Consulting
Health & Benefits

2012

Health Care Survey

Better Health. Better Results.

AON Hewitt

Better Health. Better Results.

No matter what your health currency is today, it is likely unsustainable 10 years from now. Health care costs continue to escalate—for both employers and employees. In our *2011 Health Care Survey*, we saw employers taking a cautious "wait-and-see" approach to strategic health improvement and cost management decisions. This was due in large part to the uncertainty surrounding health care reform legislation. In this year's study of nearly 2,000 employers, presented here, we see plan sponsors "taking plan design off pause." They are exploring and advancing emerging and strategic approaches to health benefits. They are investing in and improving the health of their workforces. They are engaging employees and asking them to take some ownership of their own behaviors and health. In short, they are taking a leadership position and making bold moves.

Aon Hewitt's *2012 Health Care Survey*

In this report, we share with you the findings of Aon Hewitt's *2012 Health Care Survey.* Here, we evaluate employers' responses to questions about their current and future health care practices and offer our analysis on the trends within the context of four dimensions—or pillars—of a successful health care strategy, focusing first on health behavior and then on coverage: improve workforce health and performance, engage participants, design with intent, and reduce unnecessary expenses.

We also share our point of view, stemming from our innovative work with thousands of clients each year. Additionally, we add an important new component: the perspective of the employee-consumer. In 2011, jointly with the National Business Group on Health and The Futures Company, we gathered the views of over 3,000 plan participants, aligned to the same four pillars. This 360-degree view gives us an important lens into the strategies that really work when planning turns to execution.

A Business Case for Better Health

The decreasing health of our nation is by far the single largest driver of rising health care cost, lost productivity, and increasing absenteeism. Creating a culture of health will begin to reverse this trend by changing employees' behaviors, attitudes, and actions regarding their health. Every day, Aon Hewitt's professionals create a business case for better health, offering the insights, solutions, framework, and a partnership to develop and activate a health plan strategy that results in a healthier organization and employees. If you have questions, please call your Aon representative or send us a note at aon.marketing@aon.com.

Sincerely,

John Zern
Executive Vice President, Americas
Health & Benefits Practice Director

Jim Winkler
Chief Innovation Officer
Health & Benefits

2012 Health Care Survey

Better Health. Better Results.

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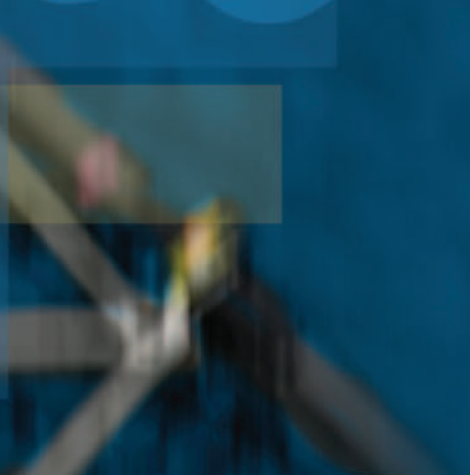
2012 Health Care Survey
Executive Summary

This is an unprecedented time in health care. The decisions employers make now—to take a fresh look at health benefit plans and programs and determine long-term needs and direction—will have a profound impact on the health of their organizations.

In the past six years, employers have seen the amount they spend on employee health care increase by 40%, to an average of $8,000 per employee. Over this same period, employee out-of-pocket and payroll costs for health care have increased 82%, to an average of $5,000 per year. The increase in cost to employees has nearly erased their average income gains over the same time period. Many experts believe the increase in employer health plan cost has been a significant contributor to wage stagnation over the past 10 years.



Aon Hewitt's consumer health research, *The Consumer Health Mindset*[1], attests that employees are extremely concerned about being able to afford health care expenses. These cost pressures, along with social and political forces, confront employers and health care plans.

Health care costs continue to climb. Without substantive change, experts say, health care costs will continue to increase at 8–9% per year.

Health care reform does not address cost. Federal and state efforts to reform health care will continue to influence the market, mainly addressing access to coverage yet failing to solve health care cost issues or adverse population health.

Population health is declining. As a nation we are less healthy. The main concern centers around eight health risks and behaviors including poor diet, physical inactivity, smoking, and lack of health screening. These risks drive the incidence and impact of the 15 most common chronic conditions, which in turn account for 80% of the total cost for all chronic illness worldwide. The impact of these 15 conditions on an employer's medical spend typically exceeds 65% of total cost.

By reducing the frequency and severity of the most costly medical conditions, employers can begin to control health care costs, improve health and performance, and build their business case for better health.

Employers who can target and impact just three of the eight health risks can save as much as $700 per employee per year.

1 Aon Hewitt. *Consumer Health Mindset Survey.* 2011.

Three Choices: Stay, Pay, or Play

In the wake of a changing health care landscape, employers are faced with challenges and opportunities. The role of the employer as health care provider, subsidizer, and plan manager is shifting. While the health care marketplace is increasingly more complex, the changing environment opens up new paths for consideration. Directionally, there are essentially three available courses of action.

Stay the Course. Continue to seek solutions that incrementally offset annual national trend levels of 8–9%. This path has become more difficult due to the impact of cost sharing, as employees have already shouldered a significant portion of the health care cost increases. Employers on this path must balance short-term cost increases, employee impact, and the need for a competitive benefits program.

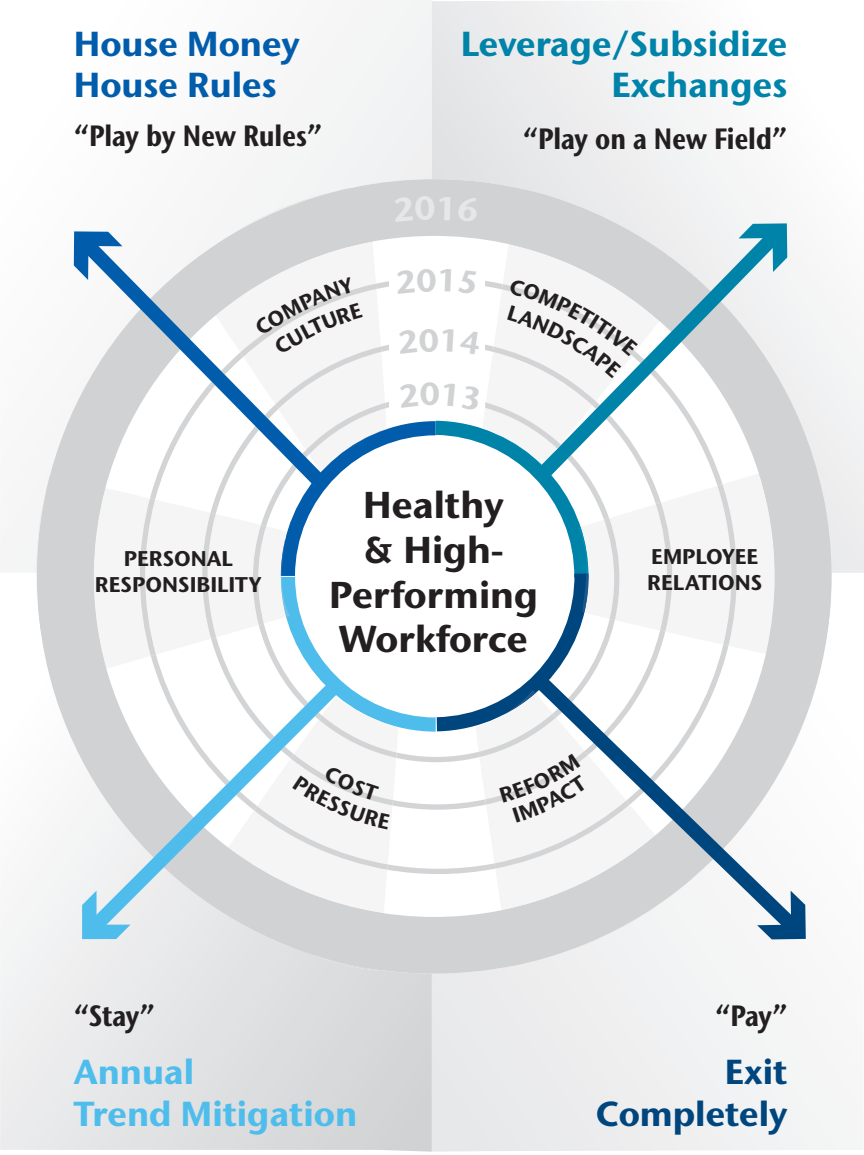
Pay and Exit. Pay any applicable penalities under federal and state laws and no longer sponsor health care benefits as an employer. Employers on this path will need to consider the potential impact such a decision has on the competitive nature of their employment deal, while also determining how best to utilize savings to further the success of the business.

Play Differently. For employers that seek to continue to offer benefits, but face financial pressure to achieve a meaningfully different cost outcome, new approaches have emerged. Our research indicates that a majority of employers are ready to play differently to achieve different health and cost outcomes. They will either:

- Play by new rules. Continue to sponsor a medical plan, but migrate from a traditional "managed trend" approach to a "house money/house rules" (HMHR) approach that is more requiring of plan participants and integrates a pay-for-performance philosophy into their benefit programs.

- Play on a new field. Change from plan sponsor (defined benefit) to coverage facilitator (managed defined contribution). Private and government-run health care exchanges will introduce new strategic options that plan sponsors owe it to themselves to evaluate closely.

Regardless of which direction an employer chooses, employee health is and will remain a driver of workforce performance and a core influence on business results. Employees who are engaged and present on the job offer a competitive business advantage. Regardless of an organization's size or industry, a health improvement focus provides a key link between benefit plan management strategy and business success.

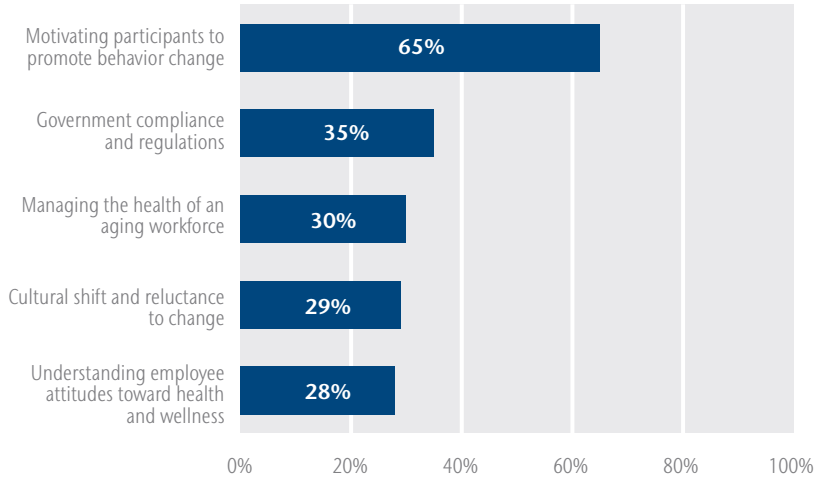


Summary of Key Findings

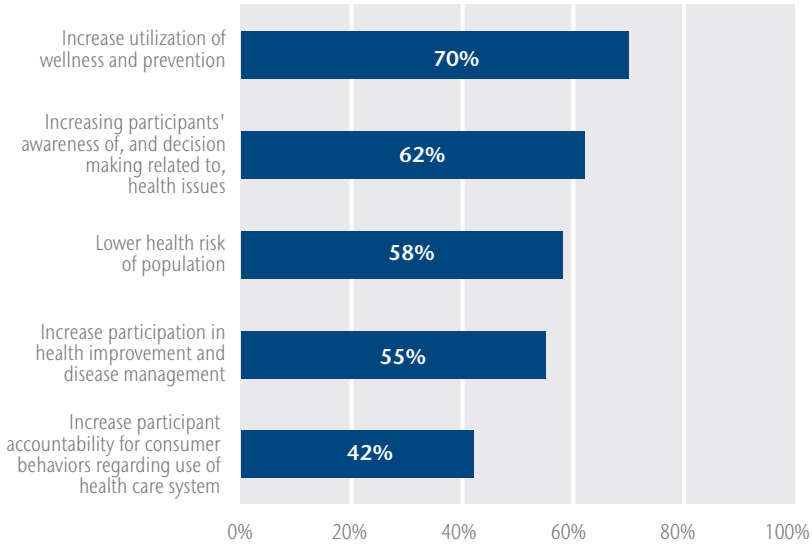
To gauge employer reaction to and action on these significant forces, Aon Hewitt conducted its annual survey of employers in late winter 2011. Interest in the survey was high, with over 1,800 participating organizations representing approximately 15 million employees and an estimated $120 billion annual health care spend. Unmanaged, at an expected trend of 8%, this spend will grow to $150 billion in three years. This year's results and our analysis point the way to some of the initial steps and innovative actions employers can take to improve the value they're getting on their health care spend.

