

# BEST PRACTICES IN MANAGING EMPLOYEE HEALTH (AND HEALTH BENEFIT COSTS)

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How do you maintain competitive health benefits to attract and retain top notch employees, while halting skyrocketing healthcare premiums? This is a profound dilemma for U.S. employers caught between two major macro-economic trends: rising health costs and a shrinking workforce.

Within the last five years, employer healthcare costs have jumped 43 percent, arising in part from the cumulative effect of ongoing inflation.<sup>1</sup> In 2003, companies averaged a gross healthcare outlay of \$5,100 per employ-

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ee—today they pay more than \$7,700.<sup>2</sup> Total U.S. health expenditures reached \$2.1 trillion in 2006 and are projected to grow to more than \$4.0 trillion by 2016, an increase of more than 6.6 percent per year.<sup>3</sup> U.S. employers (who provide health coverage for roughly 177 million covered lives today at the cost of \$1.2 trillion in healthcare spending) will bear the brunt of this increase.<sup>4</sup>

At the same time, the United States is facing a major labor shortage—particularly for skilled professionals. The Employment Policy Foundation predicts that we will have 4.3 million more jobs than workers in 2011 and 35 million more jobs than workers by 2031. While current economic conditions are top of mind for many companies, employment analysts suggest that now is the time for employers to plan and build the workplace environment needed to remain competitive in a tight labor market.

## **THE FAILURE OF TRADITIONAL HEALTH COST MANAGEMENT**

Historically, employers managed healthcare costs through procurement and benefit design practices focused on unit costs, such as network discounts, and prevention of unnecessary care through traditional techniques, such as co-insurance, deductibles, limitation of covered services, and utilization review. However, as healthcare expenditures continue to rise, these cost management techniques are no longer proving effective.

Today, the most important driver of healthcare costs is the increased demand for healthcare-related services. Research suggests that more than 70 percent of healthcare utilization is driven by the treatment and complications of chronic diseases such as diabetes, cardio-vascular, pulmonary, and renal disorders. While partially explained by an aging U.S. population, the occurrence of chronic conditions and the associated rise in healthcare utilization are primarily attributed to increasingly

## EXHIBIT 1

**Diminishing impact of supply-side cost management strategies**

Traditional cost management technique	Cause of diminishing impact on the healthcare cost trend
Negotiated network discounts	<ul style="list-style-type: none"> <li>• Differences in pricing, geographic coverage and quality between top tier networks are no longer materially significant</li> <li>• Cost per procedure is poorly correlated with total cost per episode of care due to enormous variations in provider quality</li> </ul>
Benefit design	<ul style="list-style-type: none"> <li>• Marginal increases in the incidence of acute or catastrophic care can off-set savings from higher deductibles, co-pays, and coverage restrictions</li> </ul>
Formulary design	<ul style="list-style-type: none"> <li>• Savings are less important than the cost-impact from non-compliance with medication protocols for chronic conditions</li> </ul>
Cost sharing	<ul style="list-style-type: none"> <li>• Generates one time savings, but does not impact long-term health trend</li> </ul>

unhealthy lifestyles and poor self-care. According to the Centers for Disease Control and Prevention, 55 percent of healthcare costs in the U.S. are driven by personal behavior. As such, improving the overall health of individuals and optimizing utilization of healthcare services are believed to be the only viable long-term solutions to rising healthcare costs.

Recently, there has been a proliferation of new programs available to employers to improve employee health. Unfortunately, traditional corporate health benefits procurement practices—churning between health plans and purchasing health-related services in silos—reinforces systemic ineffi-

ciencies and explains why many of these programs have had limited success in changing employee behaviors. Instead, the growth of these programs has created additional challenges for employers:

- The consumer experience can be highly frustrating due to the proliferation of programs, communications, and interfaces generated by separate sources.
- Coordination of data flow between vendors creates an additional administrative burden as well as the potential for operational breakdowns.
- Savings from one program may generate higher costs

elsewhere. For example, higher co-pays for prescription medications may reduce member compliance with medication protocols resulting in higher inpatient costs in subsequent years.

- Individual vendors may each claim credit for the same ROI savings with no tie back to actual overall health spending.

