

Reducing Healthcare Costs

for Employers

Employee Benefits Series

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Other Companies Jump On Board

Firm Deploys Primary Care Focus To Cut Costs up to One-third

A Wisconsin printing firm says its company-owned health plan, which places a priority on primary care and prevention, has been so successful at keeping down costs that it's caught the eye of other employers and has now replicated its model for five of them.

Quad/Graphics, the largest four-color printer in the United States with 11,600 employees, created subsidiary QuadMed in 1991 in an attempt to rein in cost problems and improve the quality of employee health. QuadMed, an on-site clinic launched with one nurse and one doctor, began generating 10- to 15-percent savings in the first few years. In the past five years, its health costs are 31 percent less than if the company had bought health care on the open market, according to Raymond Zastrow, MD, president of QuadMed in West Allis, Wis. The company-owned health plan

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Case Study

Value-based Payments to Providers Stops Expensive Complications

Like many North American manufacturers, Rockford, Ill.-based Aircraft Gear Corp. is coping with the combined toll of rising health care costs and a downward economic cycle, which forced it to reduce its workforce from a peak of 500 to 600 employees in the 1990s to 80 to 100 today.

The aviation and auto components manufacturer decided to turn to value-based purchasing (VBP) to help contain health care costs. And it has found a way to align provider incentives with the employer goals of managing chronic diseases and avoid avoidable complications.

The employer focused on three areas of risk to target health plan changes: (1) insurance and underwriting risk; (2) operational or technical risk; and (3) lifestyle risk, says Aircraft Gear Risk Manager Jim Knutson.

Each employee has a different underwriting risk, based on his or her genetic make-up, and the best way to impact this area is to know your employees' health problems and direct preventive efforts in these areas.

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For instance, a high tech company that largely employs people in their 20s would have very different health plan concerns than a truck manufacturer with a workforce consisting mainly of men in their 50s, says Larry Boress, president and chief executive officer of the Midwest Business Group on Health in Chicago.

Traditionally, employers have little control over operational risk since this encompasses health care mistakes when a procedure doesn't go according to plan, but VBP offers an interesting strategy for addressing this risk.

"One strategy is influencing and changing how health care providers provide care," says Andrew Webber, president and chief executive officer of the National Business Coalition on Health in Washington, D.C. (see story, this page).

"Shame on us if we as purchasers have not set up a payment system for providers that rewards quality, performance, and pays for the right things," Webber says.

The first thing Aircraft Gear put its energy into was a wellness programs, focusing on weight loss and general health issues, and holding health fairs with biometric screenings. It reduced copays for preventive treatments and diabetes management.

The next step was to address operational risk through a strategy of speaking with providers and making agreements that align quality, transparency and cost goals.

Knutson uses the value-based strategies employed by Prometheus Payment Inc., a nonprofit corporation of which Knutson is a board member. The organization was formed in 2006 by experts in health care economics, law, health plans and other fields for the purpose of improving health care quality, care coordination and transparency using restructured payments as a tool to achieve those ends.

Get Coordinated Care From Providers

Using historical plan data and analytics tools provided by Prometheus, the employer determines what the expected typical costs are for each plan member.

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Reducing Healthcare Costs for Employers

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Employer Help in Purchasing Choices Prevents Waste


Like value-based benefit design, value-based purchasing works to change behavior in a way that improves both quality and costs.

Employers can influence the provider marketplace by inserting competition back into the equation, says Andrew Webber, president and chief executive officer of the National Business Coalition on Health in Washington, D.C.

For example, in the San Francisco area, providers charge widely different rates for colonoscopy screenings. These can vary from \$400 to \$5,000, Webber says.

"Why are we paying for colonoscopies that are a significantly higher price?" he says. "So we go to employees and say they should get a colonoscopy, but we have done an analysis and found that the average price in this area is \$1,500 for a colonoscopy."

