Innovations in Employee Engagement in Health, p. 2

A T A G L A N C E

This EBRI Notes article summarizes discussion on how employers are trying to increase individuals’ involvement in health—and why it’s important, presented at the Employee Benefit Research Institute’s 78th policy forum in Washington, DC, on May 12, 2016. The topic was “Innovations in Employee Engagement in Health” and brought together about a hundred benefits-related experts to discuss a variety of health and retirement topics.

Among the presenters were:

- **J. David Johnson**, Vice President and Senior Consultant for Segal Consulting/Sibson Consulting, who spoke on the topic of “Behavioral Economics and Employee Engagement—Carrots, Sticks, or Something Else?”

- **Alan Momeyer**, Vice President of Human Resources Emeritus, Loews Corp., who described how the company has been experimenting with health incentives for years before the Affordable Care Act was enacted.

- **Michael Thompson**, Principal, PricewaterhouseCoopers LLP, and President and CEO-elect of the National Business Coalition on Health, who discussed how innovation in technology and incentives can be used to improve health, well-being, and value.

- **Peter Goldbach**, Chief Medical Officer of Health Dialog, who described his firm’s new clinical analytic tool that tracks a population’s state of health and disease over time and can help provide insights to employers on how to improve employee health.
Innovations in Employee Engagement in Health

Employment-based health insurance is the primary source of health coverage in the United States, and as health plans continue to evolve, health plan sponsors continue to look for ways to get their workers more directly involved in their own health care.

To highlight new work on how employers are trying to increase individuals’ involvement in health—and why it’s important—the Employee Benefit Research Institute (EBRI) devoted part of its 78th policy forum to the topic of “Innovations in Employee Engagement in Health.” The May 12 event held in Washington, DC, brought together about a hundred benefits-related experts to discuss a variety of health and retirement topics. A summary of the forum presentations follows.

J. David Johnson, Vice President and Senior Consultant for Segal Consulting/Sibson Consulting, spoke on the topic of “Behavioral Economics and Employee Engagement—Carrots, Sticks, or Something Else?”

Johnson said the good news is that most medium- and large-sized employers are now investing in wellness programs such as smoking cessation and weight and stress management programs. The bad news is that “too few employees are actually engaging in these very often free programs—people just are not taking advantage of them.” For instance, a recent Rand Corporation survey found that only about 7 percent of workers targeted for smoking cessation participated in the program. As a result, Johnson said, “a lot of organizations are really beginning to question whether wellness really works.”

Johnson said behavioral economics focuses on people’s “irrational” behavior that is not accounted for by traditional (“rational”) economic research. He noted that employees often make poor decisions in a predictable manner, and that “heuristics” (mental shortcuts individuals make) connect and influence their choices more than their conscious intentions.

For those who make irrational decisions, providing financial incentives or information or resources for them to change behavior can help if used appropriately, but are not enough: “You have to bring in these nudges, guardrails, habit cues, so if he’s going off the path you have to kind of help him stay on the right path.” He added that “a lot of employers don’t pay attention to the habit cues, which are absolutely crucial if we’re going to change people’s behavior.” Finally, intrinsic motivation—what a person feels inside—may be the most important determinant in whether someone changes their health behavior.

Johnson said there are three main areas that have to be changed in order to change personal behavior:

- Intentions (such as to exercise more, eat more healthy food, stop smoking), which are perhaps the easiest.
- Conscious behavior (individual events, such as joining a walking group or going to a nutrition seminar).
- Habits, which are the most important and hardest to change.

“Ultimately, employers are not going to see much savings if all they address are the first two areas. If they don’t change habits, what employees do on a daily basis, employers are probably not going to see the ROI on a wellness program,” Johnson said.

While financial incentives can be powerful for short-term or one-off events (such as biometric screening), Johnson listed several factors that behavioral research has shown are likely to make wellness program incentives work: losses
motivate more than gains (threatening to take an incentive away); use of lotteries, since people overestimate their ability to win a lottery; using team-based incentives to utilize peer pressure; careful structuring of opportunity/regret motivations (the risk of loss if they don't participate); appealing to a worker's wants, rather than needs; making a reward immediate, rather than delayed; and keeping it simple.

“Simplicity beats complexity. I see so many employer wellness programs that are so complicated, employees can't figure them out. So it's no wonder they don't actually participate,” Johnson said.

