Innovative Employer Benefits Strategies and the Business Value of Health

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Presentation content

- Business value of a healthy workforce
- Benefits innovations – demand-side strategies
- Benefits innovations – supply-side strategies
- Integrating demand and supply approaches
- Summary: employer action steps
Traditional view of employee value

Value = Work output - Cost

<table>
<thead>
<tr>
<th>Responsible department</th>
<th>Operations</th>
<th>Human Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Components</td>
<td>Business productivity</td>
<td>Wages, health benefits, WC costs, recruitment, vacation…</td>
</tr>
<tr>
<td></td>
<td>Supply chain management</td>
<td></td>
</tr>
<tr>
<td>Representative metrics</td>
<td>- Labor hours per unit</td>
<td>- PEPY healthcare costs</td>
</tr>
<tr>
<td></td>
<td>- Waste as % of total output</td>
<td>- Employee engagement</td>
</tr>
<tr>
<td></td>
<td>- Revenue per employee</td>
<td>- Turnover rate</td>
</tr>
</tbody>
</table>

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## Evolution of health as a business imperative

<table>
<thead>
<tr>
<th>Organizational Tactics</th>
<th>Measurement Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal offerings</td>
<td>Not monitored</td>
</tr>
<tr>
<td>Program-based offerings</td>
<td>Program-specific metrics (ROI)</td>
</tr>
<tr>
<td>(health impacts medical costs)</td>
<td></td>
</tr>
<tr>
<td>Integrated health and productivity programs</td>
<td>Health &amp; productivity metrics integration (total cost/value)</td>
</tr>
<tr>
<td>(health impacts productivity)</td>
<td></td>
</tr>
<tr>
<td>Organizational policies and practices</td>
<td>Comprehensive integration and reporting (business/shareholder value)</td>
</tr>
<tr>
<td>influencing health</td>
<td></td>
</tr>
<tr>
<td>(health impacts revenue)</td>
<td></td>
</tr>
</tbody>
</table>
What’s the value of a healthy workforce?

- Triple Aim goals
  - Improved quality
  - Better health outcomes
  - Lower healthcare costs
- Lies in alignment of health management strategy with company business strategy
  - Increased worker productivity
  - Enhanced worker performance
  - Increased company profitability
- Optimal services generate optimal value
Higher well-being is associated with improved workplace performance

Healthways, 2011.
What if business and HR metrics were more effectively – and strategically – integrated?

Compelling opportunities exist to more closely link health and business goals.
Companies with health as a business imperative achieve significantly better financial outcomes and lower employee turnover.

**Better Market Premium**
- Companies that effectively treat health as a business imperative: 11.70%
- Companies that do NOT effectively link health to business imperatives: -15.85%

**Reduced Turnover Rates**
- Companies that effectively treat health as a business imperative: 14.80%
- Companies that do NOT effectively link health to business imperatives: 21%
## Representative business metrics

<table>
<thead>
<tr>
<th>Industry</th>
<th>Individual business performance metrics</th>
<th>Aggregate business performance metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>All industries</td>
<td>Supervisor performance evaluation</td>
<td>Voluntary turnover rate</td>
</tr>
<tr>
<td></td>
<td>Workplace accident rate</td>
<td>OSHA injury rate and WC costs</td>
</tr>
<tr>
<td></td>
<td>Employee engagement</td>
<td>Net income</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Customer satisfaction</td>
</tr>
<tr>
<td>Insurance</td>
<td>Average handling time of claims</td>
<td>Average insurance policy size</td>
</tr>
<tr>
<td></td>
<td>Net written premium amount</td>
<td>Average handling time of claims</td>
</tr>
<tr>
<td></td>
<td>Number of new insurance policies</td>
<td>Net written premium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of new insurance policies</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>Quantity of merchandise produced</td>
<td>Throughput/work unit</td>
</tr>
<tr>
<td></td>
<td>Value of merchandise produced</td>
<td>Defects per million opportunities</td>
</tr>
<tr>
<td></td>
<td>Occupational injury prevalence</td>
<td>Production plan variance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Man-hour per equivalent unit</td>
</tr>
<tr>
<td>Retail</td>
<td>Shelf stocking efficiency</td>
<td>Comp stores sales growth year over year</td>
</tr>
<tr>
<td></td>
<td>Sales transactions per selling hour</td>
<td>Customer satisfaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Profit per customer visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sales per selling hour</td>
</tr>
<tr>
<td>Call center</td>
<td>First call resolution rate</td>
<td>First call resolution rate</td>
</tr>
<tr>
<td></td>
<td>Average time to answer calls</td>
<td>Contact quality</td>
</tr>
<tr>
<td></td>
<td>Calls handled per hour</td>
<td>Customer satisfaction</td>
</tr>
</tbody>
</table>

