

Tailoring Health Care Benefits to Your Employees

Managing employee health and health benefit costs through vendor partnerships and simple, data-driven strategies



Strategies for small and medium-sized employers

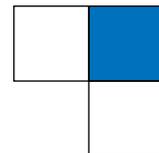


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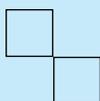
The National Business Coalition on Health acknowledges the support of Pfizer, Inc. for development of this guide. We also thank the participating corporations featured herein that provided interviews and case studies.

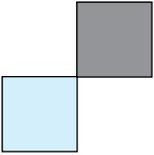
Developed and written by Emron, LLC, Wayne, New Jersey

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National Business Coalition on Health
1015 18th Street, NW, Suite 730
Washington, DC 20036

(202) 775-9300
www.nbch.org





Introduction

In today's challenging fiscal environment, firms that sponsor health care benefits are looking for benefit solutions to help them do more with less. Such solutions might involve closer scrutiny of health plan data or the creation of new partnerships with coalitions, brokers, plan managers, and employees. Large and small employers alike use strategies like these. This report on employer forays into "Total Health Benefit Management" and their successes suggests ways in which your company can tackle the challenge of rising health care costs and improve employee health in the process.

The need to take action is hard to ignore

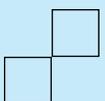
Spending on health care in the United States continues to rise. Even though the growth rate has moderated in recent years, at present rates, total spending is likely to reach more than 20% of the country's gross domestic product (GDP) by 2018. Still outpacing the inflation rate, expenditures will hit \$2.5 trillion in 2009. Employers and their covered employees share a very large portion of that bill; together, they pay 56% of the nation's spending on health care.¹

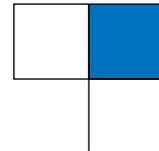
Employers pay the larger share of premium dollars, but employee cost sharing has increased so sharply in the past few years that there are signs they may not be able to absorb further out-of-pocket costs. Recent studies warn that higher cost sharing may cause patients to skip doctor appointments or screenings and skip refills of prescribed drugs, undermining the benefit that comes with good treatment.²

Hewitt Associates predicts that employees will pay just under a quarter of premium costs in 2010, which represents a 10% increase from 2009. Also in 2010, employees' share of out-of-pocket costs is expected to rise, with employees paying an additional 10% increase in copays, coinsurance, and deductibles. While facing this 20% rise in costs of health care, the average worker probably saw only a 1.8% salary increase in 2009 — the lowest in 33 years.³

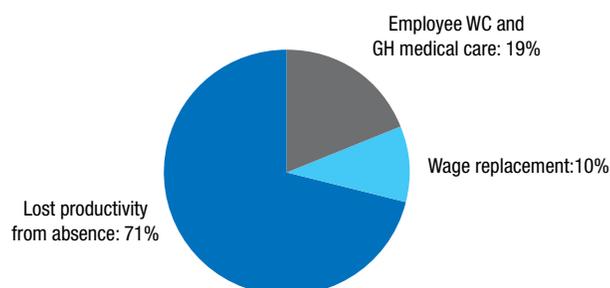
Large and Small Employers Face Common Challenges

Findings based on the 2004 report by the Integrated Benefits Institute (IBI) show that employers that continue to provide health benefits to employees not only struggle with rising health care costs and premium costs, but also with added costs of lost productivity when covered employees are injured or ill (Figure 1).⁴





**Figure 1. Full Cost of Employee Benefits
(2002 Benefit Data)**



Source: Integrated Benefits Institute, June 2004.
WC: workers' compensation; GH: group health costs of care

A 2009 study⁵ bolstered IBI findings with an analysis that combined Health and Work Performance Questionnaire survey information with medical and pharmacy claims data. The study found employers that focused only on medical and pharmacy costs in creating employee health benefit strategies might misidentify the health conditions that were having the most impact on productivity and that other factors impacting their total costs might be missed entirely. For example, cancer and coronary heart disease were consistently among the top 5 conditions driving overall benefit costs, but the chronic health conditions that were most important in driving costs related to lost productivity were depression, obesity, arthritis, back/neck pain, and anxiety. Researchers verified earlier studies

indicating that health-related productivity costs significantly exceed medical and pharmacy costs — on average, by 2.3 to 1. The takeaway is that both sets of cost drivers (the high-cost chronic conditions, as well as the conditions causing the most absenteeism) need to be addressed to achieve the greatest reductions in total costs to the employer.

“Preventable health risk factors” — those that can be identified early, before they lead to full-blown disease — were identified by the Kaiser/HRET study⁶ as being major contributors to the continuing rise in overall costs of health care and, especially, to the rising cost trend for employers. However, because much of the

Reasons Employers Are Embracing Employee Health Programs

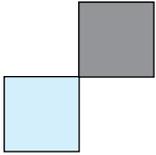
Absence-related costs alone amount to about 75% of net income when full costs of health care are considered, including lost productivity and wage replacement.⁴

When lost-time information was included in an analysis of 10 health problems, findings showed that for every \$1 employers spend on medical or pharmacy costs, they absorb at least \$2 to \$4 of health-related productivity costs from absenteeism and presenteeism.⁵

A study using information from 119,343 employees across 21 employers found that 55% of employees reported having 2 or more chronic conditions, while nearly 2 in 10 reported having 5 or more.⁷

Chronic conditions are costly to employers. For example, people with diagnosed diabetes, on average, have medical expenditures that are approximately 2.3 times higher than those without diabetes.⁸

Diabetes accounts for 15 million absent work days, 120 million work days with reduced performance, 6 million reduced productivity days for those not in the workplace, and an additional 107 million work days lost due to unemployment disability attributed to diabetes.⁸



time such risk factors remain unidentified (lack of screening) or go untreated (lack of follow-up), they fuel rising levels of health care use by patients, as those patients progress to more serious health conditions.

On the other hand, addressing health risks through workplace interventions can reduce, or at least slow, rising costs due to preventable health risks. Comprehensive worksite health promotion programs can yield a \$3 to \$6 return on investment for every dollar spent over a 2- to 5-year period.⁹ A review of 42 different programs found that workplace health promotion programs were able to reduce absenteeism, health care use, and disability workers' compensation costs by more than 25% each.¹⁰

Practical Approaches to Making Positive Changes

Information from studies like those described above reinforces what has emerged as an important understanding for beleaguered employers: that total cost of care should be their strategic focus in managing employee health benefits. This understanding has propelled the pursuit of “value-based benefit design” as well as the adoption of a growing array of employee health interventions in the workplace. Both strategic approaches seem to be establishing good track records, helping employers and employees to make every dollar count.¹¹

Not surprisingly, large employers have been pioneers in implementing a broader focus on total health benefit costs. But the core elements of such programs work just as well for small and mid-sized employers who want to make positive changes among their own employees and on their bottom line. As Dianne Kiehl, the executive director of Business Health Care Group of Southeast Wisconsin, said, “Sometimes, the smaller the company is, the more success it has in engaging employees in health care initiatives. They already understand that when they help their employer control overall budget costs, it helps the business grow and become more successful.”¹²

What does it take to make positive changes in your company?