Johnson also warned against “reward undermining,” in which incentives can be structured to inadvertently have the opposite effect of what was intended, such as conflicting with people's intrinsic motivation to do the right thing. For instance, imposing financial penalties for missing a schedule can actually induce the wrong behavior, if the penalty is viewed as an acceptable trade-off (permission to “play or pay”). Another example is that sometimes the allure of luxury goods can actually motivate people more than cash: experience has shown that “if we get something as a luxury good, it's very motivating.”

Figure 1

Links
Johnson PowerPoint presentation: bit.ly/ebri-2016-Johnson-PPT
Alan Momeyer, Vice President of Human Resources Emeritus, Loews Corp., described Loews as a large, highly diversified buy-and-hold conglomerate composed of four unrelated companies, which has been experimenting with health incentives for years before the Affordable Care Act was enacted.

Over the years, the company has learned a lot about human nature and “the way people think,” Momeyer said. For instance, they got about 75 percent participation among their workers for taking a health risk assessment with biometrics (including blood work), but the following year participation dropped to just 22 percent when a requirement was added for a medical telephone consultation with an independent health care provider if a problem was found.

“What does that tell you about human nature? It told us that people don't want their employer telling them what to do, especially in the area of healthcare,” Momeyer said.

That led to a new incentive: $200 for getting an annual health check-up, with follow-up from a doctor, which got high participation. It also prompted the company to focus on getting its workers to think like consumers of health care rather than as patients.

Regardless of the regulatory costs of the ACA, Momeyer said, providing health benefits “is still a competitive matter: if we don't offer a robust health care program, it's going to be hard to recruit and retain people.”
Because Loews provided generous health benefits, it was certain to get hit by the Cadillac tax. He said the company’s basic choice to avoid the tax was either to “dumb down” or cut the plan design to fall under the tax threshold or to have employee health cost less because workers are healthier and practice actual wellness.

The ultimate decision was to offer a menu of options and be extremely active in communicating as much health coverage and cost information as they could, and offering both incentives and penalties with their wellness program. “We found that the incentives work, but nothing really worked well until there were both carrots and sticks. No matter how good you think that incentive is, it’s made a whole lot better when there is a significant punishment.”

For instance, the only requirement with the wellness program had been to participate in it by getting an annual check-up and talking to the doctor about it. So, they created a menu of optional activities to improve healthy living, one of the most successful of which was using FitBits to create competitive walking clubs among its workers.

But there also was a penalty for those who did not participate: doubling the cost of their health insurance premiums. “That’s the stick that worked. In the initial year, we had 485 out of 500 employees participate, a 97 percent compliance rate. That’s what we were looking for,” Momeyer said. In addition, various “lunch and learn” seminars, led by a doctor, gave lots of practical information for being and staying healthy.

They currently have about 5,000 employees in the program, many of them modestly paid, and have enrolled about 90 percent of their hotel workers in a consumer-driven health plan. While “there’s not another hotel company that has anything like that participation rate,” Momeyer added, “the various wellness programs incentives have proven very effective.”

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**Michael Thompson**, Principal, PricewaterhouseCoopers LLP, and President and CEO-elect of the National Business Coalition on Health, discussed how innovation in technology and incentives can be used to improve health, well-being, and value.

Thompson noted that “consumerism in health care,” which has been debated for the past decade, is now a reality, as reflected by the fact that a large majority of employers that offer health insurance today are offering high-deductible health plans (HDHPs) and health savings accounts (HSAs). He added that the Affordable Care Act’s so-called “Cadillac tax,” which would impose an excise tax on generous health benefits but has not yet gone into effect, “is likely to accelerate that movement.”

Thompson said “the great majority of employers” are currently offering high-deductible health plans (HDHPs) with health savings accounts (HSAs) more so than with health reimbursement arrangements (HRAs). He noted a growing trend of health plan sponsors willing to do a total replacement of their old health plans with HDHPs, and “almost two-thirds of employers say they are open to moving to a total replacement high-deductible plan in the next few years.”

This is making participants increasingly worried, Thompson said, noting that one survey found that individuals say they feel less prepared to be a consumer of health care than they are of buying a house. While one of the key goals of consumer-directed health care is to reduce the amount of unnecessary health care under the current insurance
system, Thompson said that “what actually happens is that people do defer both unnecessary care but they may also defer some necessary care, which is a potential concern.”

Thompson acknowledged that some workers—especially lower-wage ones—will defer needed health care under HDHPs in order to save money. He also said the ACA has effectively established a floor of minimum health benefits an employer can provide—and that the threat of triggering the Cadillac tax, even though it has not taken effect yet, means this minimum standard will also become a cap.