We found employers face many challenges as they decide to "stay" or "play" in the evolving health care arena. The majority of the challenges cited by employers are the hardest ones to address: culture change, behavior change, and employee attitudes. The desired outcomes of participation, behavior change, and lowering risk are in line with these challenges. This creates a very demanding environment for employers. They must get at the art and science behind human behaviors and motivators, and at the same time manage the "blocking and tackling" of running a health plan of their own.

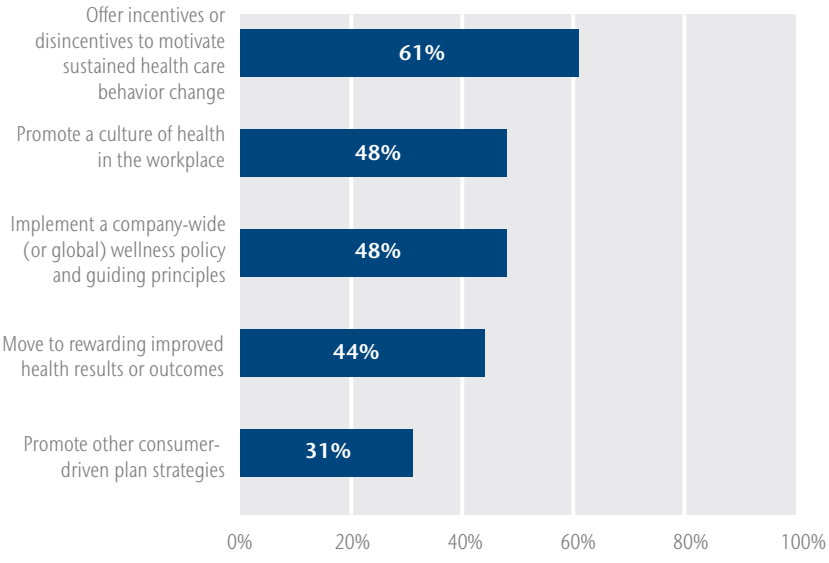
Top Challenges



Desired Outcomes



Top Tactics



In this survey report, we analyze the data in four main pillars that address employers' largest challenges, outcomes, and tactics: improving workforce health and performance, engaging participants, designing plans with intent, and reducing unnecessary expenses. We present a summary of findings here.

Improve Health and Performance

Employers clearly understand that to be successful, long-term medical cost management requires a reduction in health risk factors, which in turn will improve overall health and drive improved performance. They recognize that behavior drives personal health risk and risk drives cost. Employers also recognize that employees need help reducing their risk factors and managing their care:

- 76% of employers offer condition management programs
- 70% want to increase member utilization of wellness programs
- 62% want more effective decision making at the member level when it comes to health choices
- 70% say wellness and health improvement are part of their current strategy

However, a deeper review of the survey data reveals three potentially significant disconnects:

- Employers may be confused about what they want to achieve and what they need to do to get it
- Employers are focused on concepts, but struggling with execution
- Support for programs is significant, but confidence in their impact is lacking

Engage Participants

Research finds that employee engagement leads to better health habits, better compliance, and ultimately lower health care cost and better quality of care. We observe that employers are involved in the following strategies to ensure employees and covered family members are taking an active and positive role in managing their health and health care:

- Raising awareness and making it personal—82% offer tools to raise awareness of health status and risks
- Rewarding more, punishing less—64% reward participants for use of health awareness tools like health risk questionnaires (HRQs) and screenings
- Designing with a purpose—22% are offering value-based design tactics to drive pharmacy compliance for specific medications

What is interesting is that most employers are *not* doing a lot to gather input from their employees on the employees' attitudes toward health.

- Only 17% significantly use focus groups or surveys to gather feedback on their wellness programs
- Only 8% are using behavioral economic theory to drive behaviors, and only 17% are using consumer marketing techniques

Design with Intent

Over the past few years, as employers focused on health reform and a difficult economy, they have deployed tactics aimed at incremental cost shifting. With continued uncertainty about the impact of federal government efforts to reform the health care system, employers are recognizing the need for action; they can't wait until reform settles. Employers are taking a look at their plan designs and overall health care strategies to determine how they can achieve better health outcomes and results now. Because of this, we anticipate a faster pace of change than we've seen in prior years.

- Very few employers plan to exit the role of plan sponsor; however, interest is accelerating in the corporate exchange model.
- Consumer-driven plans are now more common than HMOs, though still second to PPOs. CDHP trend is 2% points less than PPO trend, possibly fueling the shift. And, voluntary benefits are increasingly being used as an enticement to increase enrollment in CDHP.
- Plan funding strategies remain constant, with employers funding 80% of the cost; no dramatic change is expected in the future.

Reduce Unnecessary Expenses

As health care costs continue to escalate, employers and employees alike seek efficient, understandable plan designs and program features to reduce any unnecessary expenses. At the same time, the ever-shifting health care landscape creates a broad array of tactics employers can pursue to drive employees to high-quality and high-value providers and ensure that only entitled individuals are covered as defined by plan documents. Sophisticated data analysis sits at the foundation of these efforts to reduce unnecessary expenses.

- Reliance on data continues to grow in importance. Over the next 3 to 5 years, there is a significant shift toward using third-party providers for data analytics, with 55% using this approach now and 69% saying they will move in this direction in the next 3 to 5 years.
- Employers are looking at a vast array of new delivery models, such as accountable care organizations (integrated delivery systems), centers of excellence, and other medical home pilots that provide better primary care delivery and triage.

Employers and Employees: A 360-Degree View

Throughout the remainder of the report we will highlight key findings in each of the four pillars. We will share employer responses as well as employee views on the same topics, bringing in employee views and opinions from our *Consumer Mindset Survey*. This 360-degree view of the issues will help employers determine their strategic direction and supporting tactics as they build a business case for better health.

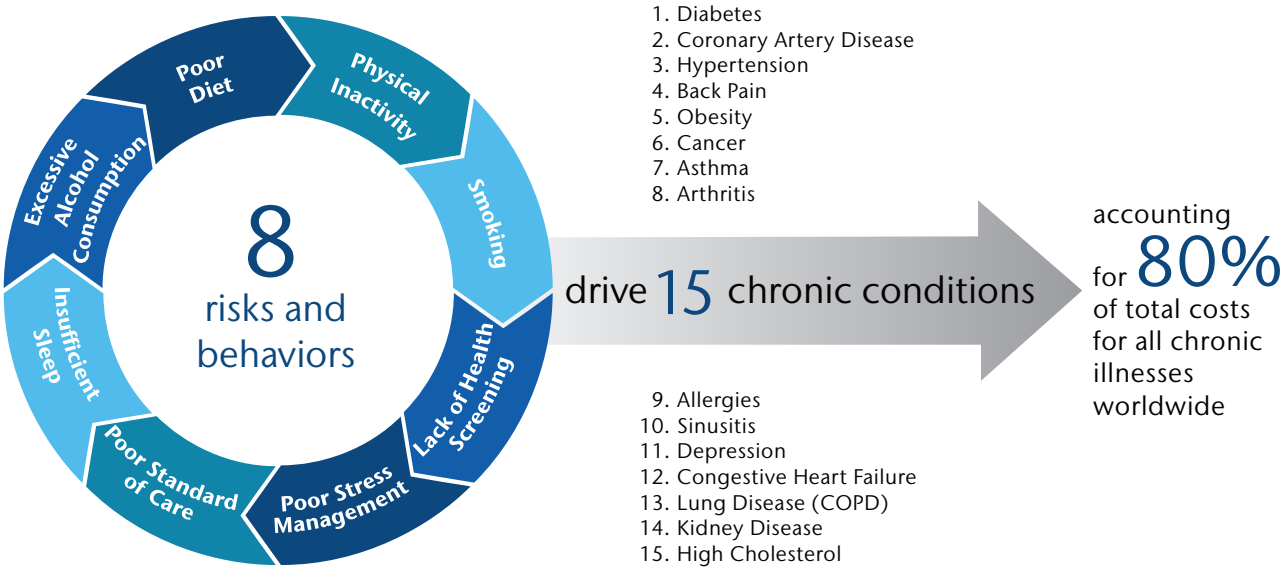
Improve Health and Performance

Many Tactics, Little Focus

As a nation, we are becoming less and less healthy. This trend is by far the single largest driver of rising health care cost, lost productivity, and increasing absenteeism. To reverse that trend, we need to change behaviors, attitudes, and actions regarding health. Doing so is difficult, but the potential impact is significant.

Reducing the frequency and severity of chronic conditions will help employers gain control of health care costs. Consider the following research:

- There are eight human behaviors (see graphic) that most significantly impact our health[2]
- Those eight behaviors directly lead to 15 costly chronic medical conditions
- These 15 conditions, caused by those eight behaviors, drive 80% of the cost for all chronic disease worldwide (health and absence cost)
- Even if employers are able to meaningfully impact as few as three of the behaviors, they can see a savings of as much as $700 per employee per year



2 2010 World Economic Forum.

Key Findings

The *2012 Health Care Survey* asked employers about their health and workforce performance improvement efforts, challenges, and successes. The data show that employers clearly understand that to be successful, long-term medical cost management requires a reduction in health risk factors, which in turn will improve overall health and drive improved performance. They recognize that behavior drives personal health risk and risk drives cost. Employers also recognize that employees need help reducing their risk factors and managing their care:

- 76% of employers offer condition management programs
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However, a deeper review of the survey data reveals three potentially significant disconnects:

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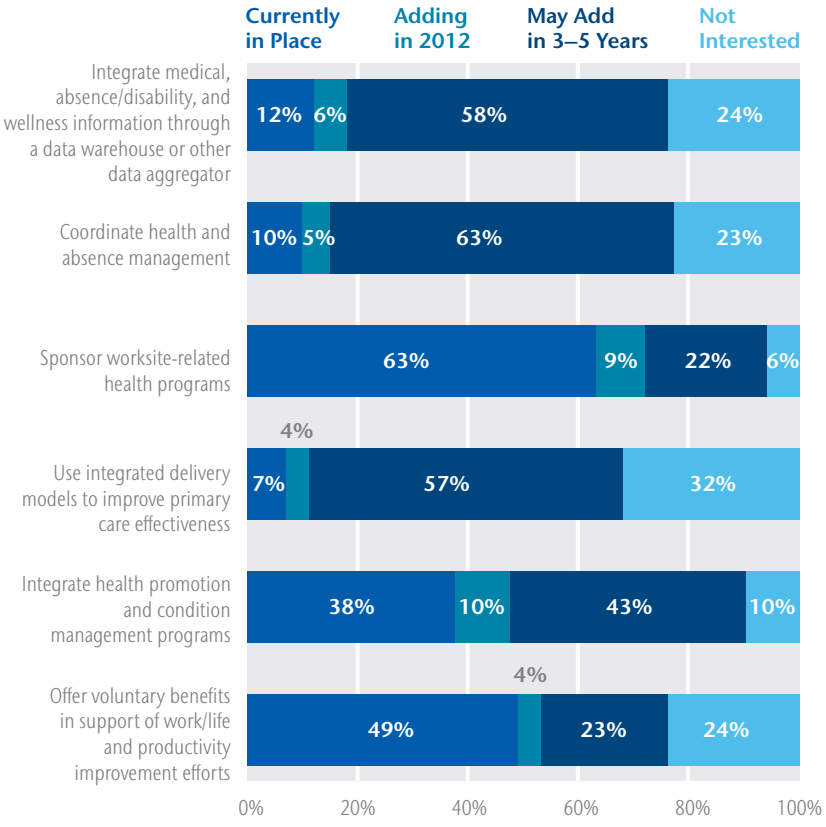
Majority of Employers Show Broad Interest in Activities to Improve Health and Performance

Sixty-three percent of employers currently offer worksite programs, with another 9% looking to add them this year. Forty-nine percent of employers are offering voluntary benefits to support convenient group purchasing options. Many employers also appear to be integrating health promotion and condition management programs, with 38% currently doing this and another 10% planning for 2012. Looking to the next 3 to 5 years, over half of employers are considering adding programs to integrate medical, absence/disability, and wellness information and programs that coordinate health and absence management.