Adapted from Healthy Employees, Healthy Profits, Optum 2012. Used with permission.
The value of data...

- Data analysis can focus investment strategies to maximize not just health, but business value

- Merge health/productivity and business metrics to strengthen business case for investments in workforce health and well-being
  - Individual level – health, well-being, and work performance
  - Organization level – business performance and profitability
Supply and demand strategies for managing healthcare costs

Supply side
- Healthcare delivery innovation
- Condition management
- Lifestyle behavior mgmt.
- Employee assistance program
- Worksite clinics
- Retail clinics

Demand side
- Cost-shifting
- Insurance design
  - Value-based
  - Account-based plans
- Incentives/penalties

Expanded focus areas:
- well-being as a broader health construct
- workplace “environment of health”
- organizational “culture of health”
The health – cost connection

- Unhealthy behaviors and health risks lead to chronic conditions
- Chronic conditions drive healthcare utilization
- Healthcare utilization drives healthcare costs

More than 75% of healthcare costs are the result of chronic conditions\(^1\).

About 70% of healthcare costs are due to unhealthy behaviors\(^2\).

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\(^1\) [www.cdc.gov/chronicdisease/resources/publications/AAG/chronic.htm](http://www.cdc.gov/chronicdisease/resources/publications/AAG/chronic.htm)

\(^2\) [The Costs of Unhealthy Behaviors. WELCOA, 2007](http://www.welcoa.org/Publications/HealthcareCosts.html)
Employer focus continues to be cost-based

Q: What do you consider the top 3 most effective steps you have taken or will take to control health care cost increases?

<table>
<thead>
<tr>
<th>Most Effective Tactic</th>
<th>Second Most Effective Tactic</th>
<th>Third Most Effective Tactic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased employee cost-sharing</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td>Consumer–directed health plan (CDHP)</td>
<td>23%</td>
<td>14%</td>
</tr>
<tr>
<td>Wellness initiatives to improve employee health</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Care management</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>Pharmacy benefit design changes</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>Utilization management</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Disease/condition management</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Dependent eligibility audit</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Specialty drug management initiative</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>Quality-focused tier networks</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Demand-side strategies

- Historically focused on cost control
- Current approaches promote use of high-value services
  - Preventive care
  - Generic medications
  - Incentives
  - Value-based insurance design (VBID/VBBD)

Issues:
- Can’t manage costs by managing cost
- Approach assumes healthcare services are commoditized
- Quality has not been a significant focus
Employer top challenges

- Motivating participants to promote behavior change: 65%
- Government compliance and regulations: 35%
- Managing the health of an aging workforce: 30%
- Cultural shift and reluctance to change: 29%
- Understanding employee attitudes toward health and wellness: 28%

Aon Hewitt 2012 Health Care Survey
Unhealthy behaviors are a major focus

8 risks and behaviors:
- Excessive Alcohol Consumption
- Insufficient Sleep
- Poor Standard of Care
- Poor Stress Management
- Smoking
- Lack of Health Screening
- Physical Inactivity
- Poor Diet

Drive 15 chronic conditions:
- Diabetes
- Coronary Artery Disease
- Hypertension
- Back Pain
- Obesity
- Cancer
- Asthma
- Arthritis
- Allergies
- Sinusitis
- Depression
- Congestive Heart Failure
- Lung Disease (COPD)
- Kidney Disease
- High Cholesterol

Accounting for 80% of total costs for all chronic illnesses worldwide.
Use of financial incentives in wellness programs is becoming more prevalent.