The emerging trend of managing healthcare costs through consumer behavior change is fundamentally reshaping the way employers design and purchase health benefits. Rather than operating health benefit programs in silos, employers are increasingly demanding consumer friendly solutions that integrate plan design, health management, spending accounts, financial incentives, and benefit administration services into a single systemic solution to drive behavioral change.

Despite the record increases, there is wide variation in individual employer performance to manage total health benefit costs. Systematic studies from multiple organizations, including annual benefit surveys by Mercer, Towers Perrin, the National Business Group on Health, and the 2007 SHPS Health Practices Study, consistently show that some self-funded employers consistently out-perform their peers in managing health costs, with no apparent diminution in coverage.

Consider Towers Perrin's 2008 Health Care Cost Survey that showed that companies that follow "best practice" guidelines can expect to save \$1,668 per active employee. The study divided employers into low and high cost groups, and looked for common

patterns and practices. The companies in the lower cost group will pay \$8,532 per employee this year, a 5 percent jump over 2007 figures, versus \$10,200 on health benefits for each employee in the high cost group, a 7 percent increase over last year.<sup>5</sup>

Similarly, the 2007 SHPS Health Practice study noted that employers using specific healthcare best practices, as a group spent 20–30 percent less for health coverage than their peers, with savings of as much as \$1,500 per employee. Evidence suggests that this cost advantage did not result overnight, but occurred due to consistently lower annual increases in health premiums over several years. For example, Pepsi Bottling Group, the only major employer to win the C. Everett Koop award in 2007 for its employee health initiatives, experienced an annual cost trend of 5.4 percent over a period of three years when most employers were experiencing 8–14 percent increases. The build-up in annual savings over time explains why the cost differences between actuarially similar employee groups can be as much as \$1,500 per employee, and why this differential will likely continue to grow.

Best practice employers can also create an enormous competitive advantage in the labor market, by investing savings from health benefits into other areas that will create a more attractive work environment, such as training, rewards and recognition programs, and enhanced compensation packages. It's a win-win situation for both employer and employee, and it's within employers reach if they re-focus their energies from the actual health benefits plan to building a true culture of health.

So what is it that “best practice” employers do to manage health costs? How applicable are these lessons to other employers? Given the enormous diversity of need among different employers, we should be rightly skeptical of applying “best practices” indiscriminately. However, research suggests that employers who achieve the lowest overall health costs make better employee health their first priority, rather than using financial procurement as their primary cost strategy. Equally important, however, these employers avoid trendy short-term fixes in favor of long-term strategies that integrate all aspects of health benefits: plan design, employee health programs, financial incentives, administrative practices, communications, and health metrics into a highly coherent program that serves the needs of individual employees.

## IDENTIFYING BEST PRACTICES

While the following best practices below can help businesses stave off annual double-digit increases in healthcare costs, they will not produce immediate savings. Best practices must be in place for several years before savings can be realized. And while none of the practices identified are meant to stand alone, all are designed to improve the health of employees, which ultimately leads to lower healthcare costs for the employer.

### Top 10 best practices for lowering healthcare costs

#### 1. Establish a corporate point of view: Why does your company offer health benefits? What is your investment horizon for employee health?

Employers offer health benefits for many different reasons. Some

offer benefits to attract and retain employees, while others use them to create a competitive advantage through improvements in worker productivity. Every employer should understand why they offer benefits, as it will have a significant impact on procurement strategies, investment timelines, and program execution. Interestingly, the HR department sometimes has a different point of view on this topic than other members of the management team. However, strong alignment between all management stakeholders is crucial to drive overall program consistency.

Employer philosophy around health benefits is closely linked to a company's horizon for investment in employee health programs. Employers that offer healthcare as a competitive necessity are more likely to place priority on high-deductible plan designs and targeted condition management programs that drive immediate savings and achieve the shortest payback of invested dollars. These plans are usually restrictive and result in higher premiums or a large deductible gap for employees that fail to comply with specific health and wellness and condition management programs. Companies focused on attracting and retain a world class workforce are more likely to tolerate a longer investment horizon, and may craft benefit programs whose scope covers the entire continuum of health for all employees, and requires several years until investment payback.