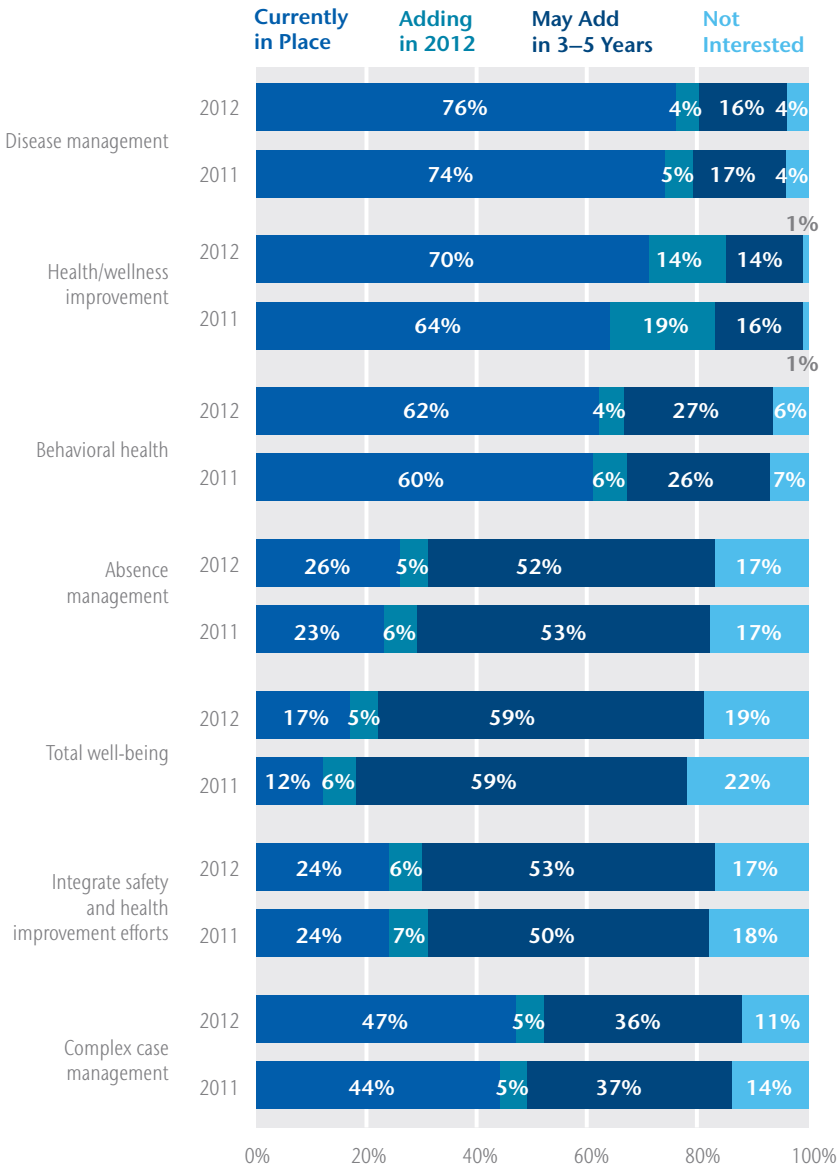
Improve Health, Productivity, and Outcomes



Disease Management, Health Improvement, and Behavioral Health Program Prevalence Remain Steady

Employer use of disease management, health improvement, and behavioral health tactics are the top three priorities when it comes to health and productivity strategies. This is unchanged from last year. The most significant change from 2011 is the increased focus on total well-being. This may represent employers taking a more holistic view of health and performance.

Health and Productivity Strategies



Health Program Prevalence and Services Remain Constant

The data show that, overall, employers continue to offer a broad array of health programs. The top five programs being offered in 2012 are health risk questionnaires, wellness programs, 24/7 nurse lines, disease management, and biometric screening programs. This is consistent from 2011. The areas that increased the most from 2011 are health improvement/wellness programs, physical fitness challenges and weight management programs. This broad spectrum of programs can make it difficult to communicate to and engage employees.

Health Programs Offered in 2011 and 2012

Health Programs	Offered in 2011	Offering in 2012
Health risk questionnaire	65%	68%
Health improvement/wellness programs	59%	65%
24/7 nurse line	68%	64%
Disease/condition management programs	64%	62%
Biometric screening	50%	57%
Tobacco cessation programs	52%	55%
Weight management (e.g., programs to improve body mass index, waist circumference)	40%	45%
Telephonic health improvement coaching	40%	42%
Physical fitness challenges (e.g., 10,000 Steps® Program)	37%	42%
On-site fitness center	32%	30%
Nutrition	25%	28%
Stress reduction	23%	25%
Online/web live-chat health improvement coaching	20%	24%
Health/clinical advocacy	14%	16%
Complex care (e.g., second opinion services, best doctors)	13%	15%

Employer Mindset and Tactics to Drive Health and Performance Changing

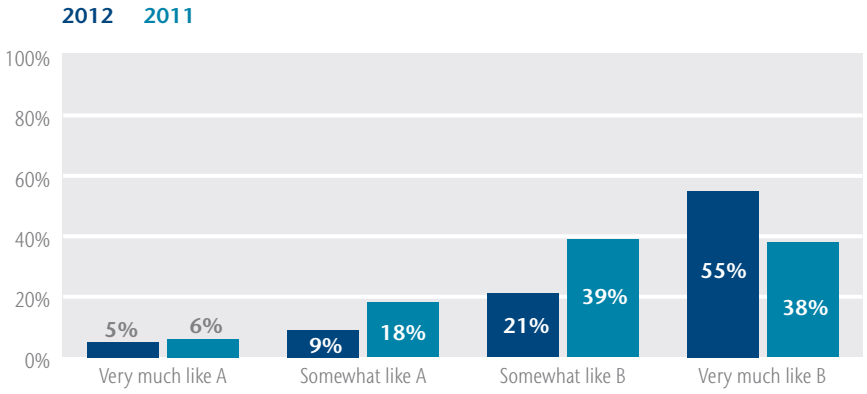
Study participants confirm a year-over-year shift in mindset from focusing on programs that will increase productivity to focusing on strategies and programs to improve population health risks ***and*** lower costs. This shows some significant changes from the 2011 survey, in which only 38% characterized their population health philosophy as dually focused on improving health risks and lowering costs—compared to 55% in the 2012 study.

Focus of Health Care Strategy

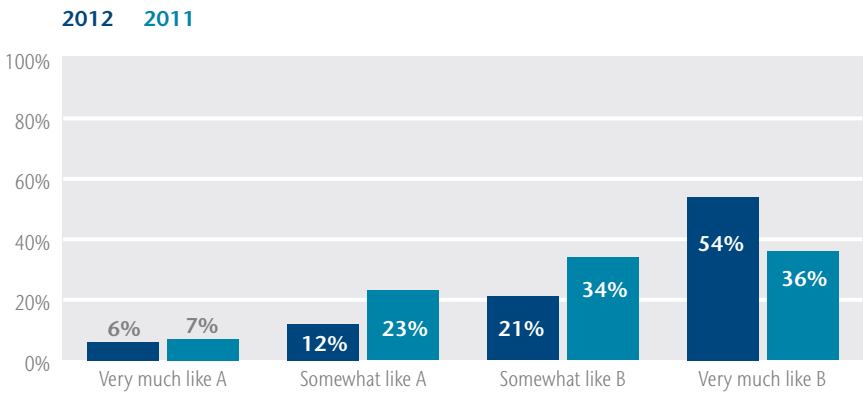
Description A
Focus strategies and programs to improve **workplace productivity** (e.g., absence reduction).

Description B
Focus strategies and programs to improve **population health risks and lower medical costs**.

My organization is more like A or B today.



My organization will be more like A or B over the next 3–5 years.



Further, when participants were asked which tactics they are using to drive health and performance results, we find that the top five today are:

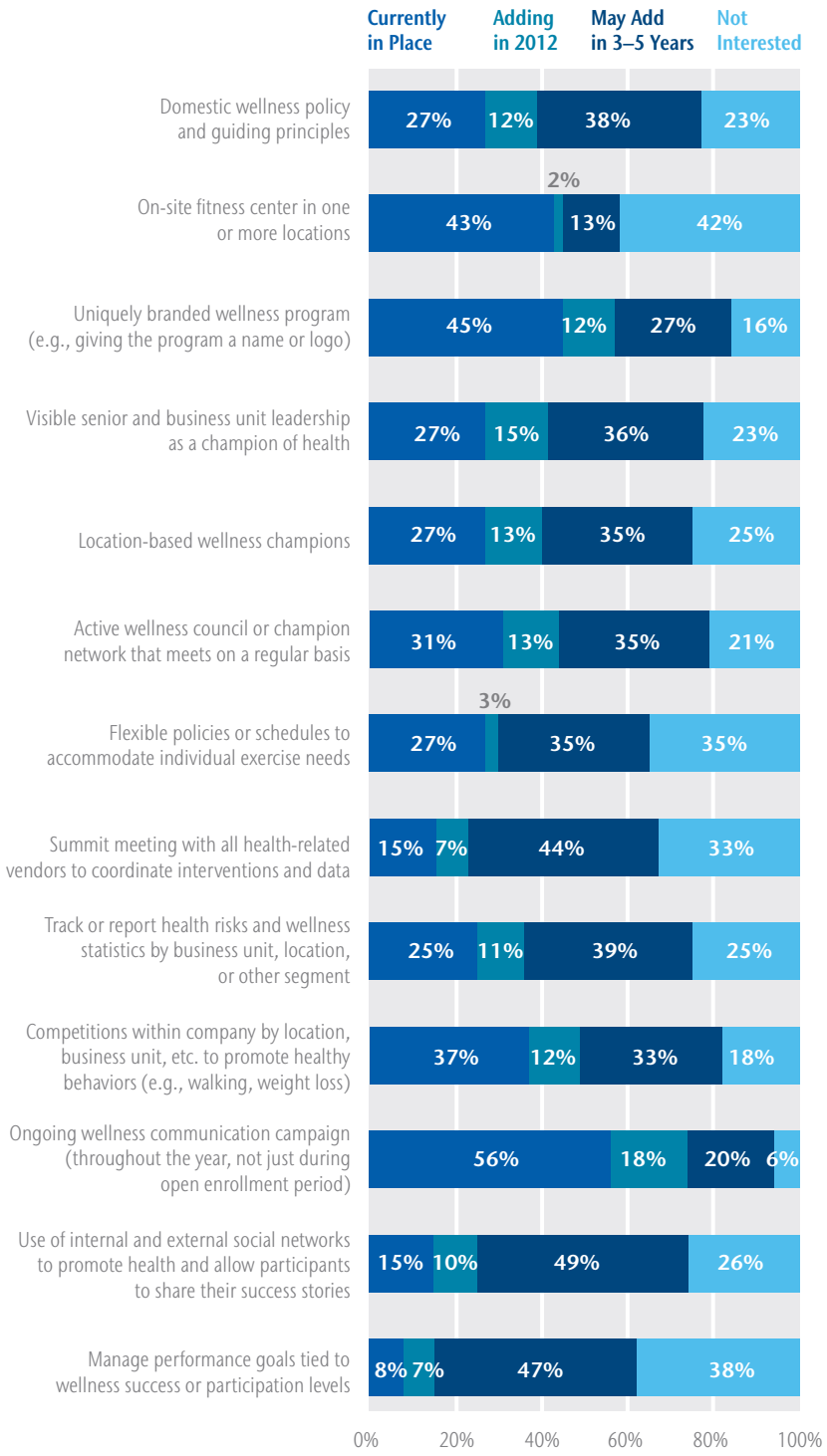
1. Ongoing wellness communication campaigns (56%)
2. Unique branding of their wellness programs (45%)
3. On-site fitness center at one or more locations (43%)
4. Competitions within the company (37%)
5. Location-based wellness champions (31%)

However, the focus in the next 3 to 5 years is a very different list of tactics:

1. Use of internal and external social networks to promote health (49%)
2. Managers' performance goals tied to wellness success (47%)
3. Summit meetings with all health-related vendors (44%)
4. Tracking or reporting health risks and wellness statistics by business unit or location (39%)
5. Domestic wellness policy and guiding principles (38%)

This shift in tactics shows a movement toward a culture of health. Aligning wellness to performance goals and tracking risks and outcomes indicates a much stronger reliance on comprehensive health care data. The movement also means employers will need to use entirely new approaches to behavior change.

Health Care Tactics



Aon Hewitt Point of View

Employers will continue to have an active interest in improving health and workforce performance no matter their short- or long-term benefit strategy. Whether they continue to offer a company-sponsored plan or choose a private exchange, healthy employees who are engaged, at work, and focused on the job at hand will be a competitive advantage. The critical question, given where we are today, is how do we move employees across the behavior change spectrum from awareness, to action, to improvement, and finally, to healthy habits?

Behavior Change Spectrum

Our learnings on behavioral change, including the results of the *Consumer Health Mindset* study, provide some key insights.