Then the employer gives plan members a list of physicians who charge \$1,500 or less. "We say we'll pay 100 percent of the cost of the colonoscopy for providers on that list," Webber says. "But if an employee goes to a provider who charges more then they'll have to pay the entire difference between \$1,500 and what their doctor charges."

This strategy has worked very well in helping employers keep some costs down. And it's even led to a price decline as the competition is lowering costs, he adds. "We need to influence individuals in their consuming behavior and influence the provider community in how they supply the goods and services, and employers have the key lever on both of these," he says. 

Successful HRAs Doggedly Pursue Reluctant Members for Plan Savings

Employers will gain little insight into plan members' chronic disease status if too few have bothered to have a health risk assessment (HRA).

A typical HRA program might be used by 25 percent to 50 percent of plan members, but a technology-based HRA strategy can increase this to 70 percent, Berger says.

"Employers want to improve health quality, worker productivity and decrease health care costs, but to do this you have to have employees' participation, which has been a huge challenge for a number of years," says Jan Berger, M.D., chief medical officer of Silverlink Communications in Burlington, Mass. As a technology-based communications company, Silverlink helps health plans design HRA strategies that engage more plan members without using incentives.

"We had one client who used the system to reach its 45 percent of members who were non-responders, the hard-to-gets," she recalls. "We were able to get these people to not only take the call and interact with us, but also to complete the full [HRA]."

Silverlink uses telephonic technology to reach plan members. People are called at times of the day and week when they most likely will be found at home.

"We know down to Zip codes when we'll find people to be more likely to respond to the calls," Berger says. "We found that we could improve engagement of the health care consumer if we reached out to them on Mondays."

The telephone calls use computer-generated, interactive voice response (IVR) systems, meaning they have computer voices, and they stick to a simple script.

The telephone calls can be combined with e-mails and letters that notify plan members that a telephone call might be coming and they could either answer the call or complete the questions online.

Another key to the IVR calls' success is that the HRA questions are personalized. For example, if the system calls a man, it won't ask him questions about pregnancy or hormone replacement therapy.

The IVR system costs less than live phone calls, Berger says. "The use of live agents can be very costly because you're not maximizing their use," she explains. "Often, you can't get the person on the phone."

IVR systems can be adapted to particular subpopulations. So a male, slow-speaking voice will call plan members who live in a region where people prefer this style.

The voice's gender, speed, tone, accent, etc. are all analyzed and adapted to the needs of any particular population. The IVR system can recognize a wide variety of slang words, including some foreign words that mean "yes."

IVR system can modify questions in response to plan members' answers.

A health plan could select only 10 questions to ask members, but since the goal is to obtain enough detailed information to inform health care plan design, this might backfire. So a better range is 25 to 30 questions. "A large percentage of people will complete a telephone survey, but the longer the questions go on, the more the number drops off," Berger says.

People Open Up to a Recording

The technological strategy also obtains more honest answers from plan members about health status, moods, and behaviors since the people being called do not fear being judged. They might hide information, such as their drinking habits or sad feelings, if they were sitting down with their doctor or nurse, Berger notes.

"In one example, we found that 62 percent of plan members called were positively screened for depression," she says. "Then 34 percent of those people who were found in the initial screening scored high on another depression test and needed to be seen by a health care professional."

Depression left undiagnosed can lead to lower work productivity and result in other health problems, possibly making a patients chronic asthma, diabetes or multiple sclerosis worse, Berger says. 🏠

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Then it negotiates with a provider to provide coordinated care for a plan member for the determined typical cost amount. In the case of patients with a chronic disease like asthma, that might include regular check-ups, and follow-up calls and care to make certain the patient complies with medication and treatment. Providers who fail to provide quality care as defined by national practice guidelines would be penalized through a compensation change.

The analytics tool also determines each plan member's potential health care costs under a category that is labeled "potentially avoidable complications" (PACs).

PACs are health care procedures that employers typically pay for, even though they could have been prevented. According to the Robert Wood Johnson Foundation and Prometheus, eliminating PACs for six chronic diseases — diabetes, congestive heart failure, coronary arterial disease, hypertension, chronic obstructive pulmonary disease, and asthma — would reduce health costs by up to 40 percent.