He said these forces are leading to a re-thinking of “value-based design” of health plans, which will lead changes in health care delivery. Just as indemnity health plans led to managed care health delivery, which in turn led to a backlash against managed care, Thompson suggested that new forms of health care delivery are evolving as a result of cost-control pressures from the ACA’s Cadillac tax and rising health costs in general.

Employers are trying to figure out how to get value out of health coverage, and also how to get the incentives right for consumers, Thompson said, which is leading toward health plans with narrow networks of high-quality providers, potentially offered as a choice with incentives. Offering health benefits remains a key business decision—for recruitment and retention of skilled workers—but increasingly is a way to increase engagement with workers as well.

“Increasingly, we will see high-performing networks competing against broader networks, and probably do it on a choice basis where people will have to opt one way or the other,” he said.
Thompson said the pace of innovation in health care has been exploding in recent years, especially in technology, noting that there are now over 100,000 health apps available. Even though only 25,000 of those apps may be potentially useful, he added, the growth has been overwhelming—both to employers that sponsor health plans and workers and consumers who may want to use them.

This is leading to the emergence of what Thompson called “a consumer hub” to help health consumers identify what they need and what's available and sort through the alternatives. Health plans, private health exchanges and other vendors are competing to serve that function, he added.

Other innovations Thompson cited include a growing shift of financial risk onto health care providers, and making “big data” more informed and useful to health care providers and patients through population health, integrating community-based initiatives, remote monitoring, and greater investments in holistic employee well-being.

Links
Michael Thompson bio: bit.ly/ebri-2016-thompson-bio
Thompson PowerPoint presentation: bit.ly/ebri-2016-Thompson-PPT

Peter Goldbach, Chief Medical Officer of Health Dialog, described his firm’s new clinical analytic tool that tracks a population's state of health and disease over time and can help provide insights to employers on how to improve employee health.

He noted the well-known statistic that about 10 percent of an employee population (its sickest members) drive about 70 percent of a health plan's costs, and that there is a “natural migration” of sick members (for instance, those who might have or might have had heart attacks) who will get better after a health emergency and become low-cost workers again. However, studying the data, his firm found that there was also a population of apparently well employees who become very expensive, “and we don't know who those people are.”

That led them to analyze not just cost of health care utilization but health and disease trajectory rates over a longer time period of three to five years. This involved looking at nine chronic diseases that tend to have a natural progression, such as cardiovascular disease, obesity or diabetes that put people at risk. By engaging in disease management with workers who may not even know they’re sick (or likely to become sick) before an emergency or hospitalization occurs, they can both improve health and reduce health costs, Goldbach said.

For certain “sentinel clinical events”—such as a heart attack or a heart surgery—the data and their experience has shown “a rather dramatic impact” in preventing events that otherwise would have likely occurred. “It's nice to see sort of an independent verification that it wasn't just cost and utilization, that you truly had an effect in helping people with managing significant disease,” he said.

He described the nine stages of wellness, ranging from completely healthy to a clinical event, which has a relatively small (but costly) number of people “ready to have these really bad events,” and that over a five-year period there is “a significant out-migration” from the healthy to the sick ends of the spectrum. While “there are clearly some people in this population you can't help,” Goldbach said, those in the middle account for about 52 percent of a plan's health care spending and can be helped.

Using analytics, he said, “if you segment your population and you understand who is at what stage, that knowledge can help you to understand where to put your resources and it can help you tailor a communication and offer a service to that person that is relevant to them at that particular stage.”
For instance, he noted that 37 percent of Americans are prediabetic, according to the American Diabetes Association, almost all of whom (97 percent) are not diagnosed. Almost a third of Americans (31 percent) have prehypertension, and half of those with hypertension do not control their blood pressure.

He cited research showing that for those who are prediabetic, employers can save $2,650 per participant over a 15-month period by helping them lose weight and prevent the disease from becoming clinical. “The money is there, if you focus the programs on the people that need them and that can use them, so it can be a very powerful intervention,” Goldbach said.

Even though the current medical system does not identify prediabetics, Goldbach said health care analytics using health reimbursement arrangement and claims data could predict the condition with a 79 percent accuracy rate. “In fact, I think you’re better situated with [analytical] programs than a typical medical practice to do an effective outreach, to help people get information that can motivate them and get them involved in the program,” Goldbach said.

Goldbach said that the secret to successful wellness and disease management programs is far more than just incentives; it’s also advances in technology, in personalization, in not just health measurement but self-measurement by health plan participants. “We think that disease management programs work. They touch a small portion of your population, who are very sick people and need all the help they can get,” he said. “You now have an opportunity to be more effective, to use healthcare benefits as a true benefit for a larger segment of your population.”

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