<table>
<thead>
<tr>
<th>Use financial incentives</th>
<th>2011</th>
<th>2012</th>
<th>Planned for 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>for individuals who participate in health management programs/activities</td>
<td>54%</td>
<td>61%</td>
<td>21%</td>
</tr>
<tr>
<td>Use penalties (e.g., increase premiums and/or deductibles) for individuals not completing requirements of health management programs/activities</td>
<td>19%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>Reward (or penalize) based on smoker, tobacco-use status</td>
<td>30%</td>
<td>35%</td>
<td>17%</td>
</tr>
<tr>
<td>Reward (or penalize) based on biometric outcomes other than smoker, tobacco-use status (e.g., achievement of weight control or target cholesterol levels)</td>
<td>12%</td>
<td>10%</td>
<td>23%</td>
</tr>
</tbody>
</table>
Median incentive amounts for healthy lifestyles are increasing.
## Sample multi-year incentive design

<table>
<thead>
<tr>
<th>Category</th>
<th>Year 1 Wellness Goals</th>
<th>Year 2 Wellness Goals</th>
<th>Year 3 Wellness Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participation in HRA</strong></td>
<td>Mandatory</td>
<td>Mandatory</td>
<td>Mandatory</td>
</tr>
<tr>
<td><strong>Tobacco/Nicotine:</strong></td>
<td>Affidavit: Tobacco Free -or- Completion of Smoking Cessation Program</td>
<td>Negative Test Result -or- Completion of Smoking Cessation Program</td>
<td>Negative Test Result -or- Completion of Smoking Cessation Program</td>
</tr>
<tr>
<td><strong>Physical Activity</strong></td>
<td>Completion of Walking Challenge</td>
<td>Completion of Challenge</td>
<td>Log a minimum of 90 minutes of exercise per week</td>
</tr>
<tr>
<td><strong>Age Appropriate Screenings</strong></td>
<td>Mandatory</td>
<td>Mandatory</td>
<td>Mandatory</td>
</tr>
<tr>
<td><strong>Blood Pressure:</strong></td>
<td>Participate</td>
<td>( \leq 135/90 )</td>
<td>( \leq 120/80 )</td>
</tr>
<tr>
<td><strong>Glucose:</strong></td>
<td>Participate</td>
<td>( \leq 125 )</td>
<td>( \leq 100 )</td>
</tr>
<tr>
<td><strong>Cholesterol:</strong></td>
<td>Participate</td>
<td>( \leq 4.0 ) (Cardiac Ratio)</td>
<td>( \leq 4.0 ) (Cardiac Ratio)</td>
</tr>
<tr>
<td><strong>Body Mass Index:</strong></td>
<td>Participate</td>
<td>( \leq 30.0 )</td>
<td>( \leq 27.0 )</td>
</tr>
<tr>
<td><strong>Coaching:</strong></td>
<td>Participate</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>Impact</strong></td>
<td>Qualify for Incentive</td>
<td>Up to 20% Reduction in Premium Contribution</td>
<td>Up to 20% Reduction in Premium Contribution</td>
</tr>
</tbody>
</table>

Adapted from Provant Health Solutions, 2012. Used with permission.
PPACA: expanding the role for incentives in benefit design

- Currently, employers may use up to 20% of the total amount of an employee’s health insurance premium to provide outcome-based wellness incentives.
- In 2014, this will increase to 30% (up to 50% discretion per HHS)
- Outcomes-based incentives for healthy behaviors
  - Essential components: Organizational assessment, goals, target population, design
- Penalties vs. rewards
  - People may be more motivated to avoid loss (i.e., penalties) than to make equivalent gains.
  - Rewards for healthy behavior are more consistent with a long-term strategy of creating a partnership culture.
Supply-side strategies

- Newer focus for employers/plan sponsors
- Focus on service delivery efficiency and effectiveness
- Reflects intent to move “upstream” in the delivery chain to improve outcomes

What do employers understand about healthcare quality?
Employers aren’t happy with health plan vendors, but don’t appear to be demanding change