While it's unrealistic to expect to reduce preventable complications to zero, it's possible to do better by aligning providers' incentives with the employer's goals to improve care and cut costs.

For example, if a diabetic plan member's PAC for 2011 is \$1,500 then the employer can negotiate with providers to share any savings achieved in that potential cost. So if the diabetic has no PAC costs for 2011, then the provider will receive \$750 in a refund, Knutson explains.

"But before we get to that point, the provider must prove he or she has met the thresholds we set for providing quality care," he says. "We don't want the savings to come at the expense of providing adequate care."

VBP uses both process measures and outcomes measures. In the example of the diabetic patient, there are process measures for whether the provider checked the patient's eyes, feet and blood sugar. The outcomes measure checks their blood sugar level and blood pressure.

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How to Create a Health Budget

Employers that want maximum savings from value-based strategies need good data about plan members' illnesses and doctor visits. They use the information to project future spending that can be used to guide future negotiations and decisions.

The health care budget is at the intersection of personalized medicine and group health, says Jim Knutson, risk manager at Aircraft Gear Corp in Rockford, Ill.

There are four categories in the health care budget. They are:

- **Budget for typical care:** Health plan members each have their own budget for services that would be appropriate for them in a given year. These are determined by their health status and past health claims. This budget estimates the amount of money it would take to provide each plan member the bundle of services that are appropriate for them and which should help prevent disease and declining health. For example, a budget for typical care of a diabetic patient might be \$3,000 to cover primary care provider visits, lab tests and diagnostics.
- **Budget for potentially avoidable complications (PACs):** This budget is an estimate of the cost of providing care due to bad health decisions or accidents. For instance, if an asthma patient is having difficulty with his or her medication, then the patient might end up in the emergency room. The cost of this ER visit is potentially avoidable. In the example of a diabetic patient, the PAC might be \$1,500 if the patient's diabetic control is not adequate and the patient has acute episodes.
- **Actual expenses in typical care:** Employers need to continually analyze their typical care budget by collecting data on each plan member's actual expenses. It could be that a plan member has developed a new chronic illness or has had an accident that will require long-term higher health costs. So these historical data must be reviewed and incorporated into future budgets.
- **Actual expenses in PACs:** Data on actual expenses of PACs will show an employer which plan members and providers are doing as well as expected. This information will show which providers and plan members are doing what they should to manage their chronic illnesses and maintain good health. Employers can use the information to change incentives that would achieve better results. 🏠

Employers Honored for Encouraging Employee Health

Sixty-six U.S. employers, including 13 first-time winners, were honored by the National Business Group on Health (NBGH) for their commitment to promoting healthy work environments and encouraging employees to choose healthier lifestyles. The “2010 Best Employers for Healthy Lifestyles” awards, now in its sixth year, were presented at the NBGH’s Institute on Innovation in Workforce Well-being Leadership Summit held in Washington, D.C., June 14 and 15.

The health care costs for employees using the clinic in 2009 was about \$443 per employee per month; for those who didn’t use the clinic, the cost was \$660 per month, about a third higher.

“Employers all across the nation are recognizing just how important a healthy workplace and a healthy workforce are to improving productivity as well as controlling health care costs,” says Helen Darling, President of the NBGH. Sixteen of the winners received “platinum” awards for established workplace well-being programs with measureable success and documented outcomes; “gold” and “silver” winners’ programs are newer.

Each employer’s program varied to some extent, but they often included wellness and health management programs and strong alignment of incentives and benefit design with health improvement targets, reported LuAnn Heinen, Vice President of the NBGH and overseer of the awards program.

Many employers, such as Nationwide Mutual Insurance Co., PepsiCo and Pitney Bowes attributed decreased health cost trends, improved employee health and higher participation rates to their programs. Bayport, Minn.-based Andersen Corp. reported that its A+ Health Program reduced participants’ health risks by 13.5 percent and medical cost trends steadily decreased during the first three years of the program, including a negative 8.7-percent move in 2007.