For positive changes to occur, it takes knowledge, commitment, and practical interventions that have the power to improve both employee health and employers' total health benefit costs.

Step 1: Gather the information you need to make smart decisions.

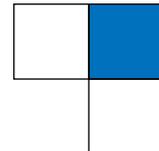
Determine your company's total spending on health care: what you pay in premiums, in medical and pharmacy claims, in disability due to illness or injury, in workers' compensation, and in lost productivity due to illness or injury.

Step 2: Gather the information that tells you what your own covered members' health issues and health risks are. Use claims data analysis, public health information profiling your region or state, or an employee Health Risk Assessment

Worksite health promotion programs can yield a \$3 to \$6 return on investment for every dollar spent over a 2- to 5-year period.⁹

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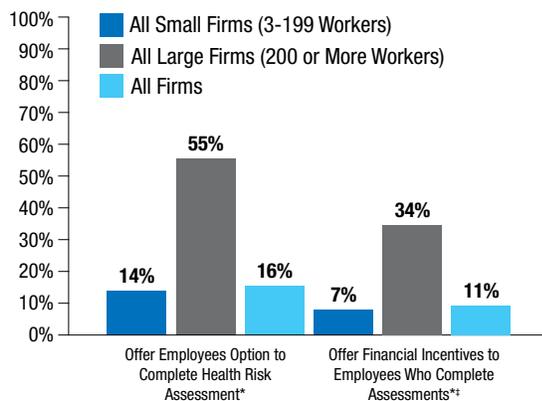


(HRA)* questionnaire. An HRA has proven to be a valuable tool in making positive changes and affecting total health benefit costs. More than half of all firms with 200 or more employees reported using HRAs in 2008, and its use by smaller firms has also grown over the past 2 years.⁶

Step 3: Build commitment to the process among management and non-management employees. Companies that decide to become proactive about controlling health-related costs have to understand that success takes time. It also takes buy-in from the top of the organization to generate acceptance and participation from all covered employees. Think broad and think long-term.

- Establish a 3-year vision to begin with, and assess your goals annually.¹¹ It is important to stay “on message” in promoting healthy lifestyles to employees.
- According to the American Heart and Lung Institute, fewer than 1 in 5 employees (18%) saw his or her employer as encouraging participation in fitness or smoking cessation programs. But when employees did see their company as being encouraging, the percentage of employees who became actively involved was much higher.¹³

Figure 2. Percentage of Employers Using HRAs and Offering Incentives for Employees to Complete Them



* Estimate is statistically different between All Small Firms and All Large Firms within category ($p < .05$).

† Among Firms Offering Employees Option to Complete Health Risk Assessment.

Note: A health risk assessment includes questions on medical history, health status and lifestyle, and is designed to identify the health risk of the person being assessed.

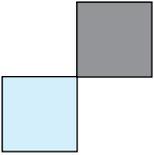
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009.

Health Risk Assessment^{6*}

Some firms give their employees the option of completing an HRA to identify potential health risks (Figure 2). HRAs generally include questions on medical history, health status, and lifestyle.

- Overall, 16% of firms offering health benefits offer HRAs to their employees. Fifty-five percent of large firms (200 or more workers) provide the option, compared with 14% of small firms (3-199 workers)
- Thirty-eight percent of firms that offer HRAs use them as a method to identify individuals and encourage their participation in wellness programs. Sixty-one percent of large firms (200 or more workers) use HRAs to encourage participation in wellness programs, compared with 33% of small firms (3-199 workers)

*In December 2009, the Equal Employment Opportunity Commission (EEOC) regulations implementing the Genetic Information Nondiscrimination Act (GINA) took effect. GINA prohibits health plans and employers from offering financial incentives to individuals participating in HRAs that request genetic information, such as family medical history, or to make HRAs a condition for their access to benefit programs or to enrollment. Therefore, HRA questionnaires should be screened to make sure they are GINA compliant.



Step 4: Select interventions that fit your needs and your resources. Smaller employers can recognize the same kind of benefits that larger firms have seen after committing to specific employee health improvement interventions. The process is sequential: investigation, planning, intervention rollout, and evaluation. With smaller workforces, both the monetary resources applied and the consequent return on investment should fit the size of the company.

As you weigh the value of interventions that are most likely to show positive results, consider:

- Strategies that fit your own goals
- Resources that fit your budget
- Interventions that can be implemented within your workplace
- Rollout that motivates employees
- Ways to evaluate your success

Determining the Right Tools for the Job

Many simple, readily available data resources are available at low or no cost to employers that want them. Gathering specific data about your own company's health costs and health drivers provides the knowledge base to support company decisions about strategic initiatives. Even more importantly, it provides baseline data you can use to evaluate the success of those initiatives.

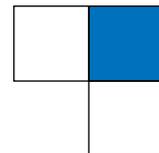
Data, data, everywhere

Claims data provide total costs, for specified timeframes, for all medical and pharmacy services used by your employees and other covered members. Medical claims are coded by diagnosis, provider, and treatment, telling you what services were used most often, what illnesses or injuries were treated most often, and what providers were used most often. The data tell you what costs were attached to those particular conditions, treatments, and providers. Pharmacy claims give you similar information, but are sorted by the prescriptions filled by patients, rather than by coded condition.

Go straight to the source

Partner with health plans, wellness vendors, and PBMs: The health plan and the pharmacy benefit manager (PBM) that provide and manage your company's medical and pharmacy benefits are the most obvious sources of company-specific health care and benefit cost information. Christopher Goff, JD, MA, is CEO and general counsel for the Employers Health Coalition of Ohio. He shared the following insights on how small employers should go about obtaining such data and using them.¹⁴

Knowing company-specific data enables employers to shift their stance from being passive “payers” to being active participants in the management of their employees’ health care and the company’s total costs.



The data clause in the self-insured employer's contract can and should be negotiated with the insurer.

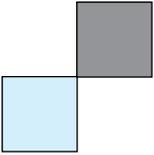
The fully insured employer's contract is the health benefit policy. Ask prospective plans what programs they can incorporate for your employees.

A self-insured, employer-plan sponsor has a right to employee-specific data held by the insurance carrier. The parameters of how the data are sorted and delivered are generally specified in a data clause in the contract. The clause can and should be negotiated with the insurer. For example, you can negotiate to direct the carrier to integrate, often without additional cost, the data streams about your employees that come from the PBM and other vendors. The timing and sorting of data are also directed in that clause. It is often difficult to convince the carrier to supply data in some different format midway through the contract's term. But it's worth working on getting what you need — through your coalition, attorney, consultant, or broker — before you launch health benefit interventions that will depend on patient information reports to succeed.¹⁴

Fully insured employers are not likely to receive quarterly claim reports, but they may receive an annual report of health care costs and services reimbursed by their health benefit carrier (plans and other vendors) and purchased through the employer's premium payment. The fully insured employer's contract is the health benefit policy. Thus, fully insured employers are not in a negotiation position regarding the kind of data runs supplied by the insurer. Nevertheless, it is possible to gather such information in more detail than the annual report may provide, if it relates to specific interventions.¹⁴ Try some of the suggestions that follow.