- Changing member behavior to drive more efficient use of health care services: 75% Favorable, 21% Neutral, 4% Unfavorable
- Changing member behavior related to making healthy lifestyle decisions: 74% Favorable, 21% Neutral, 5% Unfavorable
- Driving care to higher-quality providers: 68% Favorable, 25% Neutral, 7% Unfavorable
- Offering members information to help make clinical decisions regarding preference-sensitive care (such as back surgery, breast surgery, prostate surgery): 68% Favorable, 25% Neutral, 7% Unfavorable
- Engaging members in health improvement programs: 63% Favorable, 29% Neutral, 8% Unfavorable
- Identifying members who are not getting evidence-based care and intervening to correct “gaps” in care: 63% Favorable, 28% Neutral, 9% Unfavorable
- Engaging members in condition management programs: 60% Favorable, 32% Neutral, 8% Unfavorable
- Encouraging members to comply with appropriate preventive care guidelines: 58% Favorable, 31% Neutral, 11% Unfavorable

Employers and the healthcare supply chain

- Business supply chain vs. healthcare supply chain
- How have employers impacted the healthcare supply chain?
  - Understanding and incentivizing quality
    - eValue8
    - Pay for performance/Bridges to Excellence
    - Leapfrog
    - Community quality reporting initiatives
- High performance networks/Centers of Excellence
- Direct contracting
- Worksite clinics
Employer tactics to improve care quality

- Participate in a community-based pilot program (e.g., patient-centered medical home, ACO)
  - Consistent performers: 4%
  - Low performers: 1%
- Audit your PBM
  - Consistent performers: 16%
  - Low performers: 35%
- Integrate multiple vendors to improve the delivery of information to our members (e.g., vendor summits)
  - Consistent performers: 16%
  - Low performers: 31%
- Consolidate health and productivity programs with health plan
  - Consistent performers: 24%
  - Low performers: 13%
- Offer high-performance network(s)
  - Consistent performers: 16%
  - Low performers: 25%
- Renegotiate financial arrangements (e.g., ingredient costs, rebates) with current pharmacy benefit manager (PBM)
  - Consistent performers: 45%
  - Low performers: 30%
- Audit of medical claim payments
  - Consistent performers: 42%
  - Low performers: 30%
- Conduct a PBM vendor procurement
  - Consistent performers: 31%
  - Low performers: 29%
- Use centers of excellence for treatments other than transplants (e.g., specialty treatment networks)
  - Consistent performers: 22%
  - Low performers: 35%

Employer strategies for monitoring supply-side services

- Use hard-dollar return-on-investment calculations to support future decisions: 33%
- Purchase sophisticated analyses of health plan cost and use: 28%
- Require plans to provide complete extracts of claim data (e.g., including discounts and identifying providers): 37%
- Base decisions on health outcomes (e.g., illness burden): 47%
- Base decisions on predictive modeling: 49%
- Base decisions on provider quality indicators: 35%
- Implement data warehouse: 45%

Innovative employer strategies to improve quality and lower costs

- Evolving specialized approaches
  - Consumerism tools
  - Centers of Excellence and direct contracting with bundled pricing
  - Tiered networks
  - Narrow networks
  - Reference-based pricing
  - Outcomes-based clinician/facility incentive payments
  - Direct contracting with ACOs and worksite clinics
Managing cost and reducing unnecessary expense

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Currently in Place</th>
<th>Adding in 2012</th>
<th>May Add in 3–5 Years</th>
<th>Not Interested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use high-performing or specialty networks offered through your health plan</td>
<td>38%</td>
<td>46%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Cover domestic centers of excellence</td>
<td>28%</td>
<td>39%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Increase participants’ deductibles and/or copays</td>
<td>28%</td>
<td>16%</td>
<td>46%</td>
<td>10%</td>
</tr>
<tr>
<td>Tightly manage health of the chronically ill</td>
<td>25%</td>
<td>54%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Increase or decrease vendor compensation based on specific performance targets</td>
<td>25%</td>
<td>44%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Adopt a best-in-market model with one common plan and variable networks by state or region</td>
<td>18%</td>
<td>37%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Participate in cooperative purchasing efforts with other employers or groups</td>
<td>18%</td>
<td>36%</td>
<td>44%</td>
<td></td>
</tr>
</tbody>
</table>

Aon Hewitt 2012 Health Care Survey
Employers offering price transparency tools

- Yes, through our health plan: 65%
- Yes, through a 3rd party vendor: 14%
- No: 21%