Cerner Reports Better Outcomes, Lower Costs

Kansas City-based Cerner Corp., a platinum winner, shared the success of its “Health-e Living Program,” a customizable incentive program that awards points for participation and completion of various wellness programs and other initiatives and then lowers health insurance premiums based on the number of points earned.

Each point equals one dollar. Employees who earn the 1,000 point maximum in 2010 have \$1,000 applied to their 2011 health insurance premiums. According to Mike Heckman, Cerner’s Director of Global Benefits, Cerner has been able to measure its success with the 2½ year program, which relies heavily on use of an on-site clinic for its 11,000 covered lives. “The results have been most exciting; we’re beginning to see quantifiable results,” he noted in a panel discussion.


For instance, the health care costs for employees using the clinic in 2009 was about \$443 per employee per month; for those who didn’t use the clinic, the cost was \$660 per month, about a third higher. Those who use the clinics saw the number of health risk factors (such as body mass index, blood pressure, LDL cholesterol and triglycerides) drop from 1.8 risk factors to 1.5 from 2007 to 2009; employees who didn’t use the clinics but received treatment elsewhere saw the number of their risk factors drop slightly, from 1.9 to 1.8. Employees who were non-users of health care maintained 1.9 risk factors all three years. “That is a cost in productivity and potentially a lot of [expense] in the future because these people may need [more] health care,” Heckman explained.

See *NBGH Awards*, p. 8



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now operates 11 clinics with 270 employees and 45 full-time equivalent providers, he adds.

QuadMed's model is focused on primary care, prevention and wellness, and combines its on-site care model with aspects of value benefit design (see the March 15 issue). Employees may choose one of three plan tiers. Weekly premiums for all three tiers are: \$24 for an employee, \$37 for a couple, and \$52 for a family. The preferred tier requires use of the on-site clinics, supplemented by a network of hospitals and specialty clinics. About 85 percent of employees choose this tier. Copayments and deductibles for the preferred tier are much lower; they are zero for treatment received in a QuadMed clinic and for certain medications.

Prepare the Ground for Value-based Design

If an employer is considering incorporating/adding value-based design (VBD) to its health benefits program, it should:

- Make sure that top management supports the endeavor. "If there's no C-suite buy-in it's not likely to be successful," says Zastrow.
- Communicate prevention/wellness continually. For instance, in June QuadMed runs a mini-Olympics; in October it will publicize breast cancer awareness month. "If you only tell people at open enrollment [to engage in healthy behavior], they will not necessarily be thinking of it later in the year," notes Nayer.
- Send the message in a way that recipient wants to receive it. "Ask employees how they want to be contacted. Some prefer text, some prefer e-mail. Otherwise employees may not respond [to a communication] and you may not get their attention," Nayer warns.
- Ensure a culture of privacy. "There needs to be an informational firewall. What happens in the clinic stays in the clinic," Zastrow says.
- Lead by example. "If you see your doctor on the treadmill, it creates a personal bond behind and beyond those doors," he notes.
- Be prepared to review the data at least quarterly so you're on top of developments. "Change incentives if you have to," says Nayer. 🏠

The middle tier looks like a preferred provider organization, where members can choose from a network of 20,000 doctors and 153 hospitals. The deductible is more than double the one in the preferred tier and coverage is set at 75 percent after the deductible has been met.

The third, non-network tier allows full patient choice and covers 65 percent of care; the deductible is more than three times higher than in the preferred tier.

What's integral to the success of the program is the reliance on primary care and prevention, says Zastrow. The providers operating the clinics are primary care givers, such as pediatricians, internists and physician assistants; there are also physical therapists, dieticians, fitness coaches and diabetic counselors on site. They are all salaried employees, so there's no incentive for them for over-prescribe or over-treat patients (they can earn 10-percent bonuses based on clinical quality, customer service and collegiality).