Use existing programs offered by your health plan: The fully insured employer has most flexibility when shopping for annual benefits. In lieu of being able to receive data runs that support a workplace intervention, ask prospective plans what programs they can incorporate in benefits for your employees. Plans will differ on what they can provide. If you are interested in preventing serious cardiac events, for example, you should look for a plan that can provide or support prevention programs like the following¹⁵:

- Cardiovascular risk identification and reduction programs
- Standardized treatment and prevention protocols consistent with national guidelines for heart disease and stroke
- Health care quality assurance systems: automated physician and patient guideline reminders and electronic medical records
- Multidisciplinary clinical care teams or specialized clinics that deliver quality care for those at risk
- Patient education combined with follow-up risk factor counseling
- Patient satisfaction surveys and strategies to eliminate cardiovascular disease disparities
- Annual reporting of improvements in cardiovascular health indicators (eg, Healthcare Effectiveness Data and Information Set [HEDIS]) and related costs



Use data warehouse services: Employers who use multiple vendors to deliver health benefits and services may be good candidates for use of a data warehouse. Health data warehouses can combine all claims streams that were generated by covered members and supply those de-identified data in a way that allows the employer to analyze the data. The employer also can price the services of the warehouse to prepare the data analysis needed to assess total costs.¹⁶ Such services are widely available from commercial companies such as Ingenix, MedStat, and Health Data Management Solutions (HDMS).

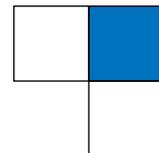
Partner with coalitions: Because employers have limited resources to perform such analyses or the clout to negotiate specialized services from health care vendors, it may make sense to form or join a local coalition. For example, Christopher Goff's Ohio coalition offers its members the option to use data warehouse services at a rate negotiated by the coalition. The coalition-wide database can aggregate and analyze health information from employer coalition members that participate in the coalition group purchasing programs. Information includes medical and pharmacy claims, biometric data, and health risk assessment information.¹⁴

Similarly, the HealthCare 21 coalition in Knoxville, TN, has long offered a data cooperative to its members. Using company-specific data, members can benchmark against peers, cooperatively develop wellness intervention programs, and track outcomes. HealthCare 21 provides 2 full-time data analysts and specialized consultants when needed. Through the co-op, employer members' "data are now in a place where they can get to it."¹⁷

Partner with brokers: Especially for small employers and for those that are fully insured, the broker is often a major resource in tailoring health benefit designs to include "value-based benefit" aspects that can address overall costs. John Kahle, senior vice president of Intercare Insurance Solutions in San Diego, CA, said insurance carriers are resistant to adopting cost-saving strategies. For example, he believes most have not made an effort even to set a value on initiatives such as disease management programs.¹⁸

What's more, Kahle said, carriers are reluctant to provide data to fully insured employers about their plan. If an employer wants to know how many diabetic employees are not compliant with their medications, for example, the insurer is unlikely to provide the data easily. "The plan will say, 'We can't give you this information because the group is too small, therefore it's not credible,'" Kahle said. "Or, the plan will use some other excuse." Kahle and his fully insured clients exclude the insurance carriers from the health risk assessment buying process, preferring to hire third-party administrators (TPAs) instead. Kahle explained, "Using the same TPA ensures consistent data year after year, even if an employer switches insurance carriers."¹⁸

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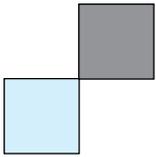
Not all carriers are willing to offer discounted premiums, but some are beginning to offer longer term premiums that fit well with customized strategies.

A few of Kahle’s clients have begun using employee HRAs that include biometrics. Employees who complete the HRA are eligible for a “gold” plan that has a higher level of benefits and costs less than the “silver” plan. Through this incentive, Kahle’s clients generally achieve an 80% to 90% participation rate in the HRA program. And using an HRA pays off in other ways: in January 2010, one of Kahle’s clients with a 200-member health plan will receive a discount on its group life, group short-term disability, and group long-term disability based on encouraging health outlook data from 3 years of HRAs.¹⁸

Not all carriers are willing to offer discounted premiums, but Neil Simons, owner of Independent Benefit Services in Rockville, MD, said that some are beginning to offer longer term premiums that fit well with customized strategies. “Actuaries hate to give up their ability to rate at 1 year,” he said. “A lot can go wrong in a month. They don’t like to commit to 2-year locks.” However, Simons named Assurant Health as an example of a carrier that already offers longer term premiums to small and mid-sized businesses, so the landscape may be changing.¹⁹

Partner with regional and state health information exchanges (HIEs): Your state or metropolitan regional area may have sponsored the establishment of a central health care database with information contributed by employers, providers, and health plans. That is the case in Indiana, Maine, and California. Statewide HIEs have often evolved from regional HIEs that were established in metropolitan service areas to help hospitals and other providers share patient information.²⁰ Recently, more HIEs have seen the advantages of including employer-based patient information in regional databases, and even statewide enterprises may be open to partnering with coalitions or medium-sized, self-insured employers.

The Indiana HIE in Indianapolis, which is considered a national leader, is building a cooperative program with the Tri-State Business Group on Health, a coalition that serves 40 employers that offer health benefits to 50,000 employees and dependents. To get the joint effort off the ground, business leaders invited hospitals, physician groups, TPAs, and insurance brokers to the table. That cross-stakeholder group makes the data exchange richer and more representative of the entire health care spectrum in the region.²¹



Strategic Use of Proven Interventions

Once an employer has set a dual goal of achieving better health for plan participants and interrupting the spiral of rising costs, the initial approach is to address those health-related costs it can affect most effectively.

Identifying specific health risk factors among employees and addressing them with effective wellness and disease management programs need not be expensive. Employers can usually manage most aspects of such programs themselves using free or low-cost, pre-packaged resources that are becoming more and more available. The following pages describe some of these.

Assessment tools and cost calculators

Several tools, such as cost calculators, are available online. One such tool, The Blueprint for Health,²² is available from the American College of Occupational and Environmental Medicine (ACOEM) (blueprint.acoem.org) and is also offered on the Web sites of the American Diabetes Association (www.diabetes.org) and the Centers for Disease Control and Prevention (CDC) (www.cdc.gov).

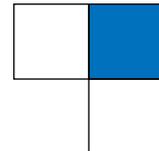
The Blueprint for Health is a free, Web-based tool for making value-based decisions on health and productivity management. This tool is valuable to all employers, regardless of their expertise in data analysis and formal tracking of absence or productivity.

The tool uses data, methods, and metrics derived from a large dataset of US employers and covers several key medical conditions including diabetes, hypertension, insomnia, obesity, cholesterolemia, and several comorbidities. It estimates the full implications of cost, including medical expenses, absenteeism, and work impairment (presenteeism). Using this tool, you can generate reports to:

- Project total cost of health care, including productivity and absenteeism.
- Learn the impact of variables such as age, gender, geographic location, and benefit design on overall health care costs.
- Understand the migration of employees to higher or lower cost levels over time.
- Help initiate a health and productivity management program.