Consumer Mindset: Make It Meaningful

Employees get it. They understand that health care costs are an issue and they know they can take steps to maintain or improve their health. What they want from their employers is clarity and facilitation—"Tell me what I need to do, how to do it, and what's in it for me."

Start at the Top

Our *Consumer Health Mindset Survey* corroborates what the *2012 Health Care Survey* tells us. Leaders and managers are the face of the organization to employees. To effect real culture change, leaders and managers must lead by example. They need to model healthful choices and changes in their own lives. Manager performance goals and pay-for-performance targets should include some level of support for accomplishing the health and workforce performance targets of the entire population.

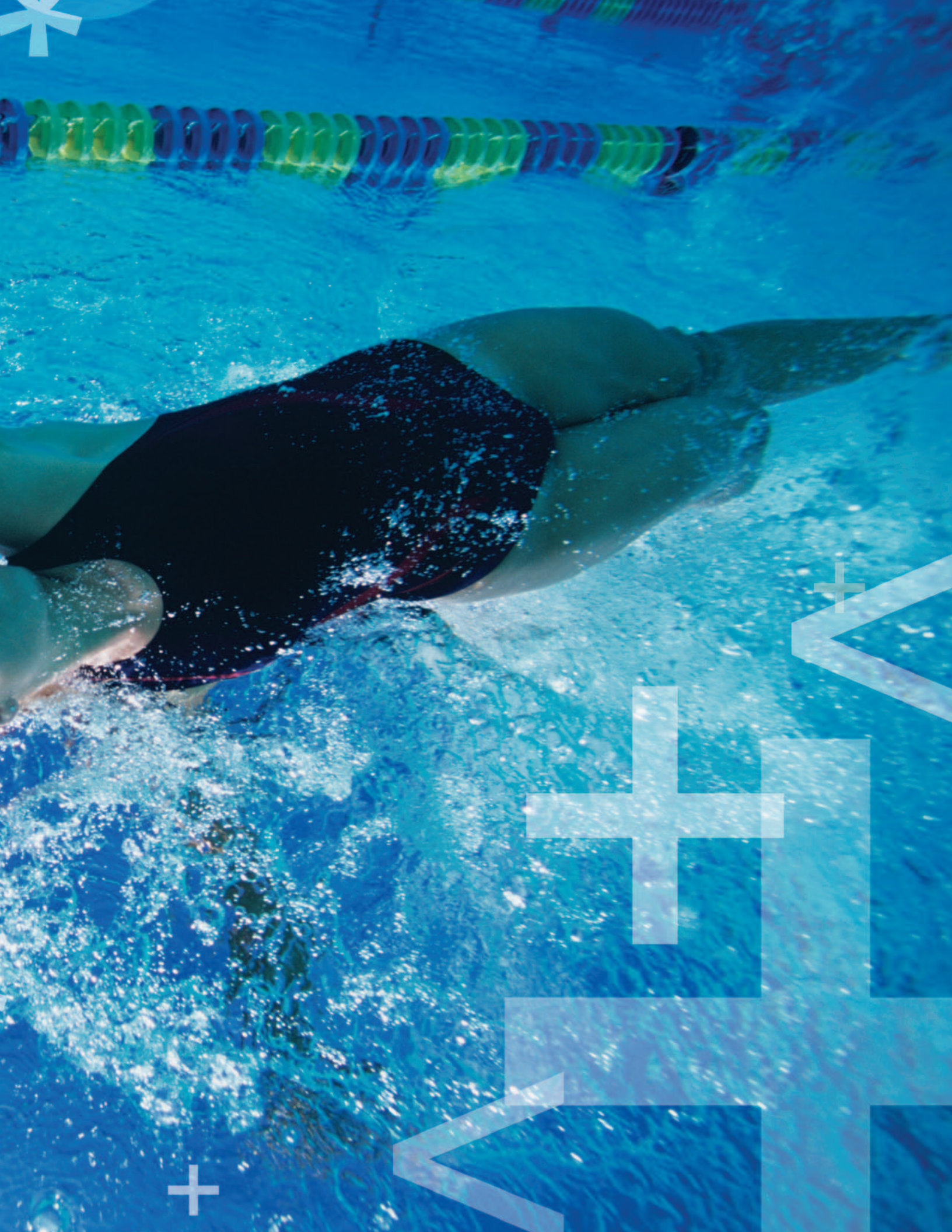
Connect Better Health to Better Performance

Forty-five percent (45%) of survey respondents reported they have a wellness "brand," but it takes more than snappy taglines and logos to convince employees there is something in it for them. Employers must visibly link health and performance in every aspect of their business, just as they link safety and performance today.

Determine Your Corporate Currency

What is the "currency" that drives your organization? Is it cost per widget, NOI, EPS, EBITA, or something different? Consider positioning your health care cost in terms of your business currency—what matters? Is it that every 1% increase in health care costs decreased your gross margin by 0.075%? Speak the lingo of the business to get the attention of senior leaders. For example: "We need to align pay and benefits with performance management, and those employees at all levels who are leading the way should be rewarded for doing so."

Improving health and workforce performance is a strategic imperative. The focus is shifting from implementing a vast range of wellness programs to more targeted initiatives that achieve better results, both health and financial. Health benefits leaders, and senior leadership across the organization, can break away from traditional benefits programs to innovative models that impact health, performance, and business outcomes.



Engage Participants

Finding the "What's in It for Me"

How can you enage someone who dosen't want to talk to you in a conversation about an uncomfortable topic? That's the dilemma facing most employers when it comes to engaging employees in a new conversation about health. It is engagement, research finds, that leads to better health habits, better compliance, and ultimately lower health care cost and better quality of care.

Key Findings

The *Aon Hewitt 2012 Health Care Survey* asked employers about their challenges when it comes to getting employees and covered family members to take an active and positive role in managing their health and health care. They are doing these things in 2011 and 2012:

- Raising awareness and making it personal—82% offer tools to raise awareness of health status and risks
- Rewarding more, punishing less—64% reward participants for use of health awareness tools like health risk questionnaires (HRQs) and screenings
- Designing with a purpose—22% are offering value-based design tactics to drive pharmacy compliance for specific medications

What's interesting is that most employers are *not* doing a lot to gather input from their employees on the employees' attitudes toward health.

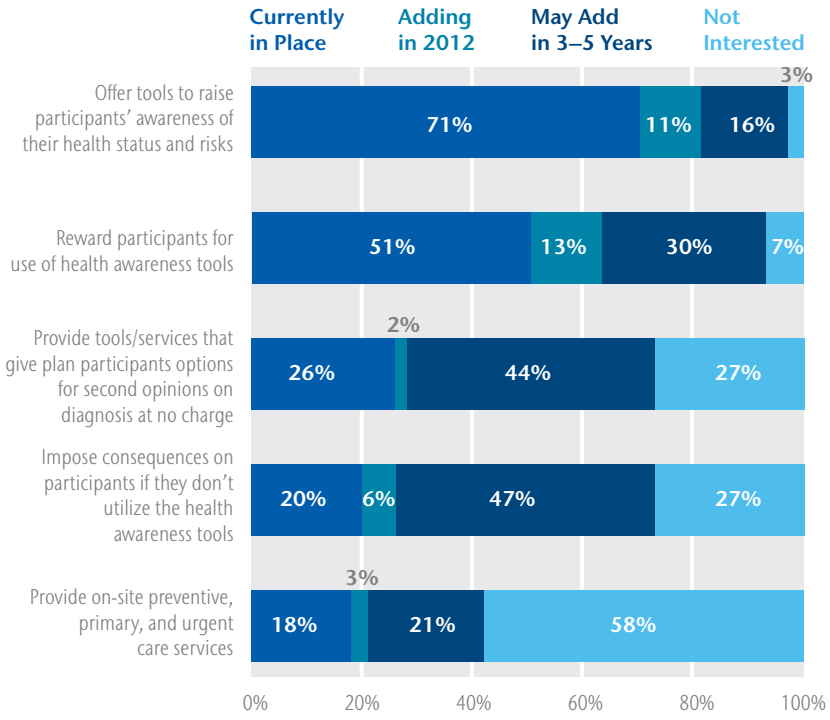
- Only 17% significantly use focus groups or surveys to gather feedback on their wellness programs
- Only 8% are using behavioral economic theory to drive behaviors, and only 17% are using consumer marketing techniques

Raising Awareness and Making It Personal

The majority of employers (82%) offer tools (e.g., health risk questionnaire, biometric testing) that raise awareness of health status and risk, and reward participants for use of these tools.

Use of penalties or consequences for nonparticipation in health awareness tools and providing services that give plan participants options for second opinions are only used by about a quarter of employers, with on-site services being of less interest as ways to promote health engagement at this time.

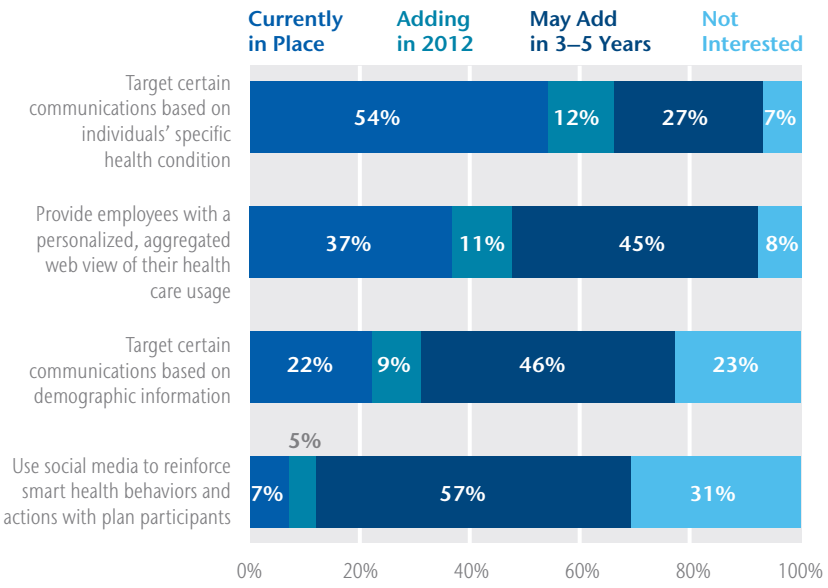
Activities to Engage Employees in Managing Health Care Costs



The data further show that employers are also getting personal when it comes to health care. This is good news, because that is exactly what employees say they want and expect when it comes to their health. Employees want tools and tactics that provide personal, targeted communications based on individuals' specific conditions, demographics, health risks, and biometric results. They also want recommended actions and available resources.

Two-thirds (66%) of employers report targeting certain communications based on individuals' specific health conditions as currently in place or adding in 2012. And almost one-half (48%) are providing a web-based personalized view of the individual's health status and suggested actions that could improve their health. Other tactics such as the use of social media (e.g., Facebook, blogs) are not in wide use currently, but are on employers' plans to add over the next 3 to 5 years.

Activities to Engage Employees in Managing Health Care Costs



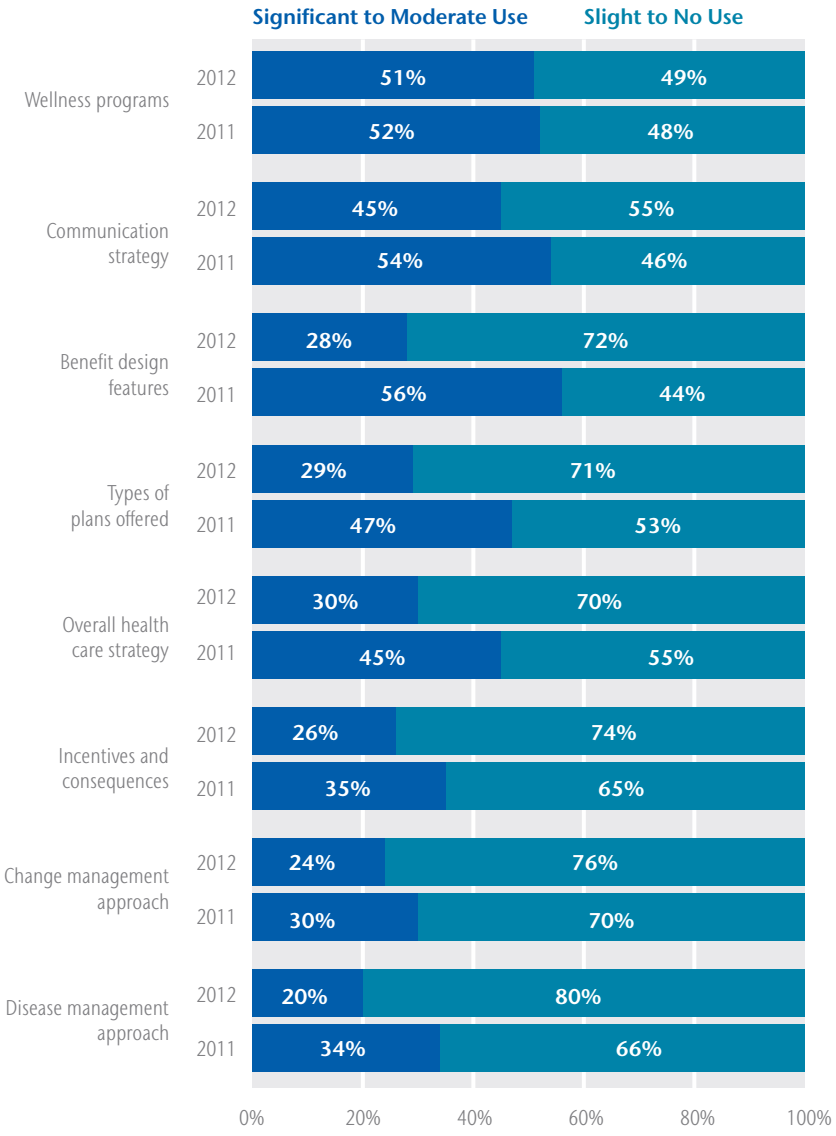
Employers Are Not Likely to Use Their Health Data

Recently, organizations have begun to collect data on participant attitudes toward health to drive better participation in health programs, promote behavior change, and ultimately reduce cost and improve productivity. But the use of such data has just begun to take root in the health care space over the past few years, and organizations struggle with how to use available information effectively.