Large Employers’ 2013 Health Plan Design Survey, NBGH
NCQA Diabetes Recognition Program (DRP) certification and impact on quality of care

Patients of DRP clinicians had:
- Greater medication use
- More office visits
- Fewer ED and inpatient visits
- Lower healthcare costs ($3,424 vs. $4,097)

Higher quality care results in improved efficiency of care delivery and lower costs

Direct contracting with providers

- **Surgical Centers of Excellence**
  - Currently: 11%
  - Considering: 21%

- **Patient-centered medical home (PCMH)**
  - Currently: 11%
  - Considering: 18%

- **Intensive outpatient services (e.g., high cost or chronic cases)**
  - Currently: 3%
  - Considering: 20%

Note: Respondents were allowed to select more than one option.

Large Employers’ 2013 Health Plan Design Survey, NBGH
Use of COEs and second opinion services

- Centers of Excellence for transplants: 28% offer service and differentiate cost-sharing, 57% offer service but don't differentiate cost-sharing
- Centers of Excellence for selected conditions other than transplants: 30% offer service and differentiate cost-sharing, 46% offer service but don't differentiate cost-sharing
- Second opinion services: 7% offer service, 42% offer service
- High performance networks: 10% offer service, 32% offer service
- Patient-centered medical home: 6% offer service, 22% offer service

Large Employers’ 2013 Health Plan Design Survey, NBGH
Investments in primary care provide the highest value to the healthcare system

<table>
<thead>
<tr>
<th>Cost Drivers in Health Care System</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>61%</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>50%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>47%</td>
</tr>
<tr>
<td>Specialty care</td>
<td>46%</td>
</tr>
<tr>
<td>Wellness programs</td>
<td>43%</td>
</tr>
<tr>
<td>Health insurance plans</td>
<td>39%</td>
</tr>
<tr>
<td>Retail clinics</td>
<td>31%</td>
</tr>
</tbody>
</table>

*Large Employers’ 2013 Health Plan Design Survey, NBGH*
Typical US employer healthcare cost distribution

- Primary care: 39%
- Outpatient: 34%
- Inpatient: 19%
- Pharmacy: 6%
- Emergency dept.: 3%

Current state

• By improving care quality with a PCMH, primary care costs will increase.
• However, implementation of PCMH has been shown to result in lower hospitalization rates – leading to lower overall health care costs.

PCMH implementation

Thomson Reuters and MarketScan and Milliman databases, 2010
Putting it all together: Integrate supply and demand strategies to maximize value

- Identify high-value services; steer individuals accordingly

<table>
<thead>
<tr>
<th>Offering</th>
<th>Supply strategy</th>
<th>Utilization incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers of Excellence</td>
<td>Use quality facilities</td>
<td>Waived co-pay</td>
</tr>
<tr>
<td>Generic medications</td>
<td>Chronic meds</td>
<td>Waived co-pay if DM participation</td>
</tr>
<tr>
<td>Lifestyle management</td>
<td>Outcomes-based, participation-driven</td>
<td>Higher benefit tier for non-participants</td>
</tr>
<tr>
<td>Minimally invasive surgery</td>
<td>Specific experience</td>
<td>Waived co-pay</td>
</tr>
<tr>
<td>Reference-based pricing</td>
<td>Low cost service use</td>
<td>Cap coverage at low cost pricing</td>
</tr>
<tr>
<td>Patient-centered medical home</td>
<td>NCQA-recognized practices</td>
<td>Reduced co-pay</td>
</tr>
</tbody>
</table>
Summary: Employer action steps

- **Data drives decision-making**
  - Demand actionable data from health plans – identify issues and opportunities

- **Supply chain strategies:**
  - Incorporate *meaningful* performance metrics into plan contracts
  - Demand system improvements in care delivery – or take independent action
  - Identify efficient, high quality clinicians and hospitals, and promote use

- **Demand-side (benefit design) strategies:**
  - Understand population health profile and utilization patterns to identify improvement opportunities – condition management, primary care
  - Prioritize interventions based on anticipated value to the organization

- Integrate supply and demand management strategies to maximize value of healthcare investments [expenditures]
- Don’t forget to review HR policies to ensure they’re aligned with promoting a healthy workforce
Thanks for your attention!

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