Identifying specific health risk factors among employees and addressing them with effective wellness and disease management programs need not be expensive.

The screenshot displays the IBI website interface. At the top, the IBI logo is on the left, and the text 'INTEGRATED BENEFITS INSTITUTE' and 'health + productivity at work™' is on the right. A navigation menu includes 'Home', 'About IBI', 'Membership', 'Products+Services', 'News+Events', 'Annual Forum', and 'Help!'. A search bar is located on the right. The main content area features a large image of an abacus with the headline 'How much does lost productivity cost your company?' and a sub-headline 'Find out with IBI's new Lost Productivity Calculators >'. Below this, it states 'Latest Measurement Tool from IBI: IBI Lost Productivity Calculators' and describes the tool's capabilities. A sidebar on the right contains sections for 'Headlines', 'IBI BENCHMARKING', 'WHAT'S NEW' (listing 'Lost Productivity Calculators', 'Free Business Case DVD', 'Benchmarking Overview/Access', and 'Free IBI Employee Membership'), and '2010 IBI/NBCH H&P Forum' (with links for 'For 2010 Information' and '2009 Summary and Press'). The footer includes copyright information for 2009 and a 'Powered by Beyond SQL' logo.



Another group of free cost calculators are on the IBI Web site (<http://ibiweb.org>). These include a basic lost productivity calculator, a version that focuses costs by type of employee, and another that calculates costs related to a specific group of claimants with measured lost time (eg, workers' compensation or short-term disability).²³

More about using HRAs* — company-specific information from your employees

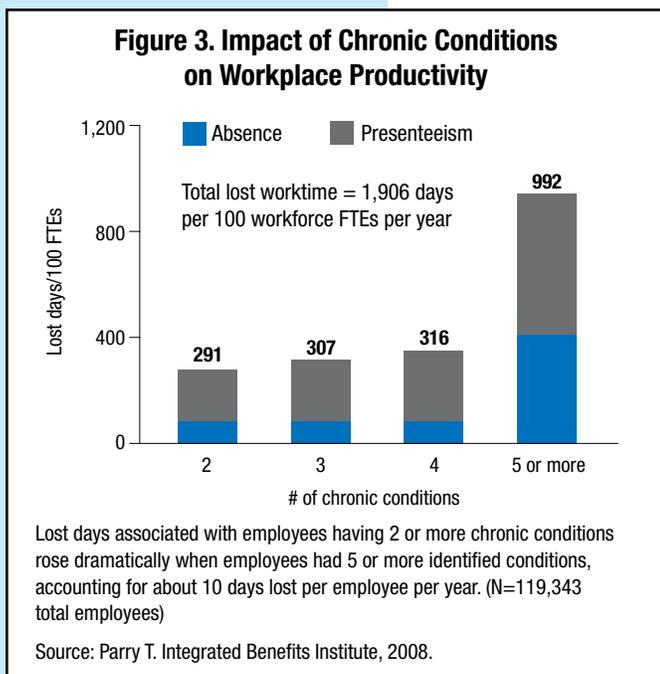
A GINA-compliant HRA questionnaire is a cornerstone in the design and evaluation of most employer interventions that are intended to address total health benefit costs by improving employee health over time. It is one of the most powerful tools you have in analyzing your company's specific needs.

Even employers that do not undertake workplace health interventions directly can benefit from an HRA by using the information about their employees' health issues to make benefit design decisions with their broker's or coalition's help.

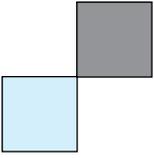
The HRA form asks a series of questions that the employee answers either on a paper form or online. HRAs can be administered by health insurers (the health plan) or by a TPA. Basic health risk assessment instruments are available online for free, and employers can initiate their use directly as long as the collection of the information is through a third party so that employees' privacy is maintained. The employer only receives the de-identified, aggregated information.

Ideally, HRAs are used to set goals and determine strategies for improving identified health outcomes and are administered each year to assess how well the strategies are working by bringing the covered population closer to meeting the goals.

What is the effect of chronic diseases among your workforce? **Figure 3** shows the impact on productivity among workers having 2 to 5 such conditions. A study using information from 119,343 employees across 21 employers found that 55% of employees reported 2 or more chronic conditions, while nearly 2 in 10 reported 5 or more. Analysts found that when the number of conditions increases from 4 to 5, employees experience a huge jump in absence and presenteeism. When lost time for those with chronic conditions is spread over the entire workforce, it results in 19 lost workdays per year, per worker.⁷



*In December 2009, the Equal Employment Opportunity Commission (EEOC) regulations implementing the Genetic Information Nondiscrimination Act (GINA) took effect. GINA prohibits health plans and employers from offering financial incentives to individuals participating in HRAs that request genetic information, such as family medical history, or to make HRAs a condition for their access to benefit programs or to enrollment. Therefore, HRA questionnaires should be screened to make sure they are GINA compliant.



Using the HRA to evaluate improvement: The HRA, coupled with information from claims data and/or reports from wellness and disease management intervention programs, can yield evaluation information. One large company that committed to learning about health care needs through use of HRAs clearly defined baselines and measured progress using the following metrics:²⁴

- Gross per employee health care costs
- Net per employee health care costs (after cost sharing)
- Percentage of employees who have taken the HRA at least once in the past 3 years
- Percentage of employees who are at low or no risk
- Percentage of employees who have participated in a company health screening activity and engage at least to the point of entering their cholesterol and blood pressure readings

Using national health statistics for benchmark information

It is also possible to use the vast national health data repositories to find state and regional information about risk prevalence and incidence of disease in your own region.

The National Center for Health Statistics (NCHS) houses readily useable data tables and analyzes those specific conditions that are of most importance to employers in terms of treating preventable risk and in identifying key causes of lost productivity in specific regions.

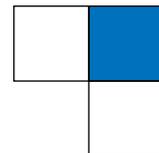
The NCHS Web site (www.cdc.gov/nchs) is a portal to other core national health information sites such as Medicare data, injury data, Social Security data, and disease risk data, primarily from the CDC. Other national agencies are also open to the public, offering their databases on treatment use, health care costs, and risk factor tracking (eg, Veterans Affairs, Centers for Medicare and Medicaid Services [CMS], national disease registries, etc).

Data collections available on the NCHS site:

- National Health Care Surveys
- National Health Interview Survey
- National Health and Nutrition Examination Survey
- National Vital Statistics System

A *Health Data Interactive* program available on the site generates tables on the health of all Americans by age, gender, race/ethnicity, and geographic location.

The NCHS Web site is worth a visit. If you want to customize a data report, the site teaches users how to access and manipulate the available tools.



Several national organizations have made strategic use of national and state health data to design workplace intervention programs that your company can easily adopt.

