or more each year for the past three years, while real wages have increased a mere one to three percent.

At the same time, employers are equally frustrated. They see healthcare eroding profitability and competitiveness. Based on focus groups with large diverse employers, it is clear that most remain committed to providing healthcare for their employees, and they see it in their best interest to do so. For them, consumerism is a strategy to preserve the health benefits their employees so greatly prize.

The one theme we consistently hear from our clients is that they would like their employees to "take more responsibility for their own health." What exactly do they mean? A client of ours, the vice president of human resources for a large firm put it this way:

"If an employee gets into a car accident on the freeway, we are glad to pay the hospital to get them back on their feet. If an employee has the bad fortune to suffer a catastrophic illness, like breast cancer or leukemia, we will support them in every way we can. What bothers me is the employee who has severe asthma, fails to use their medication, smokes three packs a day, and keeps cats in her house against the advice of her doctor."

This gets to the crux of the consumerism argument. The fundamental concept of health coverage is very noble: by pooling the health risks of large groups of people, we as a society, through private employers, payors and government agencies, can guarantee that anyone who gets sick or hurt is cared for, and their family will not suffer catastrophic financial loss. The system provides a level of personal security and stability which is good for the individual, employer and society alike.

But what happens when 50 percent of covered healthcare costs are driven by avoidable personal behavior and lifestyle choices within our covered populations? Should individuals be free to choose smoking, poor nutrition, lack of exercise and avoidance of preventive healthcare as lifestyle choices? Absolutely, but those who choose to follow healthier lifestyles should be rewarded for doing so. Moreover, our current healthcare system does not reward prevention – it rewards

treatment of acute care services closely associated with poor lifestyle choices. The value for convincing 100 people to stop smoking, lose weight, and exercise regularly accrues primarily to the employer through avoidance of medical expense (and to the healthier lives created). The actuarially equivalent value of treating four new patients for heart bypass surgery accrues to the healthcare industry.

SHPS believes that no one should be denied healthcare coverage for conditions beyond their control. The challenge is to design a system that provides fair and equitable coverage for everyone, encourages healthy behavior and intelligent health purchasing decisions and transforms the healthcare system to deliver better overall value.

The early returns suggest that most employees, many providers, and some payors don't like consumerism. But without a fundamental structural change, our current healthcare system will collapse under its own weight – an ugly truth that will not go away, regardless of whether we pay for our health insurance through individual premiums, payroll deductions, or state or federal taxes. We believe that healthcare consumerism will be a permanent part of our country's changing healthcare landscape. In some form:

- Healthcare will become more focused on the individual;
- Visibility will evolve around pricing and quality;
- The influence of the healthcare network will evolve to personalized and specialty or pay-for-performance networks to stratify risk and manage costs based upon reinventing delivery around wellness and disease states; and
- A branded healthcare experience will exist, particularly for primary care, specialty care and chronic diseases.

While consumerism requires employees to be better consumers of healthcare, it also requires employers to be better suppliers of healthcare. That means understanding your workforce's unique needs and demographics and supplying them with relevant information, the right mix of decision-support tools and the preferred communication medium to maximize awareness during the annual enrollment event and ongoing throughout the year.

The concept of employee financial and information empowerment is very strong, and SHPS is committed to supporting the coming transformation.

About SHPS

SHPS provides a broad range of innovative health management tools, resources and services that empower consumers to make wise healthcare decisions. With comprehensive services that transform consumer health behaviors, SHPS' integrated delivery system maximizes the value of consumers' and employers' healthcare dollars.

SHPS business lines:

Employer Solutions

- Spending accounts & incentives
- Benefit plan administration
- Care management
- Advocacy services
- Productivity management
- Program design & communications

Partner Solutions

- Financial & administrative services
- Clinical services & medical management
- Cost management strategies
- Software & technology
- Fulfillment & communications

For more information about healthcare consumerism and its benefits for your organization, please call us at 1-888-421-SHPS (7477) or visit www.shps.com.

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