#### 2. Make better employee health your primary objective, and build a comprehensive strategy to get there.

Companies with lower health costs are far more likely to report

that employee health and productivity are their first priority. They are also far more likely to report that they have developed a comprehensive three to five year employee health strategy to achieve their goals. These organizations select all elements of the employee health benefit to improve health and optimize health spending, including:

- Plan design
- Employee health and wellness programs
- Biometrics
- Financial incentives
- Administrative practices
- Communications
- Formularies
- Health analytics and financial reporting

These plans specify which programs will be rolled out in year one, year two, and so forth, as well as how each element fits in to the overall strategy to drive positive health behaviors. Health incentives are often very simple in year one, but evolve to greater levels of specificity over time. Ultimately, the strategy drives the entire employee experience, and establishes consistent and meaningful communications for each individual covered life.

**3. Know your workforce. Use data to pinpoint critical health risks, establish priorities, and drive tactics.**

Effective health cost management starts with an objective fact base. Before undertaking any major health initiative, best practice companies conduct a thorough retrospective claims analysis across their entire covered population to

understand the health risks that exist in their covered population, as well as the underlying *causes* that may be driving risk (e.g. personal lifestyle, provider non-compliance with evidence based treatment, lack of access to appropriate care, and/or patient non-compliance with medication protocols).

Every workforce has unique health challenges, depending upon gender, age, socio-economic status and geographic location. Workers who smoke, for instance, have a greater risk of developing cancer than non-smokers, and obese employees are prone to high blood pressure and diabetes. Workers with active lifestyles will have different healthcare needs than their more sedentary colleagues. Below are two simple real life examples:

- A bank with a primarily long tenure female workforce has a population with a high risk of undiagnosed heart disease, and markers for heart disease. Its workforce is highly de-centralized, but everyone is computer literate, and has access to on-line tools. Overall, incidence of smoking is on par with national norms, but smokers tend to be highly concentrated within one region of the country. Claims analysis suggests that a recent increase in medication co-payments has led to lower levels of medication compliance. Employee focus groups suggest that some employees view heart disease as a health risk that applies more to men than women.
- A steel company has a somewhat younger, primarily male population, concentrated in 10 plants, and has a strong

work culture built around safety. Musculo-skeletal issues and pre-diabetes are primary risks. The workforce is highly concerned about health and privacy issues, but is very comfortable with the company's safety initiatives. During benefit enrollment, elections are often completed by spouses, and the company has a relatively high number of covered dependents under the age of ten. Several of the plants are located in rural areas where there is limited access to specialty medical practices.

As it turns out, each of these real-life companies has been very effective in managing overall health costs, but the specific programs and strategies that they used were *highly tailored* to the needs of their specific populations. In practice, a handful of specific conditions may be driving a high proportion of total health spending, and it is more important to pin-point these conditions, than to implement a generic broad brush program.

Companies may also use a brief employee survey to explore employee lifestyle and attitudinal barriers that make it difficult for employees to adopt healthier lifestyles. What is the workforce's perceptions and feeling related to health benefits? How engaged is the workforce? What will motivate them to change unhealthy lifestyle habits? Do they understand how healthcare benefits are funded, and where they can receive additional education? How do they want to receive communications related to healthcare?

#### **4. Deploy total population health management programs.**

Effective healthcare plans address the entire workforce, regardless of their health status. The primary goal of healthcare management is to keep employees on the “well” and “at risk” side of the care continuum and to improve health and reduce spending for those who with chronic or catastrophic conditions.

According to the *2007 SHPS Health Practices Study*, the most effective employers at managing health costs directly manage the clinical risk of their population. Companies that focus on improving employee health through targeted, clinically focused care management programs have an average of 18.2 percent lower healthcare costs, or \$1,400 per benefit-eligible employee. Nothing else measured on the survey had a greater impact on costs.

It's important to point out that care management programs typically require several years of investment to achieve their full impact. In fact, employers with a high prevalence of undiagnosed or untreated chronic diseases that use a disease management program should not be surprised to see *increased* costs in the first year. The level and rate of return will vary by program type, and employer and executive expectations should be managed accordingly.