Making use of program materials from national health care agencies

If you believe that a significant portion of your current health benefit costs are driven by a few specific chronic conditions or that future costs are likely to be linked to a noticeable level of risk among your own employees — or within the region where you do business — you can use free programs to reduce risk and financial exposure. For conditions such as heart disease or diabetes, for instance, free data from the national health associations mentioned on the previous page can substantiate a reasonable prediction of risk in your covered population, quantify the associated costs, and identify the levels of improvement that are needed.

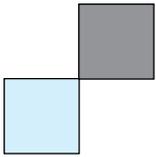
Several national organizations have designed workplace intervention programs that your company can easily adopt. Two such programs are described on pages 17-18, and many more are available.

- Centers for Disease Control and Prevention (See page 19 — Successful Business Strategies to Prevent Heart Disease and Stroke)
<http://www.cdc.gov/nchs>
- American Diabetes Association (See page 20 — Diabetes at Work)
www.diabetesatwork.org

Employee education programs

Employee education is the first line of defense for most employers. Any employer, no matter how large or small, can provide widely available information from reliable sources to employees about how to manage their health better. This information may come from any of the sources mentioned in this paper. Employers could provide brown-bag lunch seminars on health care topics or lists of local resources, such as support groups.

One such educational program is detailed on page 17. It is a custom-designed, multimodule education program to help employees become savvy users of their benefits and managers of their own health care costs. The program was designed by the Business Health Care Group of Southeast Wisconsin. Dianne Kiehl, executive director of the coalition, explained why her coalition decided to develop tools for employee education to support employers that wanted to address total health benefit costs. The coalition's "Average Joe" educational modules give employees basic information about how health care works, what it costs, and information about how to approach health benefits as a "consumer" before making any important purchase. "There has to be a basic understanding of issues like these before the idea 'kicks in' and starts to make a difference in helping to manage the employer's overall costs," Kiehl said.



A health benefits broker, Susan Bonds Hinkle, managing director of the employee benefit division for Sterling Risk Advisors in Atlanta, GA, agrees with Kiehl. She advises small and mid-sized employers that want to reduce health benefit costs to start with employee education. “It’s not as difficult as people think,” Hinkle said. “It’s about educating employees on how to use the plans. Stay out of the emergency room. Use generic drugs when possible. Be proactive with your health. Get a physical exam each year.”²⁴

Employers can also help change the public mindset by educating employees about the cost of insurance. “Most employers do not share information about the actual cost of their benefits with employees,” Hinkle said. “They take a paternalistic view, but employees need to understand that health benefits are part of their compensation. The more an employer has to spend for their health benefits, the less money there will be for their salary increases and bonuses.”²⁴

Educating with specialized pricing tools

Working with its insurer, Humana, Dianne Kiehl’s coalition was able to provide customized pricing tools to the employees covered by Humana’s benefit plan provided through the coalition. The designers built a simple database of local costs of care and services that helped employees/consumers understand exactly what the costs would be before they used a covered service. To begin, Humana determined through claims data what treatments, services, and conditions comprised 75% of the coalition members’ total health care spend. To collect the cost information, claims were examined to identify what codes the doctors used for treatment of conditions producing the 75% of costs, and the tool provided a list of contractual prices under the health benefit for those services. The actual service costs were listed for various provider groups, hospitals, outpatient treatment and diagnostic facilities (imaging, infusion centers, etc). These per-provider costs were presented in terms of the cost to the employer and to the user of the benefit. Employees had the information they needed to decide whether cost was important to them in specific instances.¹²

Because it is particularly difficult for patients to understand what the total cost of an inpatient hospital stay will be, the pricing tool designers devised a list of inpatient “event” costs. “Patients don’t understand that they will receive multiple bills for a single inpatient stay — from the doctor, pathologist, anesthesiologist, and so on,” Kiehl said. “So, an average cost per-inpatient event was determined based on the average total costs for a complete inpatient visit resulting from common conditions among the covered members. The event-based costs were presented in the tool as a fairly tight range of total-cost-per-event at various hospitals.”¹²

Claims data to build region-specific pricing tools provided very specific information tailored to the coalition’s specific employee population.

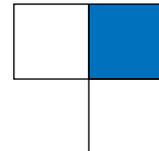
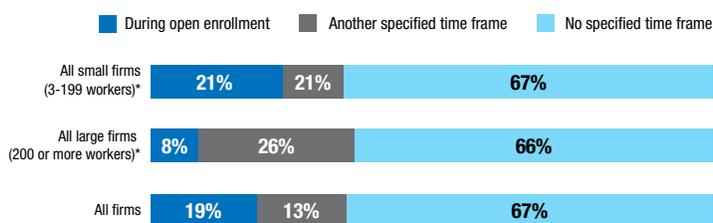


Figure 4. Among Firms Offering Health Benefits and Health Risk Assessments, Distribution of Firms Reporting the Following in Terms of When Employees Must Take Health Risk Assessments, by Firm Size, 2009



Distribution for “all small firms” and “all large firms” are statistically different ($p < .05$).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009.

Promoting program initiatives to employees

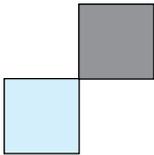
Using monetary incentives to motivate employees to take steps to improve their health or lower identified health risk factors is a common component of benefit designs that seek to change employee behaviors. Many employers use monetary incentives to encourage employees to fill out HRAs, for example.

Self-insured employers can reward employees directly with monetary incentives for using the most cost-effective or least-costly provider. An incentive might be offered for attending a health fair where cholesterol and blood pressure are

measured. A coupon can be issued for using a particular drug formulary product. Among large employers or coalitions having a single health plan, network providers may be offered financial incentives for meeting cost-effective or “best price” goals.

Self-insured employers can use this technique because it is the fiduciary of its health plan. Fully insured employers cannot administratively provide monetary incentives directly to providers or to employees; however, they may work through the plans with which they contract to take advantage of programs the plan already has in place, by alerting employees, or by making such covered services more convenient for them.

Even if you cannot or don't want to use monetary incentives for employees, encouragement to participate takes many forms, and using a range of outreach efforts has been shown to be more successful than using just one.¹⁴ Support and education materials can be available in multiple formats: online for download, interactive programs, in person (one-on-one coaching or interview sessions), or in groups (lunch and learns, open enrollment, health fairs). If the health plan is administering the program for you, it's typical to offer information call-in lines as well as care management phone calls made to employees with identified conditions. Don't overlook the pay envelope stuffer, workplace bulletin boards, and newsletter articles. Offer worksite, local hospital, or pharmacy screening opportunities. Distribute information about the importance of screening tests that are covered benefits and about managing conditions such as back pain and depression, and about the importance of healthy eating. Publicize any plan benefits that cover or offer discounts/coupons for fitness center memberships, smoking cessation programs or supplies, flu shots, and other preventive services.¹⁴



Designing Your Own Initiatives, Step by Step

Use the checklist on page 16 of this paper to guide your process as a proactive health benefit cost manager. You can also use the many valuable Web-based materials to study more intervention designs. The list of Web sites on page 21 should get you started.