"We also slowed down the pace of care. The minimum visit is 30 minutes, so that the practitioners can get into the patient's wellness and preventive care and ask how that smoking cessation program is going," explains Zastrow.

The model relies on data kept in the clinics' electronic health records to track blood pressure and body mass index over time, and monitors claims data so the clinics can track medication compliance and adherence to preventive screening protocols.

For example, QuadMed's diabetes program charges no copayment for diabetes medication, so long as the patient takes the medication, meets with the diabetes counselor, meets with physicians and undergoes other tests, such as an annual foot exam. "But these are all best practices for being a healthy, fully engaged diabetic. We're taking away the financial barrier. Referring to the amount the company pays for supplies, Zastrow says, "\$545 for sticks is cheap compared to blowing off [the preventive care and ending up with absenteeism and hospitalization.]"

"Other companies may just give free drugs. But I say you have to have skin in the game so you need to stay adherent," he adds.

With such a focus on primary care, not surprisingly the percentage of Quad/Graphics' costs for primary care is higher than for other Midwest employers. But its costs for more expensive items are lower: the costs for hospital inpatient care is 38 percent lower and pharmacy costs are 62 percent lower than the national norm, Zastrow reports; emergency room and diagnostic imaging use

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are also down. Use of QuadMed's program has reduced Quad/Graphics healthcare costs to about \$6,800 per employee per year. "The return on investment is huge," he adds.

What's particularly interesting is that other area employers, impressed with QuadMed's success, have joined the bandwagon – not by creating their own clinics but by hiring QuadMed to do it for them. Of the 11 clinics now operated by QuadMed, only five service Quad/Graphics employees and dependents; the other six are for other companies, including Coors, Briggs and Stratton and Northwest Mutual, says Zastrow.

Incorporating Value-based Essentials

A key aspect of QuadMed's program is its use of the value-based design (VBD) insurance strategy, which encourages patients to engage in healthy behavior and is not illness-only oriented. "In its most simple definition, VBD is lowering cost sharing and eliminating financial barriers for essential care," explains Jennifer Boehm, a health management consultant at Hewitt Associates in Atlanta. "It's more than tweaking the copayment. VBD is a component to a much larger health improvement strategy," she adds.

There are three pieces to VBD: personal health management/prevention/wellness; chronic care management; and provision of incentives to use the appropriate amount of services, according to Cyndy Nayer, president and CEO of the Center for Health Value Innovation, St. Louis. The Center is the leading organization dedicated to information exchange for VBD; Zastrow, who is vice president for evidence of the Center, was recently recognized by BizTimes Milwaukee for Corporate Achievement in Health Care for his design of QuadMed and savings accomplishments.

"It's about getting the full value worth of the money you're spending. Wellness teaches you to manage health. VBD reinforces the behaviors to manage the health," says Nayer.


More Employers Turning to, Contemplating VBD

VBD is increasingly being seen as a valid alternative to traditional health insurance to improve employee engagement in preventive care and lower health care costs, and more employers are incorporating elements of VBD into their health insurance programs (for more information see box below). "An employer paying for preventive care is a basic, simple form of VBD. Some employers now offer that; some who have offered just that are expanding their use of VBD," says Nayer.

It's primarily being embraced by self insured employers, although several health plans are thinking of adding it to their programs, says Boehm.

Note that while VBD has cost and health benefits, some employers are taking a wait and see attitude about its usefulness. For example, it's still hard to prove that reduced health costs are solely attributable to VBD, although intuitively it makes sense, notes Boehm. "The literature is currently light," she explains. Employers whose employees are more likely to comply with their health and medication regimes may have less of a need for the incentives inherent in VBD; some employers philosophically don't want to give anything away for free.

"There's a fear of the unknown. It's not a core competency for an employer. There's also an unfounded concern that it will disenfranchise employees," says Zastrow.

"Employers can manage health care just like they can manage their supply chain. It's such a big expenditure. We really screwed up with the fee-for-service model. An ounce of prevention is better than a pound of cure. We're getting out of the reactive break fix," he notes. 