Health and wellness programs are designed to improve workers' health can help employers to create a culture of health. But in order for healthcare management programs to have both an immediate and long-term impact on health behaviors, they must utilize a comprehensive, seamless set

of interventions that are designed around the needs of each, unique individual. Health benefit vendors should maintain a 360-degree view of the individual, including their health status, benefits coverage, and program participation activity and history, and foster seamless transitions to and from various health management programs.

#### **5. Leverage integrated metrics to validate program results.**

One of the challenges facing self-insured employers is quantifying the value proposition to the chief financial officer (CFO). Explaining that you want to spend a million dollars to change people's health behavior is a tough sell unless you have credible metrics. Traditional return-on-investment (ROI) strategies are insufficient, as there is not a standard, generally accepted methodology for ROI calculations—and thus no easy way to compare different vendor offerings.

Employers need to have metrics that span an entire health and benefits strategy, and illustrate the value of all care management interventions—and each specific program intervention—back to actual health costs. Metrics must be actuarially validated, and provide insight into how deeply to invest in specific health and wellness programs. In addition, the strategy must identify the contribution to net savings from each individual program element so the CFO can recognize the program's value.

Furthermore, since workers' healthcare needs are subject to change, metrics must provide some insight into ongoing opportunities for intervention. Determining the impact of health management can be complicated by the fragmented nature of

healthcare and the data within a typical benefits plan. It is almost impossible to neutralize all factors that influence the consumption of healthcare and isolate the causes and impacts of specific management initiatives. Recognizing and understanding utilization patterns can be obscured by changes in plan design, enrollment, and provider reimbursement levels. The success of any organizational strategy is based on a sound business case that is supported by hard data and a clear, positive return on investment.

#### **6. Create a unified participant experience.**

Best practice companies are far more likely to report that their participants receive consistent, uniform, branded communications, and consistent tools and services across all vendors. They also are far more likely to report that their vendors work effectively together to create a unified participant experience.

Given that one of the primary goals of healthcare strategy is to improve personal health through behavioral change, employers can no longer ignore the importance of the overall participant experience. Multiple health programs delivered by separate vendors working in silos may not only lead to participant confusion, but can actually be highly annoying to employees, generating cynicism around a company's health objectives.

Care management programs, in particular, are a potential point of vulnerability for inconsistency and generic approaches. One of the goals of care management is to reduce the occurrence and frequency of illness among relatively healthy individuals. Care manage-

ment programs also are designed to improve the health and reduce spending for those with chronic or catastrophic illnesses. The key challenge in creating a healthier workforce is the ability to convince people to change deeply ingrained lifestyle habits.<sup>6</sup>

The focus on behavior modification forces employers to reconsider the way they design, communicate and deliver health and wellness programs.<sup>7</sup> These programs can no longer be generic or release information on one or two basic health problems. Successful care management programs are those that take a “member-centric” approach to health and tailor behavioral modification strategies to individual needs. By taking a member-centric approach to health care, employers recognize that their workers’ professional, personal, familial and social obligations can affect their health.

The first step employers must take before they can implement a member-centric care management program is to conduct a needs assessment among their employees. The assessment measures demographics and lifestyle factors and helps them determine the best way to communicate details of the program with workers. Member-centric programs typically rely on three categories of metrics: objective clinical metrics to gauge health-improvement outcomes, behavioral metrics and cost savings tied to improved health, and productivity gains.<sup>8</sup> However, the key to a successful member-centric care management program is integration across all elements of an employer’s health strategy.

## **7. Incorporate well-designed financial incentives into your plan structure.**

Employers can lower healthcare costs by offering workers cash-based incentives to participate in clinical programs. Though many different kinds of financial enticements can be used, companies using cash-based incentives average a 15.1 percent reduction in total cost per benefit-eligible employee, or about \$1,165 per employee.<sup>9</sup>

Cash-based incentives can include a reduction in plan premium, a direct cash payout and/or a contribution to a health reimbursement arrangement (HRA) or a health savings account (HSA). Cash-based incentives are usually more effective than other types of incentives because they force employers and workers to engage in a conversation about healthcare.