Most information we have mentioned is free. Some tools have minimum fees. For example, take a look at the ACOEM Web site. It is a portal to a range of workplace health care tools, articles, and strategic examples of interventions that have worked for many employers. To help you get started, ACOEM provides a toolkit called “Health and Productivity Management” that is worth an investment in its low-cost subscription. The toolkit’s online, interactive chapters include case studies, tools for measuring health and productivity, and ideas for promoting programs to senior management.

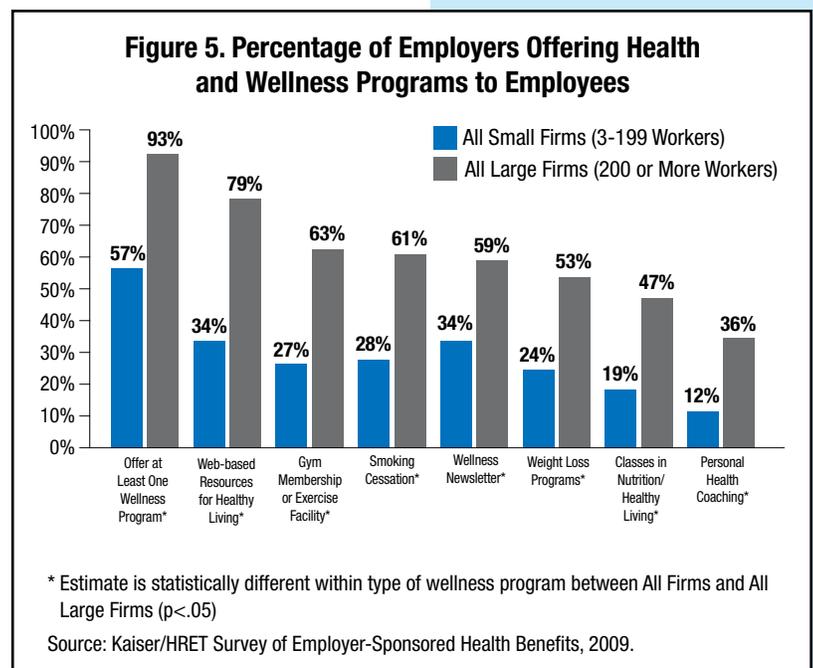
Subscriptions are \$199 (\$149 for ACOEM members). The initial subscription fee provides 1 year of online access to the kit, which includes periodic research updates, additional case studies, and other new material. The annual subscription fee after the initial year is \$89 (\$49 for ACOEM members.)²⁵

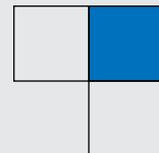
So, Get Started...

It’s likely that more pre-packaged programs that meet this goal will become available. Recent employer health benefit survey results (like those shown in **Figure 5**) assure us that more and more employers are addressing total health benefit costs through strategic health improvement interventions. It should be inspiring to note that more than half of small employers offered at least one wellness program in 2008, and most offered several.

Employers are taking proactive approaches because they have been shown to work, reducing total health benefit costs for the company and improving the health of your employees. It’s worth the effort.

More than half of small employers offered at least one wellness program in 2008, and most offered several.





Checklist of Steps to Take

Step 1: Gather Cost Data

Source of Claims Data

- Plan, PBM, etc.
- Coalition
- Data warehouse
- Cost data
- Other

Data Elements (Medical and Pharmacy)

- Match claim codes to conditions
- Match claim codes to providers
- Match drugs to conditions
- Match drugs to providers
- Match all to cost
- Cost to employee
- Cost to employer
- Identify the conditions costing the most

Source of Productivity Data

- Internal human resource (HR) records
- National/regional benchmark data
- Coalition benchmark data

Productivity Data Elements

- Disability costs
- Workers' Compensation
- Wage replacement
- Absenteeism
- Presenteeism

Step 2: Gather Health Information

Source of Employee Health Information

- Employee-specific, overall, from claim reports
- Employee-specific, overall, from HRAs
- National/regional benchmark data
- Coalition, HIE, plan
- Other

Information Elements (Medical and Pharmacy)

- Top 5 conditions (in terms of claim costs)
- Top 5 conditions (in terms of absenteeism)
- Risk factors to target
- Risk reduction possibilities

Step 3: Build Internal Commitment

Management Commitment Building

- Put the data and information together
- Prepare a company-specific report
- Have clear costs tied to specific health conditions
- Suggest reachable goals; perhaps 1 or 2 conditions to address
- Suggest a working budget
- Suggest a possible timeframe
- Indicate how evaluation might work
- Don't present a program right away; present a plan to put together a program to address a specific need

Employee Commitment Building

- Think long-term, but set annual goals
- Decide what benefits the employee
- Determine types of promotion
- Keep it simple

Step 4: Select Interventions

Investigate All Options

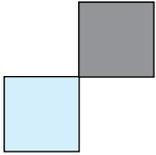
- Web-based programs
- Programs used by other employers
- Programs offered by plans
- Programs offered by regional groups
- Educational outreach
- Other

Design Programs Around More Than One Option

- Make internal-specific adjustments to pre-packaged options
- Attach implementation plans
- Attach evaluation plans
- Attach timeline
- Attach promotional outreach
- Determine budget

Present options to management; then, select the intervention and the path it will follow.

Once you have selected your interventions, fine-tune your plans and determine what needs to be done to succeed. Work with an internal team to roll out the plan to employees. Be accessible every step of the way — to management, the team, and the employees. Set clear benchmark goals and let everyone know what they are and when they will be presented company-wide.



Best Practice Profiles

The “Average Joe” educational module series

Dianne Kiehl, ED, Business Health Care Group of Southeast Wisconsin
dkiehl@businesshealthcaregroup.org

These 7 video modules were devised to provide basic information about health care benefits to improve the level of understanding among employees and to show them that they can play an important role in controlling health care costs. The modules include practical steps that employees can take to become more actively engaged as “wise” health care consumers.

The program also provides a tool to assist HR personnel in explaining key aspects of health benefits, such as how to use an explanation of benefits (EOB). Finally, the ancillary information created to accompany the video series provides employees with resources and tools that enabled them to dig deeper into the information they had seen in the videos. These are available through online links to safe sites with more information, in a list of 10 key takeaways—“Joe’s Tips,” and in a downloadable dictionary of insurance and benefit terminology.

The first module focuses on understanding the health benefit and the drivers of benefit costs — those for the employer as well as those borne by the employee who buys the services and shares cost.

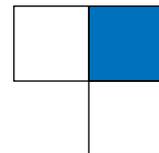
Description and use of educational materials

The videos can be presented to a large audience or viewed on a personal computer. The program is available to all member companies in the coalition and has been used by the majority of companies in ways that fit the particular employer’s needs and company culture. Some have asked all employees to view the modules on their own on the company Intranet, and others have shown the modules at scheduled employee meetings. One small employer made personal DVDs of the full series and handed them out during open enrollment. HR has used the videos as discussion starters.