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The goal is to see improvements in the patient's control before incentive funds are distributed to providers.

Also, the concept can translate into giving incentives to plan members who reduce their PACs.

"If you have someone with a chronic condition who is compliant and using typical care in appropriate amounts and is not incurring PACs, then as an incentive and reward that person could share in some of that savings," Knutson suggests.

This concept is new and providers have been cautious as might be expected, Knutson says. "They raised some legitimate points about patient behavior," he says. "They say they can't go to a patient's house every day and make sure they take their medication three times a day."


While that's true, providers can work with patients by having a nurse or care coordinator make follow-up phone calls and by providing a 24-hour number for patients to call if they feel they're having a medical emergency. In some cases, an ask-a-nurse hotline call might prevent a patient from making an emergency room visit. 

Employers See Value-based Design's Health and Productivity Gains

Value Based Design (VBD), a relative newcomer in health insurance plan design, is gaining in acceptance, according to a recent study conducted by Buck Consultants for the Center for Health Value Innovation, based in St. Louis. This is the first study to verify the experience of employers with at least two years of VBD.

The study, "Value-Based Design 2009" surveyed 100 employers in 16 major industries and reported on more than 1 million covered lives. Of the respondents who currently have VBD incorporated into their health program, 79 percent made no changes in 2009 and 56 percent anticipate no changes in these benefits for 2010, indicating their satisfaction with their programs despite the economic downturn.

Other results include the use of VBD to improve employee engagement:

- 87 percent use for prevent/wellness
- 80 percent use for disease management
- 70 percent reduce/waive copayments for using the lowest cost appropriate site of care
- 63 percent waive employee cost sharing for a yearly screening exam
- 60 percent use for chronic care management
- 58 percent provide incentives for the use of employee assistance programs
- 54 percent cover depression under a care management program. 

NBGH Awards (continued from p. 5)

"Of the 3,200 employees who have been through the program from 2007 through 2009, 77 percent got better or stayed the same; 77 percent are on the right track and all of them got two years older," Heckman points out (38 percent showed positive results, 39 percent stayed the same).

"A lot [of our cost savings] was in productivity gains. In the future we will measure [even] more," he points out.

While Cerner doesn't yet have data on how the direct incentive affects health care costs, the data obtained so far is positive. "We're still [obtaining] a return on investment even by giving \$1,000 to healthy people," he explains.

Even Smaller Non-profits See Success

Heckman admits that Cerner has some advantages when it comes to promoting healthy employee lifestyles. Most employees are on the same campus, so they can more readily attend the clinic, weight watcher classes, and other activities. It's also a larger employer with a healthy budget for employee programs.

But even employers that have fewer resources and a dispersed workforce report success. For instance, The non-profit U.S. Nuclear Regulatory Commission (NRC), based in North Bethesda, Maryland, with 3,400 employ-

ees concentrated in five states plus inspectors assigned to 68 nuclear power plant and fuel facility sites around the country recently launched several programs to promote employee lifestyles, such as health and fitness, ergonomics and employee assistance programs, despite its small size and lack of funding, according to the NRC's Jon Lobe, who also spoke at the panel discussion. The NRC earned a silver award from the NBGH.

Lobe is also coping with the fact that as NRC staff are federal employees, he needs to justify expenditures on employee health not just to the NRC but to Congress and the public. "This is particular to the NRC. I have to keep the taxpayer in mind," he notes. He does what he can with what he has to work with. For instance, Lobe separated out some of the wellness vendor contracts to increase competition among vendors and thereby lower the costs of the programs. "I try to get the most bang for the buck," he explains.

As a federal program, the NRC also doesn't get to see cost savings and outcomes, since they go through the Office of Personnel Management. Lobe hopes to measure return on investment and other measures in the future, and promote health further.

"It often feels like I'm putting a finger in the dike. I wish I had more staff. But there are good reasons to invest in [these initiatives]," he explains. 