Approximately one-half of employers are using employee input (e.g., focus groups, surveys) on participant attitudes toward health to influence wellness program and communication strategy decisions (51% and 45%, respectively). Employers do not appear to be using employee input to a great extent beyond this:

- About 1 in 4 employers seeks input on its incentive and disincentive designs
- Use of employee input has declined from 2011 to 2012 across every decision-making process in place to drive effective health strategy and engagement, with significant decline of input on benefit design features and types of plans offered

Use of Employee Input to Design Programs



Reward or Consequence?

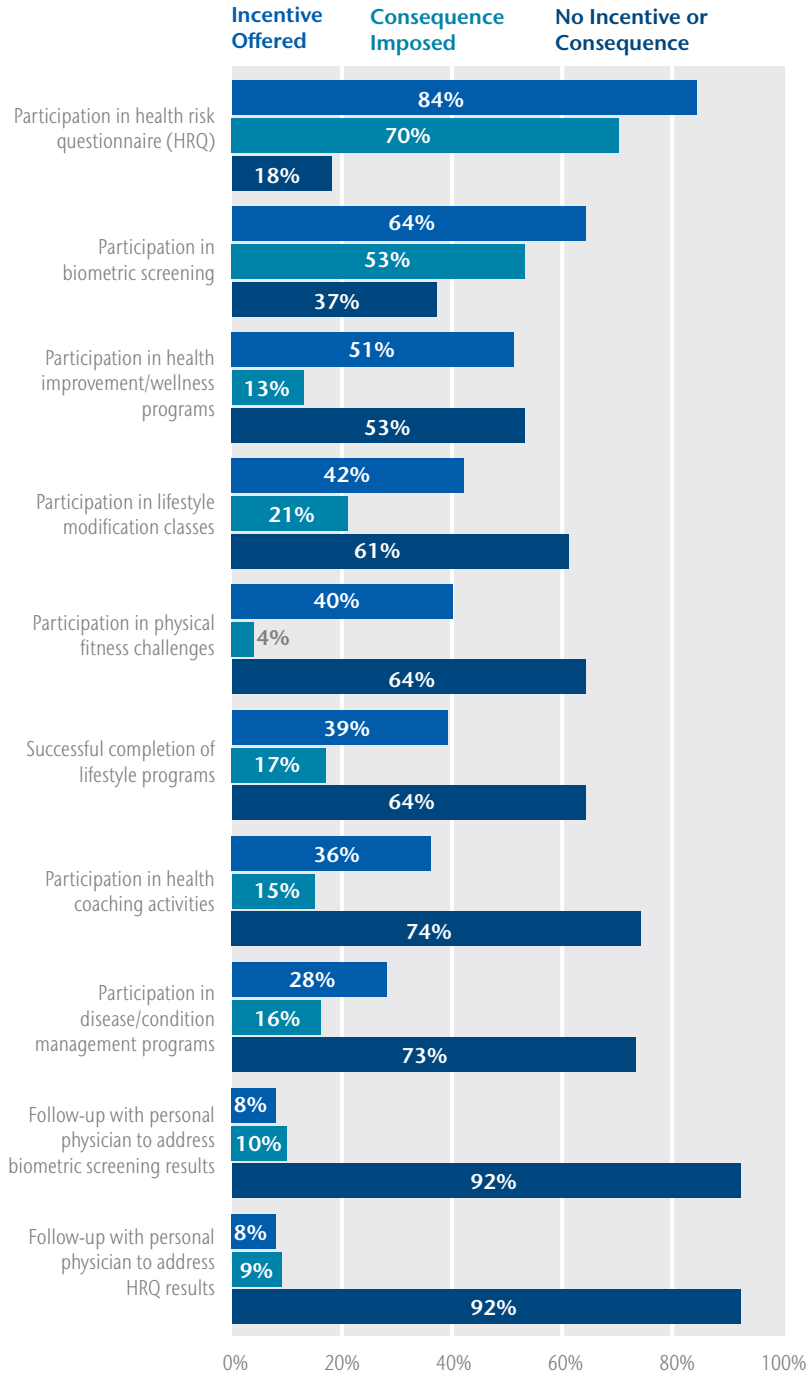
Participants in the study are more likely to use incentives to drive participation:

- Participation in health risk questionnaires (HRQs) and biometric screening are the two most popular programs where incentives are offered to participate (84% and 64%, respectively)
- Just over one-half (51%) offer an incentive for participation in health improvement/wellness programs
- About two-fifths report using incentives for participation in lifestyle modification classes or physical fitness programs

Consequences/penalties for nonparticipation in health programs are primarily imposed for HRQs and biometric screening (70% and 53%, respectively), with one-fifth (21%) imposing some form of consequence for not participating in lifestyle modification classes (e.g., weight management, tobacco cessation).

However, employers have neither an incentive nor a consequence strategy in place across a broad array of behavior change metrics. For example, 92% lack programmatic motivation for employees to share either biometric or HRQ results with their physicians.

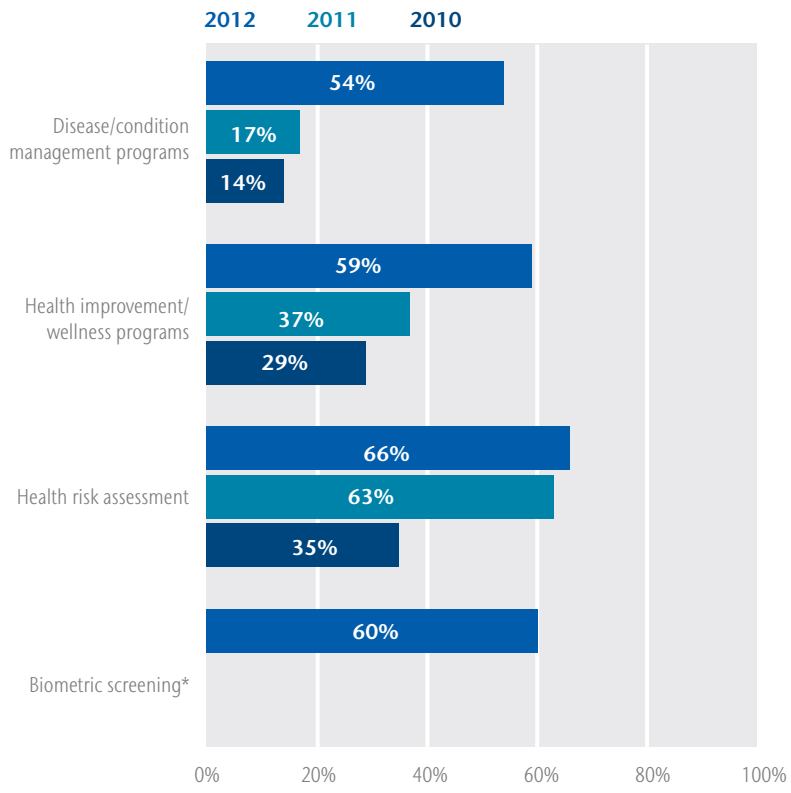
Incentive Is Offered or Consequence Is Tied to Participation or Results Achieved



Monetary Incentive Trends

Use of monetary incentives to promote participation in particular programs has increased dramatically over the past year. Monetary incentives used to promote participation in health improvement/wellness programs increased 22 percentage points, from 37% in 2010 to 59% in 2011. Employers offering monetary incentives for disease/condition management program participation almost tripled, increasing by 37 percentage points from 2010 to 2011. The results are not surprising, given the interest employers have in improving the health habits of their populations and increasing employee participation in health improvement/disease management programs—these being identified as key employer objectives.

Monetary Incentive Offered to Promote Participation in the Following Programs

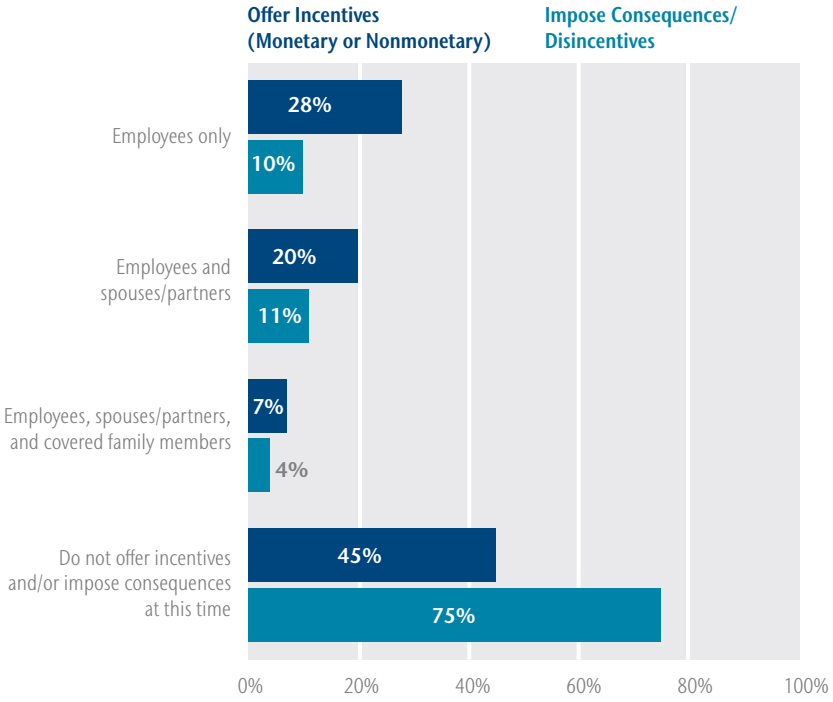


**New program added to survey in 2012, no historical data available.*

Including Families in the Discussion

Most employers are focusing their incentives/penalty actions primarily on employees. A growing number are expanding this focus to spouses/partners and the full family. An employer typically spends 50% or more of its health care dollars on dependents enrolled in the plan. In response, some employers are taking steps to address this issue by including spouses and family members in their program rewards and consequence structures. Further, by engaging the entire family, employers are more likely to involve the family decision maker for health, who is often not the working employee.