Some employers introduced the modules as a voluntary activity for employees and publicized links to the information in newsletters, handed out the printed downloads, or posted them in the workplace.

The Module Series

- Joe—A Health Care Consumer
- How Insurance Works
- Right Plan, Right Doctor
- Getting the Most From Your Health Care Visit
- Going to the Hospital
- Prescription Drugs
- Prevention and Lifestyle



Diabetes medication therapy management

Sue Szymanski, FrontPath Health Coalition, Northwest Ohio
sszymanski@frontpathcoalition.com

FrontPath Health Coalition, the largest health care purchasing coalition in Northwest Ohio, implemented a pharmacist-conducted Medication Therapy Management (MTM) program for employees and dependents of the city of Toledo and Toledo firefighters.

Program overview

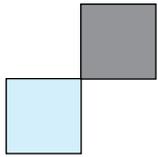
Pharmacists agreed to provide education to patients about their disease in a series of 5 counseling sessions over a 1-year period. The goal was to improve outcomes for diabetic employees and dependents on both clinical outcomes (eg, hemoglobin A1c [HbA1c] levels and blood pressure) and humanistic outcomes (eg, satisfaction with care and quality of life). The program also sought to reduce emergency room visits and hospitalizations.

Program results

A total of 97 employees and dependents enrolled in the program. By April 2009, 72 participants had completed their second session (3 months) and 51 patients had completed their third session (6 months). The MTM program successfully decreased participant HbA1c levels and blood pressure readings. The average HbA1c level after 6 months was 7.59% compared with 7.77% at baseline. Additionally, 26% of participants experienced an absolute decrease in HbA1c levels by more than 1%.

What's more, the average number of sick days (over a 3-month period) decreased from 1.2 at baseline to 0.3 at 6 months. Pharmacists observed significant improvement in patient knowledge about their disease for all disease states assessed (diabetes, hypertension, and hyperlipidemia). The percentage of patients who saw a podiatrist in the previous 6 months increased from 32% at baseline to 57% at 6 months, an improvement in appropriate health care utilization. Meanwhile, the average number of emergency room visits dropped from 1.9 visits in the year prior to the program (Jan-Dec 2007) to 1.3 visits in the year of the program (Jan-Dec 2008). The number of hospitalizations fell from 1.6 to 1.3.

“We are very excited with the results that we were able to achieve during the first year of the pilot project,” Sue Szymanski, president and CEO, said. “We believe that this program has potential on a long-term basis to achieve significant improvements in health quality and in reducing health care costs. We hope to expand the program beyond its initial pilot phase.”



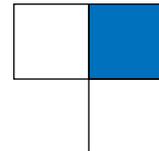
Tools for Positive Change

Successful Business Strategies to Prevent Heart Disease and Stroke: Toolkit Components

Centers for Disease Control and Prevention. Heart-Healthy and Stroke-Free Worksites www.cdc.gov/dhdsp/library/toolkit

The materials in this toolkit are intended to motivate employers to provide prevention health benefits and services for their employees and establish effective worksite programs to prevent heart disease and stroke. State program staff may use all or some of these materials, depending on the type of meeting or presentation conducted with an employer, business group, or health association. A CD-ROM with all the toolkit materials is included for easy reproduction and adaptation. Materials are also available online at www.cdc.gov/dhdsp/library/toolkit. The toolkit provides the following resources:

Tool	Purpose
<i>Reducing the Risk of Heart Disease and Stroke: A Six-Step Guide for Employers</i>	A handout that allows users to make a strong case to employers for investing in comprehensive programs and services to prevent heart disease and stroke. It includes information about promising employer practices and effective interventions. It also allows employers to estimate how much they can save on costs related to health care, absenteeism, and lost productivity by investing in these programs.
<i>Evaluating Health Plan Benefits and Services to Promote Cardiovascular Health and Prevent Heart Disease and Stroke</i>	A checklist to help employers choose and negotiate a health benefits package that fits their business and workforce.
<i>Promising Practices Summary and Koop Award Winners</i>	A summary of successful heart disease and stroke prevention programs in different worksite and health care settings.
PowerPoint Presentation	A presentation for employers and business groups using the information in the <i>Six-Step Guide for Employers</i> .
CVD and Business Glossary	Definitions and business terms related to heart disease and stroke prevention and disease management.
Additional Resources	Information such as national guidelines, additional worksite toolkits and assessment tools, and associations and agencies that address heart disease and stroke prevention.
Articles	Selected articles on prevention benefits and services that support the business case for cardiovascular health.



Diabetes at Work Program

American Diabetes Association <http://www.diabetesatwork.org>

diabetesatwork.org
Taking on diabetes. Together, we are making a difference.

Home Getting Started Next Steps Program Evaluation Success Stories Tools & Resources FAQ

DiabetesAtWork.org can help you reduce healthcare costs and improve productivity by keeping your employees healthy.

Who should use this site?

Occupational Health Providers Diabetes Educators Health Programs People at Risk for Diabetes Healthcare Providers Health Plans

hot topics

- Assessment Tools
- Making the Business Case
- Lesson Plans
- Designing Your Program and Benefits
- Worksite Health Promotions, Presentations and Additional Resources
- Business Stories

take aim

Lesson Plans/Resources for People With or At Risk for Diabetes, Their Families and Caregivers

Lesson plans include:

- Understanding Diabetes
- How to Get and Stay Healthy with Diabetes
- Get Moving and Eat Well
- Emotional Well-Being
- Cardiovascular Disease
- in Spanish

NEWS YOU CAN USE

Spotlight on HHS and people with diabetes: The following links provide important resources for the business community during the 2009-2010 flu season.

- Diabetes and H1N1
- CDC Guidance for Businesses and Employers to Plan and Respond to the 2009-2010 Influenza Season
- Preparing for the Flu: A Communication Toolkit for Businesses and Employers

Number of People in U.S. with Diabetes Increases to 24 Million
Diabetes now affects nearly 24 million people, or 8 percent of the population.

Devastating Fall of Diabetes Deaths
Study reveals death rates have climbed 22% since 2002.

Headlines: Eating at Work

Controlling Obesity in the Workplace

CDC ON DEPRESSION AND DIABETES NOW AVAILABLE ON DiabetesAtWork.org
Recent studies have shown that people with diabetes have a higher risk of developing depression.

This site can help you:

- Develop a diabetes prevention or management program
- Estimate the number of employees in your company with diabetes
- Estimate the total cost of diabetes in your company
- Choose or design a health plan for people with diabetes
- Obtain support from leadership for a diabetes program

DiabetesAtWork.org is a cooperative effort of the National Diabetes Education Program (NDEP), National Business Group on Health, National Business Coalition on Health, and America's Health Insurance Plans. NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations.