Most employers use incentives to drive increased participation in high-valued programs, such as preventative screenings, health risk assessments, wellness program and condition management programs. Generally speaking, incentives only make sense if there are strong care management programs in place.

One of the challenges companies face in designing an incentive program is coming up with ways to encourage all employees to take a more active role in the management of their health. To make incentive programs fair, employers might consider crafting a program that contains tiers of incentives so every employee has the chance to achieve at least one incentive.

## **8. Manage eligibility with strict control.**

One of the ingredients to successfully implementing a health-

care plan is effectively managing eligibility. In many cases, the importance of managing eligibility is overlooked for the more “glamorous” features of an employee healthcare plan. Administrators of these plans often make the mistake of considering eligibility management a straightforward job that is merely a way to enroll participants into benefit packages. However, minor slip-ups in eligibility administration can wreak havoc on the health and welfare programs for employees and their beneficiaries. It is imperative that employers create a tight management process that ensures equity, integrity and unity.

Employers commonly end up paying for health benefits that some workers are not eligible to receive. It is estimated that as many as 10 percent of an employees may have an ineligible dependent enrolled on their health plan.

This phenomenon, called “leakage,” can affect as much as five percent of the population, and can cost medium-sized companies several million dollars each year in the form of overpaid claims, premiums and ASO fees. Employers with poor health plan administration practices can improve healthcare costs through a one-time, immediate cost reduction by bringing premium leakage under control. In fact, effective administration and communication of employee benefits can lower healthcare costs for employers by as much as 12.7 percent per worker. The successful administration of benefits is the backbone for delivering effective healthcare strategies.

### **9. Focus enrollment communications on health rather than benefits selection.**

Annual enrollment—the time of year when employees make their benefits selection for the coming plan year—needs to be repositioned as a health planning event, rather than simply a benefit administration requirement. This means reframing communications materials to drive open, and honest, discussions on healthcare, including the need for employees to take an active role in their health improvement. It can also include creating a health fair where employees can complete biometric screenings, take a personal health assessment, or speak with a clinician about their specific health concerns.

Employees often spend too much of annual enrollment contemplating between plan design options. Companies can circumvent this process and simultaneously keep healthcare costs down by offering a single plan to their global employee population. The practice of offering multiple plan designs—once standard—has been correlated with substantially higher healthcare costs per employee.

Allowing workers to choose their healthcare plan has its roots based in actuarial science. Creators of these plans drafted detailed price and coverage schedules to help employees minimize spending. While this practice can provide some financial relief to employers, it does not give employees the opportunity to address health problems, nor does it change the clinical risk of workers.

By offering employees one primary health plan, companies can streamline their benefits delivery and help workers focus on maintaining or improving their health.

The lack of health plan options also places all employees on an equal footing and provides them with insight into their company's contributions to healthcare costs.

Employers can use incentives and discretionary spending accounts to meet the needs of individual workers. Companies in areas with spotty coverage can still provide health insurance to workers by offering them a plan with identical structure but permits multiple networks.

### **10. Integrate health benefit procurement practices.**

In order to fully integrate the health management of its employees, companies must establish procurement processes that are both strategic and tactical. This includes redefining request for proposal (RFP) procedures to meet strategic objectives. Historically, employers sought to identify “best-of-breed” vendors for a specific program. However, the proliferation of single product vendors has created enormous administrative complexity for many employers.

As a result, RFP's are rapidly evolving to consider “best team of vendors” to deliver integrated solutions that provide participants with a unified participant experience. The ability to consolidate vendors, IT platforms, participant interfaces, and metrics are crucial elements in the emerging health benefit delivery model, and RFP.

Best practice companies procure services not to minimize individual vendor cost, but to optimize overall health spending and services across their entire covered population. Companies must determine the kinds of vendor relationships that they require and design a plan to achieve those

relationships. Companies cannot help employees better manage their health unless they re-evaluate their health and procurement strategies as well as vendor expectations, and recruit a team of vendors willing to work together to change workers' attitudes about their health and healthcare.

### **Bottom-line results of health improvement**

The emerging strategy for managing rising health costs is—simply stated—better health. When individual employees adopt healthy lifestyles, obtain preventive care, and effectively self-manage chronic conditions, they consume fewer healthcare services, and they cost less to insure.