Employees and Dependents Offered Incentives or Penalty Actions Imposed to Promote Participation

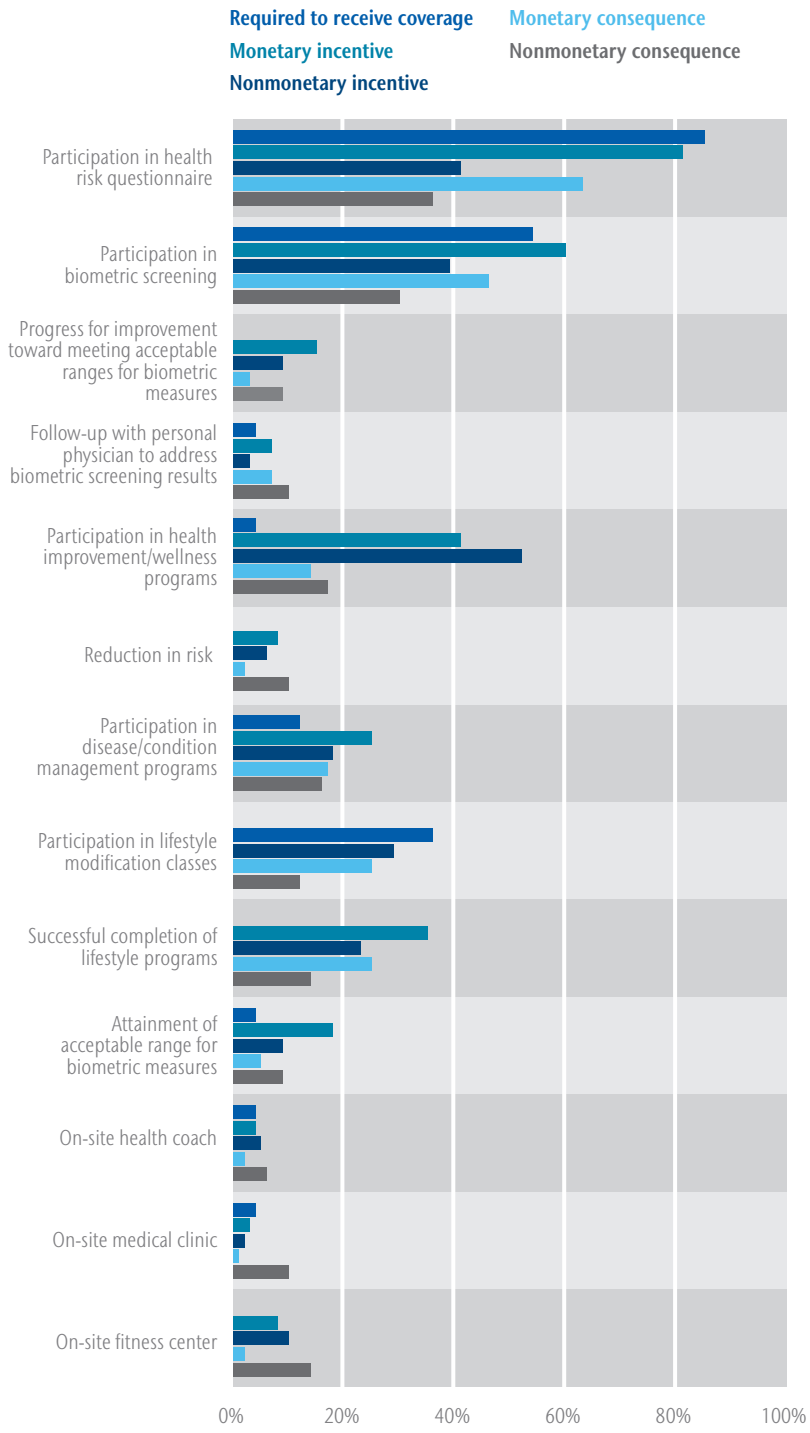


Linking Incentives to Results

Employers are now starting to link incentives to a result, as opposed to simply completing or not completing a task. For example, of those who do offer incentives or impose consequences, over one-half (58%) offer some form of incentive for completion of lifestyle modification programs (e.g., quit smoking, lose weight) and about one-quarter of those organizations using incentives/consequences strategies report offering incentives (monetary or nonmonetary) for progress or attainment made toward meeting acceptable ranges for biometric measures such as blood pressure, body mass index, blood sugar, and cholesterol.

Employers are also positioning these incentives as "consequences" for lack of participation in specific health programs (e.g., the percentage of organizations imposing consequences for nonparticipation in a health risk assessment is 63% in 2012, versus 9% in 2011). These survey results indicate that employers will likely be exploring various tactics in the near future that include both rewards and penalties linked to promoting participation and results.

Type of Incentive Offered or Penalty Imposed to Promote Participation in the Following Programs



Value-Based Insurance Design

Value-based insurance design (VBID) is typically part of a broader strategy to engage employees in better managing their chronic conditions. High copayments for medical or prescription drug services can potentially lead to under-use of essential therapies. VBID attempts to address this problem by allowing different cost-sharing provisions for different services (e.g., copayments are set at low levels for high-value services).

Historically, employers utilizing VBID as a strategy were doing so outside a "house money, house rules" culture. Today, there is strong evidence that this is changing. Of the 46% of organizations that incorporate some type of VBID approach in their health plans (e.g., provide lower copays or cost sharing for medical services, treatment, or drugs), almost one out of three require completion of a health risk assessment or required program participation (e.g., disease management, tobacco cessation program) to receive the enhanced benefits. This is a 33 percentage point increase from 2011, where 9 out of 10 employers *did not* impose any requirements. These results indicate that employers are becoming more requiring of participants in order for them to be eligible for enhanced benefits.

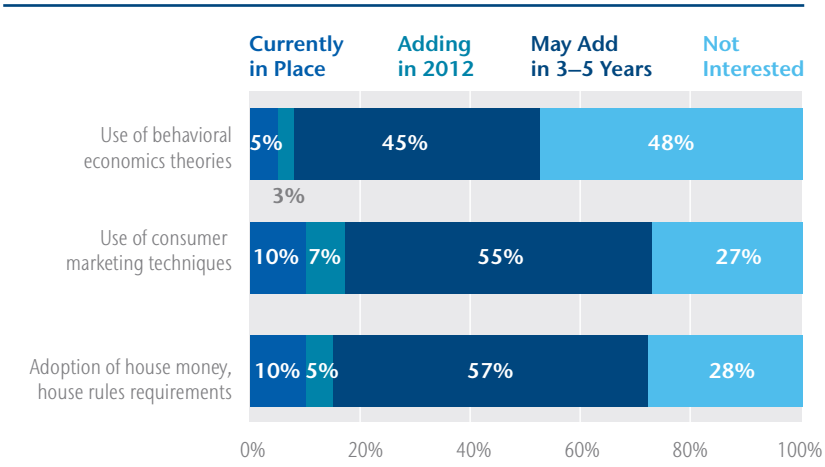
When organizations were asked if they are or will be targeting specific health conditions (e.g., asthma, diabetes) through VBID plan features, 25% reported doing so, with diabetes, hypertension, asthma, and cardiovascular disease being the most popular conditions targeted. This is up nine percentage points from last year, where only 16% of employers reported using VBID features to target health conditions.

Behavioral Economics Influence Benefit Plans

A growing area of analytics is the use of behavioral economics in designing and communicating employee benefit plans. Many organizations have already applied behavioral economic principles to improve employees' involvement in their defined contribution retirement plans, and are now exploring emerging strategies to do the same with their health plans. These techniques follow the foundations of consumer marketing, used by businesses for decades to advertise and promote products to their target consumers. In a similar sense, employees are the consumers of benefit professionals' services, and therefore these same principles can be used to help influence behavior change.

There is significant opportunity for employers to leverage these approaches to gain insight on health care design features and communications strategies that aim to promote positive change and reduce cost. However, very few of these approaches are in wide use today. In 2012, less than one-fifth of employers will use behavioral economics (such as loss aversion, social norming, or temporal discounting to reposition communication messages and access to rewards/consequences), consumer marketing techniques (such as consumer segmentation based on health attitudes), or adoption of "house money, house rules" requirements (predicating access to certain benefit levels based on participant completion of important health behaviors like screenings, assessment, wellness and prevention). However, 45–57% are interested in incorporating these techniques over the next 3 to 5 years.

Strategies Aimed at Changing Participant Health Behaviors to Improve Health and Reduce Costs



Aon Hewitt Point of View

As we've learned through our *Consumer Health Mindset* survey, employees know what they need to do to be healthy—85% of employees say good health is mainly a result of making smart choices in their health care and getting regular preventive care. Providing participants with more information and encouraging them to participate is not going to help them get healthy. Moreover, most people want to be healthy; they just need the right motivation to change what they are doing today.

Consumer Mindset: Make It Move Me!

Our consumer research gives us some clues about what will motivate employees.

Carefully choose the messenger. Most consumers see their doctor as the most credible and influential source of health information, followed by friends and family. Try to find ways to promote the doctor-patient connection and engage providers in engaging your employees (consumers).

Reposition incentives to motivate behavior change. Most consumers welcome incentives, and most prefer cash incentives over other types of rewards and penalties.

Use health and attitudinal data to more precisely target communication. Marketers are the experts at motivating behavior change, and they have been relying on attitudinal segmentation insights to understand and motivate consumer behaviors for decades.

Playing by New Rules

For most employers, good health is still a suggestion for employees rather than an articulated priority. More than two-thirds of employers make health risk questionnaires and biometric testing available to their employees. One-quarter of employers are making second opinion services available at no charge to employees, and more than half of employers are targeting communications to the health conditions within their populations. There are even a few employers, about 10%, who have begun to use social media to provide access to health information and suggested actions. All of these are tools that can create *awareness* of health status and opportunities to improve health—but, on their own, do not result in health improvement.

While more than 80% of employers provide an incentive to complete a health questionnaire, less than 10% provide an incentive to address the results of the questionnaire. More than 60% of employers provide an incentive to complete biometric screening, yet again, less than 10% provide an incentive to take any action. Less than 20% of employers provide an incentive to employees who achieve targeted clinical results. This focus on participation and access to information rather than *outcomes and results* won't move the needle when it comes to health improvement, and is unlikely to produce any relief for employers who need to mitigate cost. In addition, over time, incentives tied to participation tend to become entitlement programs, with employees expecting to earn an incentive without any sense of accountability for better health.

Consider the Semantics: Will Rewards or Consequences Move Participants?

By more than a two-to-one margin, employers prefer rewards to penalties. In an environment of difficult compensation messages, it's not surprising that employers favor a positive message over a penalty. Responses indicate that this preference for rewards in not likely to change in the future. More than half are likely to rely more on incentives than disincentives to drive desired program participation and health behaviors.

Money talks. It's simple, but true. Employees respond to financial incentives—either in the form of a premium reduction or a cash equivalent. Interestingly, employers pay out significantly more in premium reductions than in cash equivalents. Premium reductions are most likely to be $300 or more, while cash incentives are most likely to be in the $50–$150 range.

Make It Individually Relevant

Success in creating individual behavior change starts with really knowing who your employees and dependents are, and how to engage them. We can use time-tested marketing techniques to better understand critical health and wellness attitudes, barriers, and motivators in the employee and dependent population. Segmentation data can enhance branding and messaging, but it can also inform plan design and incentive structure. As an example, it may be possible to offer two actuarially equivalent medical plans that appeal to and motivate different segments in your population. The end result is that all groups select the plan that meets them where they are, motivates them to change, and in combination, achieves desired ROI.

Don't Design Plans in the Dark

Employers rarely seek input from employees when setting their health care strategy, deciding which plans to offer, designing incentives, or in their approach to change management. When employers do seek input from their employees, it is most likely to be on their communication strategy and wellness programs. Engaging participants in a new conversation regarding their health is unlikely to be successful if employees feel they don't have an opportunity to provide input. Without the opportunity to contribute, employees are more likely to ignore messages—and employers are more likely to get the message wrong.

Using consumer marketing techniques that have been successful in commercial settings can give participants a sense of connection to the messages and a reason to engage or take action. Employers are not embracing this marketing approach to benefits. Only 10% of employers are using these techniques today. While more than half may consider this approach at some point in the next 3 to 5 years, this "not now, but not never" perspective suggests real skepticism that consumer marketing is relevant to communicating employee benefits.

More than any other area, the challenge of behavior change looms large for employers. This means we need to use both the art and the science available to us to do this in new and meaningful ways.

Design with Intent

Take Plan Design off "Pause"
Over the past few years, as employers have been focused on health reform and a difficult economy, they have deployed tactics aimed at incremental cost shifting. With continued uncertainty, employers are recognizing the need for action; they can't wait until reform settles. Employers are taking a look at their plan designs and overall health care strategies to determine how they can achieve better health outcomes and results now. Because of this, we anticipate a faster pace of change than we've seen in prior years.

Key Findings

The total cost of health plans continues to trend at a pace that far exceeds Consumer Price Index, with overall increases ranging from 5 to 8%. Even though little is changing with plan offerings and contributions, there are some early signs of market interest toward defined contribution types of models.

- Very few employers plan to exit the role of plan sponsor; however, interest is accelerating in the corporate exchange model.
- Consumer-driven plans are now more common than HMOs; though still second to PPOs. CDHP trend is 2% points less than PPO trend, possibly fueling the shift. And, voluntary benefits are increasingly being used as an enticement to increase enrollment in CDHP.
- Plan funding strategies remain constant, with employers funding 80% of the cost; no dramatic change is expected in the future.