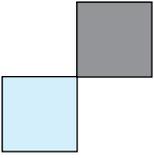
Home | email your employer | become a NDEP partner | contact us | Copyright © 2010

Department of Health and Human Services National Institute of Diabetes and Digestive and Kidney Diseases CDC Centers for Disease Control and Prevention National Diabetes Education Program

This online program provides all the materials an employer needs to launch a continuing care program for employees at risk for diabetes and those already diagnosed. Content includes a planning guide, assessment tool, tips on choosing a health plan that supports diabetes treatment and information on a wellness program, fact sheets, and other resources that can be used at the worksite.

General educational materials include managing diabetes skills, nutrition, weight control, physical activity, how to handle emotional well-being, and the risks of cardiovascular disease.

In addition, the site provides access to lesson plans that can be used to present lunch-and-learn programs: *High and Low Blood Glucose Symptoms and Causes, Making Your Doctor Visit Count, Cardiovascular Risk Factors, and Foot Care.*



Links to Programs That Improve Employee Health

The State of Health Care Quality: 2009 Report **National Committee for Quality Assurance (NCQA)**

<http://www.ncqa.org>

The State of Health Care Quality: This report is NCQA's thirteenth annual assessment and interpretation of key trends in the health care industry and their effect on the nation's overall health. This edition is based on data collected for *Quality Compass*, NCQA's database of managed care information, and on NCQA's accreditation and recognition programs. *Quality Compass 2009* contains audited, plan-specific information on clinical performance, accreditation, and member satisfaction from 979 commercial, Medicaid, and Medicare organizations that submitted performance results to NCQA for public dissemination, collectively covering more than 116 million lives.

AHA white paper on workplace wellness programs

<http://www.americanheart.org/downloadable/heart/1244735385073Start%20White%20paper%206-4-09.pdf>

Breast Health Month (October) Resources

nbcam.org/help_worksite_initiatives.cfm

Weekly E-mail Blasts	Brochure	Screening Fact Sheet
Newsletter Articles	Poster	Biopsy Fact Sheet

Beat the Pack

ehpco.com/_PDFs/BeatthePack.pdf

Information on Smoking Cessation Program

Centers for Disease Control and Prevention

www.cdc.gov

FluStar

www.flustar.com

HealthSmart

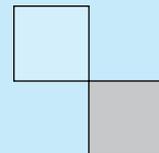
www.healthsmart.org

WebMD

www.webmd.com

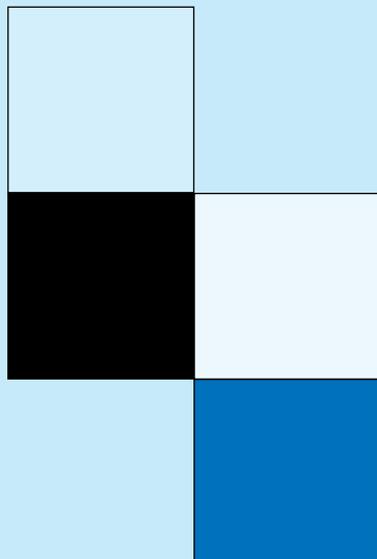
Wellness Council of America

www.welcoa.org



References

1. Centers for Medicare and Medicaid Services. National health expenditure data. http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp. Accessed December 11, 2009.
2. Schoen C, Osborn R, How SK, Doty MM, Peugh J. In chronic conditions: experiences of patients with complex health care needs, in eight countries, 2008. *Health Affairs (Millwood)*. 2009;28:1-16: Epub 2008 Nov 13.
3. Hewitt Associates. As costs continue to rise, active decision-making remains critical for employees during this year's open enrollment period. [Press Release]. September 30, 2009. <http://www.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=7363>. Accessed November 22, 2009.
4. Integrated Benefit Institute. The business case for managing health and productivity. June 2004. http://www.acoem.org/uploadedFiles/Career_Development/Tools_for_Occ_Health_Professional/Health_and_Productivity/IBIFull-CostResearch.pdf. Accessed November 15, 2009.
5. Loeppke R, Taitel M, Haufle V, Parry T, Kessler RC, Jinnett K. Health and productivity as a business strategy: a multiemployer study. *J Occup Environ Med*. 2009;51:411-428.
6. Kaiser Family Foundation and Health Research and Educational Trust. Employer health benefits 2009. <http://ehbs.kff.org>. Accessed December 11, 2009.
7. Parry T. Diseases vs. populations – the impact of chronic conditions. August 2008. <http://ibiweb.org/do/loginlogout/Welcome?sessionId=5FF8AA251095244AFBCFEC4665AEC433>. Accessed December 11, 2010.
8. American Diabetes Association. Winning at work—diabetes facts. <http://www.diabetes.org/community-events/programs/winning-at-work/winning-at-work-diabetes.html>. Accessed November 10, 2009.
9. Pelletier KA. A review and analysis of the clinical- and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: 1998-2000 update. *Am J Health Promot*. 2001;16:107-116.
10. Chapman L. Meta-evaluation of worksite health promotion economic return studies: 2005 update. *Am J Health Promot*. 2005;19:1-11.
11. Change Agent Work Group. Employer health asset management: a roadmap for improving the health of your employees and your organization. <http://www.ihpm.org/pdf/EmployerHealthAssetManagementRoadmap.pdf>. Accessed December 11, 2009.
12. Personal conversation with Dianne Kiehl, November 29, 2009.
13. American Heart Association, 2009. Worksite wellness. <http://www.americanheart.org/downloadable/heart/1244735385073Start%20White%20paper%206-4-09.pdf>. Accessed December 11, 2009.
14. Personal conversation with Chris Goff, September 11, 2009 and November 16, 2009.
15. Centers for Disease Control and Prevention. Reducing risks of heart disease and stroke: a six-step guide for employers. http://www.cdc.gov/dhdsp/library/toolkit/pdfs/six_step_guide.pdf. Accessed December 11, 2009.
16. Whiting R. Data analysis to health care's rescue. *Information Week*. September 24, 2001.
17. HealthCare 21 Business Coalition, Knoxville, TN. HealthCare 21 data cooperative. http://www.hc21.org/data_warehouse.html. Accessed December 11, 2009.
18. Personal conversation with John Kahle, November 6, 2009.
19. Personal conversation with Neil Simons, November 5, 2009.
20. iHealthBeat. November 17, 2009; October 27, 2009; November 4, 2009.
21. National Business Coalition on Health. Annual report 2008. <http://www.nbch.org>. Accessed September 14, 2009.
22. Integrated Benefits Institute. Blueprint for health. Online productivity calculator. <http://ibiweb.org/do/loginlogout/Welcome?menuId=74&linkId=38678&submitAction=link&resourceId=38678&isParent=false&sendToServer=true>. Accessed December 12, 2009.
23. Columbi A, Pringle J, Welsh G. Not waiting for Godot: the evolution of health promotion at PPG Industries. *Amer Health and Drug Benefits*. 2008;1(3):30-38.
24. Personal conversation with Susan Bonds Hinkle, November 5, 2009.
25. American College of Occupational and Environmental Medicine. <http://hpm.acoem.org>. Accessed November 18, 2009.



National Business Coalition on Health

1015 18th Street, NW, Suite 730
Washington, DC 20036
202.775.9300 • www.nbch.org