However, the companies that spend fewer dollars on health benefits for their employees share certain characteristics. In general, they are significantly more aggressive and systematic in managing their health programs and delivery processes.<sup>10</sup> They understand that traditional methods of cost reductions—restricting coverage, raising deductible and co-pays, and increasing employee premium contributions—are unsustainable and incapable of driving long-term value. Instead, they are able to maintain competitive health benefits package for a reasonable expenditure by improving employees' overall health, and encouraging adoption of healthy lifestyles.

It is clear that employers and employees must change their attitudes toward healthcare coverage and work together to control the cost of healthcare. Companies have unique requirements based upon their business model and workforce, and employers must tailor their health programs to fit

their individual needs—with industry studies pointing to these ten best practices to jump-start the initiatives. Proactive, best-practice employers are finding that an investment in their employees' health may translate into substantial dividends to their bottom line.

### WHAT DO HIGH COST COMPANIES HAVE IN COMMON?

In the 2007 SHPS Health Practice Study, certain common benefit practices were actually associated with higher overall health costs per employee. They included:

- The use of self-service web-based portals as the primary strategy for managing employee health, without specific program objectives, metrics, or focus on specific health conditions.
- The tendency to offer workers multiple health plan choices through multiple carriers.
- The inability to distinguish quality of care in a provider network, an approach that forces them to look for other ways to manage provider quality. This can drive up the cost of healthcare by as much as 29 percent.
- Using health benefits to become the “employer of choice.” Ideally, every employer should have competitive health benefits plan,

but workplace climate and culture are far more important to attract and retain a competitive workforce. An overly generous health plan misallocates resources, and can lead an employer to become the employer of choice for the wrong reasons.

### SELF-FUNDING AS A COST MANAGEMENT STRATEGY

The struggle to keep costs down and gain more control over their health plan offerings is leading many companies to self-fund their HMO plans. Self-insured PPOs and point-of-service plans have been around since the early 1970s but they are becoming more commonplace now as companies look for ways to tame uncontrollable healthcare spending.

More than half of all companies in the United States now have self-funded healthcare plans.<sup>11</sup> These plans are more likely to be found in large firms—an Employer Health Benefits Survey conducted in 2006 by the Kaiser Family Foundation revealed that 89 percent of companies with 5,000 or more workers self-fund their health benefits plan.<sup>12</sup> Self-insurance for smaller employers also exists but is not as common because these firms usually require greater stop-loss insurance protection than larger employers.

The reason employers self-fund their healthcare plans is simple: to reduce costs. Self-funding not only

allows employers to reduce insurance overhead costs and state premium taxes, it also exempts them from state-mandated insurance laws and improves cash flow.<sup>13</sup> In addition, self-funding enables companies to create custom health plans and choose a claim administrator. Self-funding is not “best practice” per se, but it provides an effective foundation upon which best practices can be built.

### NOTES

1. Towers Perrin 2008 Health Care Cost Survey, pg. 1.
2. Towers Perrin 2008 Health Care Cost Survey, pg. 1.
3. Centers for Medicare & Medicaid Services (CMS).
4. U.S. Census Bureau, 2006 Figures.
5. Towers Perrin 2008 Health Care Cost Survey, pg. 5.
6. BenefitNews.com, ‘Person-centric’ approach to health management emerging as key to behavior modification. By Bruce Shutan.
7. BenefitNews.com, ‘Person-centric’ approach to health management emerging as key to behavior modification. By Bruce Shutan.
8. BenefitNews.com, ‘Person-centric’ approach to health management emerging as key to behavior modification. By Bruce Shutan.
9. 2007 SHPS Health Practices Study, What Every Self-Insured Employer Should Know, pg. 9.
10. Towers Perrin 2008 Health Care Cost Survey, pg. 7.
11. Gibson Insurance Group, Benefits Briefing Newsletter, Spring 2007.
12. Gibson Insurance Group, Benefits Briefing Newsletter, Spring 2007.
13. Gibson Insurance Group, Benefits Briefing Newsletter, Spring 2007.