Interest Accelerates in the Corporate Exchange Model

One in four employers is considering shifting from a traditional health care programs to a private or corporate health care exchange model, which offers defined contribution funding and competitive, fully insured group health insurance marketplace. Although interest today is low (2%), more than a quarter of employers expect to provide access to a health care exchange in the next 3 to 5 years. In contrast, the percentage of employers embracing today's common model of offering a choice of employer-sponsored plans is expected to drop from 75% to 43% over the next few years. Finally, a steady percentage of employers (21% today, 20% going forward) offer a simplified model of a single employer-sponsored plan. Few employers plan to exit their role as plan sponsor, with only 1% saying they will let their employees choose from plans available in the open market; only 6% are considering an exit strategy longer term.

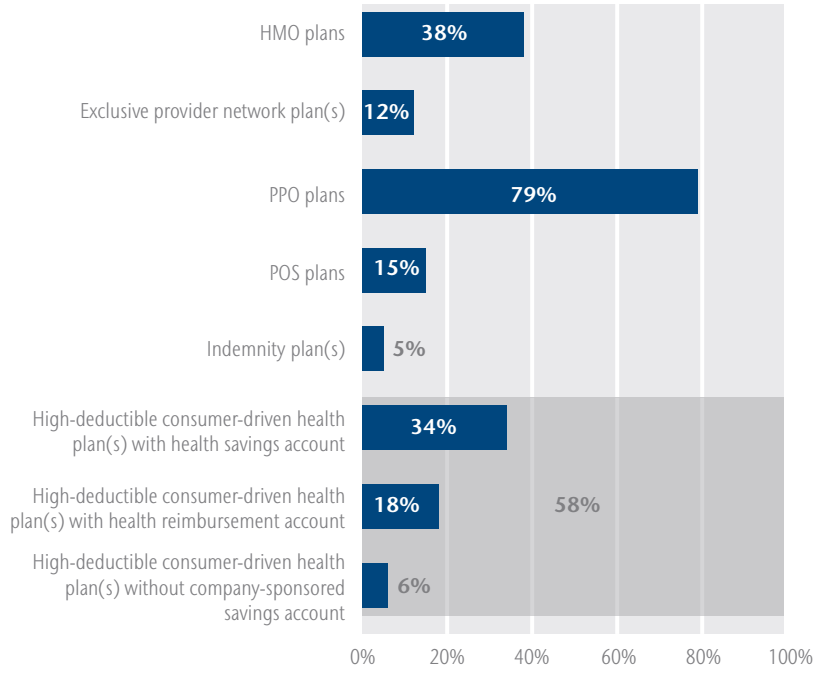
Approach to Providing Health Care Benefits for Largest Active Employee Population

Approach	Current Approach	Future (next 3–5 years) Approach
Employees choose a plan on their own from options available on the open market (employer neither sponsors nor contributes to health benefits).	1%	6%
Employer provides access to a corporate or private health exchange giving employees various plans to choose from (employer sponsorship through a fixed-dollar amount).	2%	26%
Employer actively manages and provides a few plans for employees to choose from (through sponsorship of traditional health benefit plans where employer pays a percentage of premium).	75%	43%
Employer selects a single health plan for all employees (employer pays most, if not all, of the cost).	21%	20%

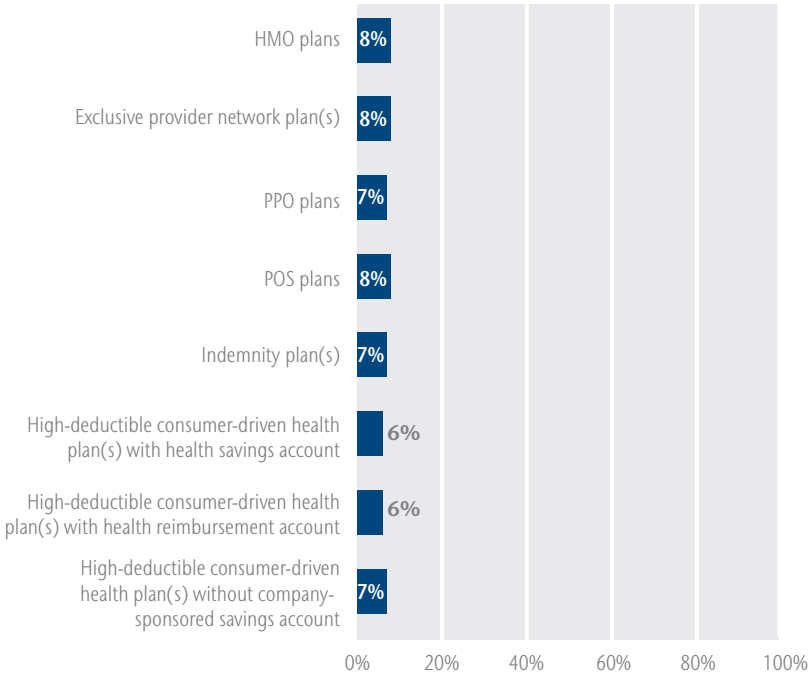
Consumer-Driven Plans Are Now More Common than HMOs; Still Second to PPOs

Employers offering a consumer-driven health plan (CDHP) increased over 2011, with 58% having a CDHP in place for 2011 and another 9% adding it as a choice in 2012. For the first time, we see account-based consumer plans as the second most common choice in plan design, behind PPOs (79%) and overtaking HMOs (38%). Employers report a 2% point lower trend cost for account-based consumer plans versus PPOs; this likely fuels the increased interest by employers. HSAs now outpace HRAs by nearly 2 to 1, with 34% of employers offering an HSA and 18% offering an HRA.

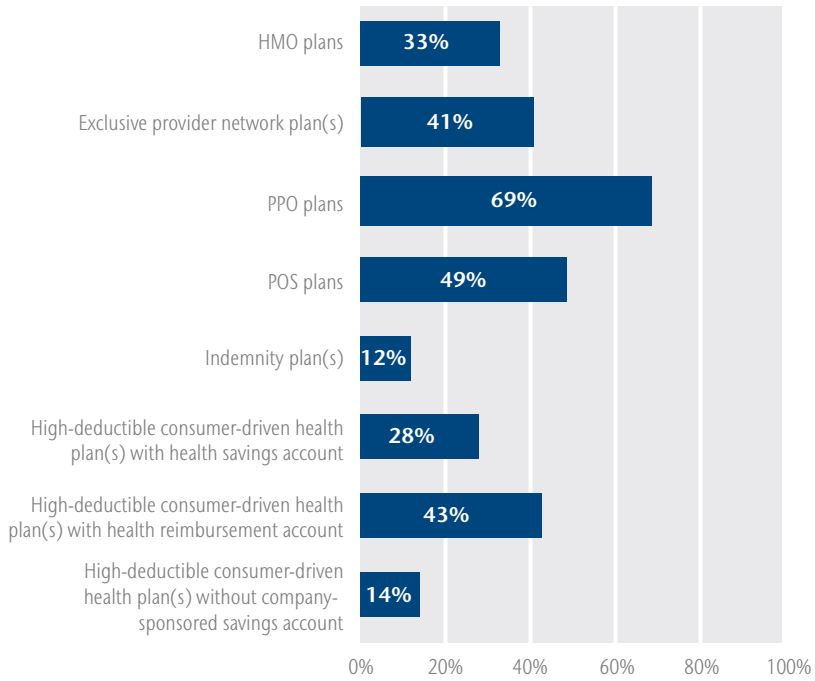
Health Plans Offered



Actual Cost Increase Year Over Year

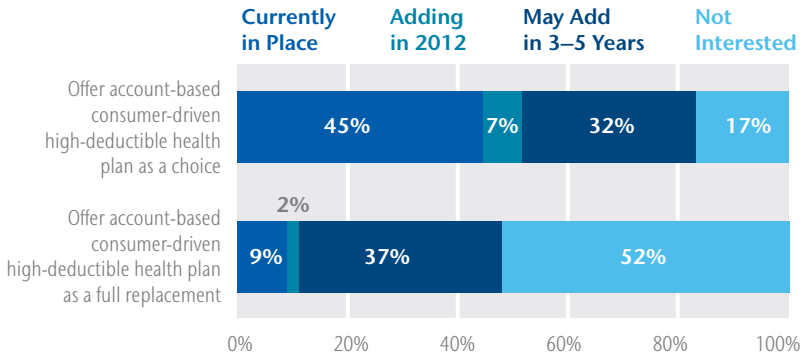


Average Enrollment Percentage in Each Plan Type



There continues to be employer resistance to a full-replacement CDHP strategy. Employers still prefer to offer CDHPs as a "slice" offering (52%) rather than a full replacement (11%). This has not changed since our 2011 survey.

Plan Designs Offered



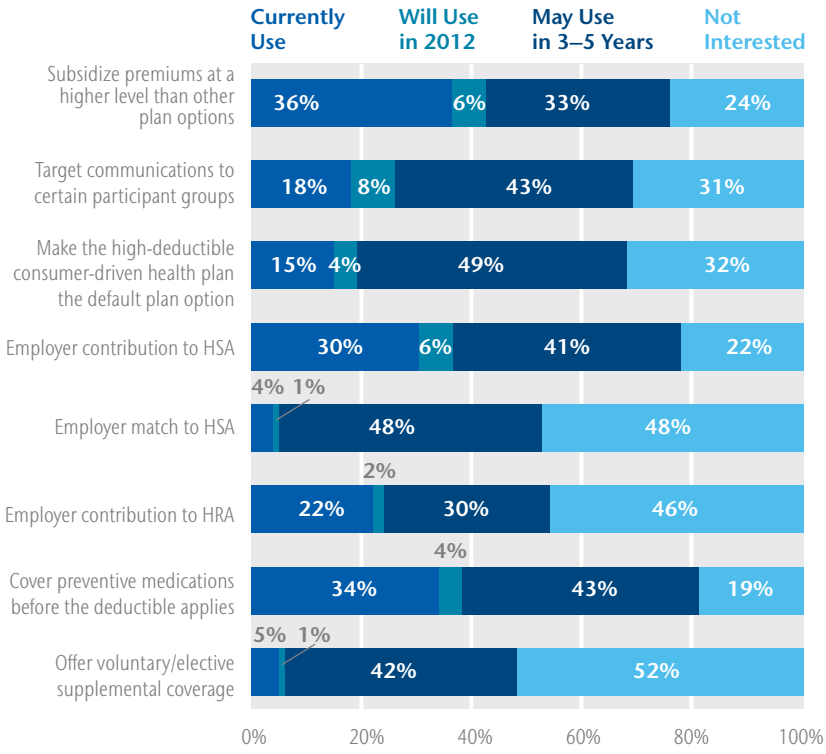
Subsidizing Premiums and Elective Benefits Can Increase Participation in CDHPs

Employers are using a variety of tactics to drive enrollment in their CDHPs. The most common tactics are:

- Subsidizing premiums at higher level than other plan options (36%)
- Covering preventive medications before the deductible (34%)
- Contributing employer funds to the HRA (22%) and HSA (30%)

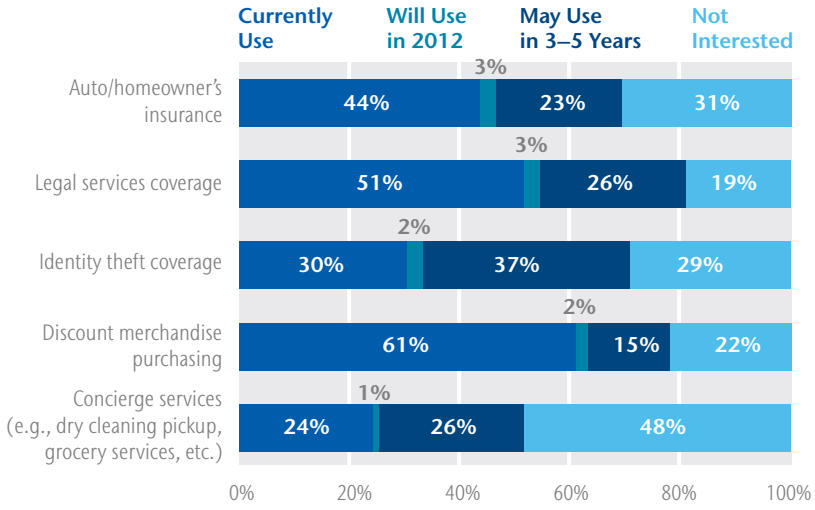
An emerging trend in 2012 is the utilization of voluntary/elective benefits in promoting enrollment in a CDHP. Although 6% use voluntary/elective benefits today to complement the CDHP and promote enrollment, 42% report they are considering this approach in the next few years. Of those currently using this tactic, 26% report significant to moderate increase in enrollment attributable to offering voluntary or supplemental medical benefits. Employers may want to consider offering some type of "gap" insurance to complement their high-deductible health plan (HDHP) strategy in order to decrease employee fears of high-deductible plans and the perceived financial risk of participation.

Tactics Used to Promote Participation in the High-Deductible Consumer-Driven Health Plan



Beyond driving enrollment in CDHPs, employers offer other voluntary benefits as a means of leveraging their group purchasing power. The most common voluntary work/life benefits offered are discounted merchandise (63%) and auto/homeowners coverage (47%).

Voluntary Benefits Offered to Support Work/Life Balance and Productivity Initiatives



Plan Funding Strategies Remain Constant

In the past few years, we have seen little change in the premium cost-sharing approach of employers, with employers contributing approximately 80% of the cost of health care, excluding out-of-pocket costs at point of care. As reviewed earlier, employers have increased plan design-based cost sharing over the past six years, resulting in an 82% increase in employee cost (contributions and out-of-pocket costs combined). Over the next 3 to 5 years, employers expect to reduce their subsidy levels, resulting in higher contributions for employees. As is the case now, employers expect to subsidize dependents at a level a few percentage points below the subsidy level for employees.

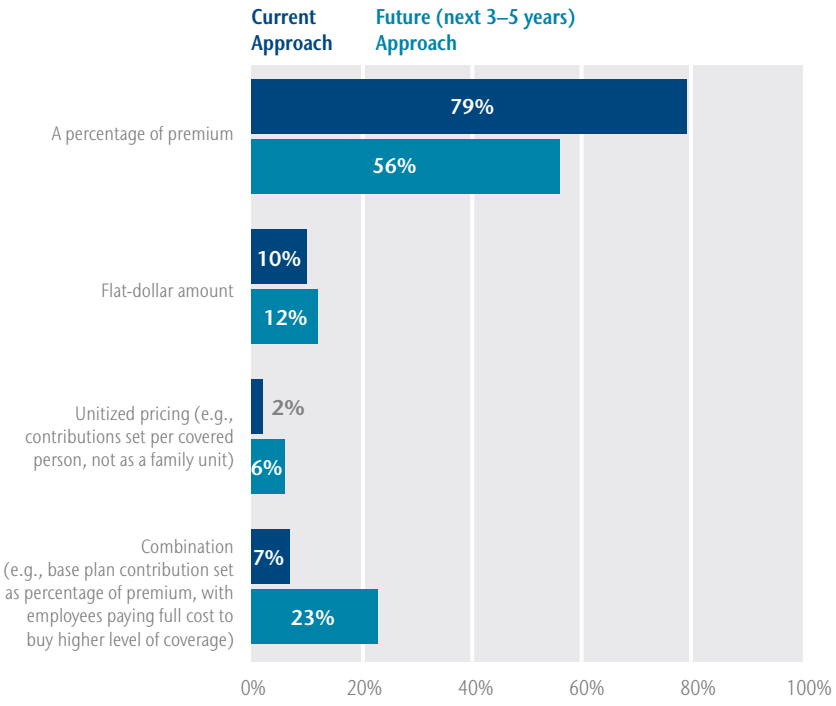
Cost Sharing for Employee and Dependent Health Care Coverage

Plan Participant		Actual 2011	Planned 2012	Expected Next 3–5 Years
Employee coverage	Employee contribution	23%	23%	25%
	Employer subsidy	77%	77%	75%
Dependent coverage	Employee contribution	28%	29%	31%
	Employer subsidy	72%	71%	69%

Flat-Dollar Employee Fee Approach Gaining Popularity

In the wake of rising costs, employers are considering alternatives to the traditional approach of setting the company contribution as a percentage of premium. While 79% of employers utilize percentage of premium today, that will drop to 56% in 3 to 5 years. One method gaining in popularity is a flat-dollar, or defined-dollar approach, where the employer establishes the amount each employee has to offset premiums for all plans offered. Twelve percent of participants responded that they will move to a fixed, defined-dollar amount in the next 3 to 5 years. An additional 23% indicate a desire to move to a combination of flat dollar and percentage of premium in the next 3 to 5 years.

Approach to Establishing Employee and Dependent Health Care Coverage Premiums for Largest Active Employee Population



Trend Toward Basing Subsidy on Total Rewards Cost

While 81% of respondents describe their subsidy as based on health plan cost and increases tied to the overall health plan budget today, this percentage decreases to 47% over the next 3 to 5 years, with a shift toward evaluating the subsidy based on the total rewards budget. Such an approach aligns well with "flat-dollar" or defined contribution models, enabling the employer to establish its subsidy in the context of its overall total rewards philosophy and budget.

Strategy for Company Subsidy

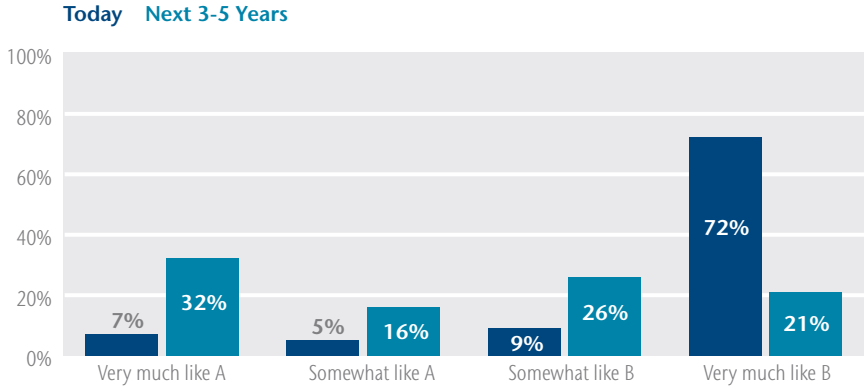
Description A

Company subsidy is a defined-dollar amount with increases managed as part of the **total rewards budget**.

Description B

Company subsidy is determined based on health plan cost, with increases managed as part of the **health plan budget process.**

My organization is more like A or B.



Traditional Tactics Prevail but Do Not Address Underlying Cost Drivers

Increasing a participant's deductibles and/or copays is still the most common cost-shifting lever utilized by employers. Few employers are currently increasing dependent premium surcharges; however, a large percentage (52%) are considering doing so in the next several years. These levers are really only focused on cost shifting to employees and their covered dependents. Employers need to look at approaches that save cost for both the employee and the organization.

Aon Hewitt Point of View

Health benefit designs of the future may follow similar historical events of the past. Consider the stagnation of defined benefit (DB) pension plans. In 1996, two-thirds of all employers offered a DB pension plan. By 2009 this had shrunk to 35% of employers offering a DB plan and 32% having frozen their plans.

We may be facing a similar land shift now in health care. Consider the impact of the upcoming W-2 disclosure to employees required by the Affordable Care Act. Employees will now have visibility into the true employer cost of health care, and may gain knowledge of the higher employer subsidy dollars for employees covering family members. Knowledge alone won't create change, but combined with increasing health care trend rates and the evolution of exchanges, both public and private, it may provide the environment for change and more defined contribution types of models.

Employers are intensely focused on improving health care results. Most recognize it's time to do things differently. A rising number are considering a health care exchange. Many others are applying the "play by new rules" strategy, using rewards and consequences and creating a culture of health. Either strategy requires change.

Whether an employer is ready to move to a true defined contribution health plan via an exchange of some sort, or wants to remain in the game as an active provider of benefits, the employer must embrace the pace of change in the market, and must seek ways to make new approaches understandable and useful for employees.

Consumer Mindset: Make It Easy

To drive behavior change, employers must engage their employees in making good decisions about their health—initially and for the long term. Making this happen is a tough challenge for employers. Our consumer research shows us that employees don't view their personal health as the problem; unfortunately, national health data tell us consumers may be overstating how healthy they really are. Employees also tell us they know what they need to do to get and stay healthy, but they have some real barriers: lack of time and money and an unwillingness to make changes. Employers will make progress by simplifying plan design and incentive structures so employees can clearly see the link between health improvement behaviors and access to better benefits. These designs then need to be accompanied by a targeted outreach communication plan that reaches key populations among their employees and dependents. Employees need messages that will personally move them to action.

Creating Health Action "Gates" to Enhanced Benefits

One tactic increasingly being used to engage employees in behavior change is redefining eligibility, either for specific options or the entire plan. Today, the majority of employers define eligibility in a traditional way—employees are eligible for all options regardless of individual health actions or outcomes. Over the next 3 to 5 years, 47% of employers will move away from traditional eligibility definitions and require more from the employee—adopting a move to "gates" for better benefits, where specific actions (completion of health risk assessment or biometric screening) and/or health outcomes (body mass index, improvement in health status) must be completed to be eligible for certain plan options.

Employer Subsidy: Rethinking Your Commitment to Employees and Covered Dependents

The only benefit where employees get more value for being married is health, dental, and vision coverage. Employees don't get more pay, vacation, or higher retirement benefits because they are married. So why do they get more health care funding? As market options become available for spouses, some employers are rethinking their commitment to employee vs. spouse/family coverage tiers. In addition, the transparency inherent in flat-dollar and defined contribution subsidy strategies will require employers to be able to articulate a rationale for higher support for families, within the context of the overall total rewards philosophy.

Plan designs should still be a key area of focus. Employers need to explore the links between design and behavior and develop approaches that lead participants to the obvious decisions. This includes VBID concepts and Rx strategies around generics, specialty medications, and mail order medications.

Reduce Unnecessary Expenses

The Intersection of Cost, Quality, and Care

As health care costs continue to escalate, employers and employees alike seek efficient, understandable plan designs and program features to reduce any unnecessary expenses. At the same time, the ever-shifting health care landscape creates a broad array of tactics employers can pursue to drive employees to high-quality and high-value providers, and ensure that only entitled individuals are covered as defined by plan documents. Sophisticated data analysis sits at the foundation of these efforts to reduce unnecessary expenses.

Key Findings

Understandably, survey results show that employees are anxious to reduce expenses and are taking steps to do so.

- Reliance on data continues to grow in importance. Over the next 3 to 5 years, there is a significant shift toward using third-party providers for data analytics, with 55% using this approach now and 69% saying they will move in this direction in the next 3 to 5 years.
- Employers are looking at a vast array of new delivery models, such as accountable care organizations (integrated delivery systems), centers of excellence, and other medical home pilots that provide better primary care delivery and triage.

Reliance on Data Continues to Grow

Over half of current survey participants are using normative data to identify key cost drivers and find cost savings ideas within their plans. Another 40% are considering more widespread use of normative data in the next several years, including 11% who have begun doing so this year.

Employers currently are split as to whether they rely on their health vendors to develop and interpret their program data (42% of employers), or whether they use a third-party vendor and internal resources to develop and interpret their data (55% of employers). Over the next 3 to 5 years, we anticipate a sizable swing away from using the health plan for this type of function, with 69% responding that they will use a third-party analytic partner.

Employers Looking at Streaming Plans and Improving Primary and Triage Care

In the current health care system, health plan contracts reward providers based on volume and complexity of services delivered. As a result, the provider market is tilted toward specialty care, and lacks provider accountability for how a patient navigates various aspects of the system. In response, both the federal government and private-market health plans are exploring approaches to provider contracting that encourage use of primary care, and which create rewards tied to the clinical outcomes for a patient, integrated across the care system.

Ensuring Access to High-Quality Care: Focused Performance Networks Emerge

High-performance provider networks that meet cost and quality objectives, as well as primary care-centric systems, are emerging as the centers of care delivery. Employers are turning to alternative network management tactics to manage overall and condition-specific plan costs. Over one-third of employers (42%) currently utilize a high-performing or specialty network, with 46% of respondents considering this in the next 3 to 5 years. And one-third of the organizations tightly manage the health of the chronically ill through mandatory condition/case management or special networks for care. Close to half of employers are considering these two strategies in the next few years.

The Quest for Transparency: Getting to the Bottom of Cost and Price

Over half of those surveyed (55%) are considering reference-based pricing arrangements, whereby plan reimbursements, for which there is a wide cost range in a geographic area, are limited to a set dollar amount for certain services such as MRI, radiology, colonoscopy, etc. Setting a fixed price still allows for member choice of providers, but employs the consumerism aspect in which participants pay higher out-of-pocket costs for more expensive providers. Employers and employees alike want to know "What does it cost?" and "How much will I owe?" when it comes to specific health care procedures. Reference-based pricing starts to answer these questions.

Traveling Globally for Less Expensive Care Is Not Popular

One tactic that does not have much momentum currently is international medical tourism, with only 5% of employers using this approach and only 27% considering it for the future. This, and direct contracting with providers, are the categories employers are least interested in pursuing.

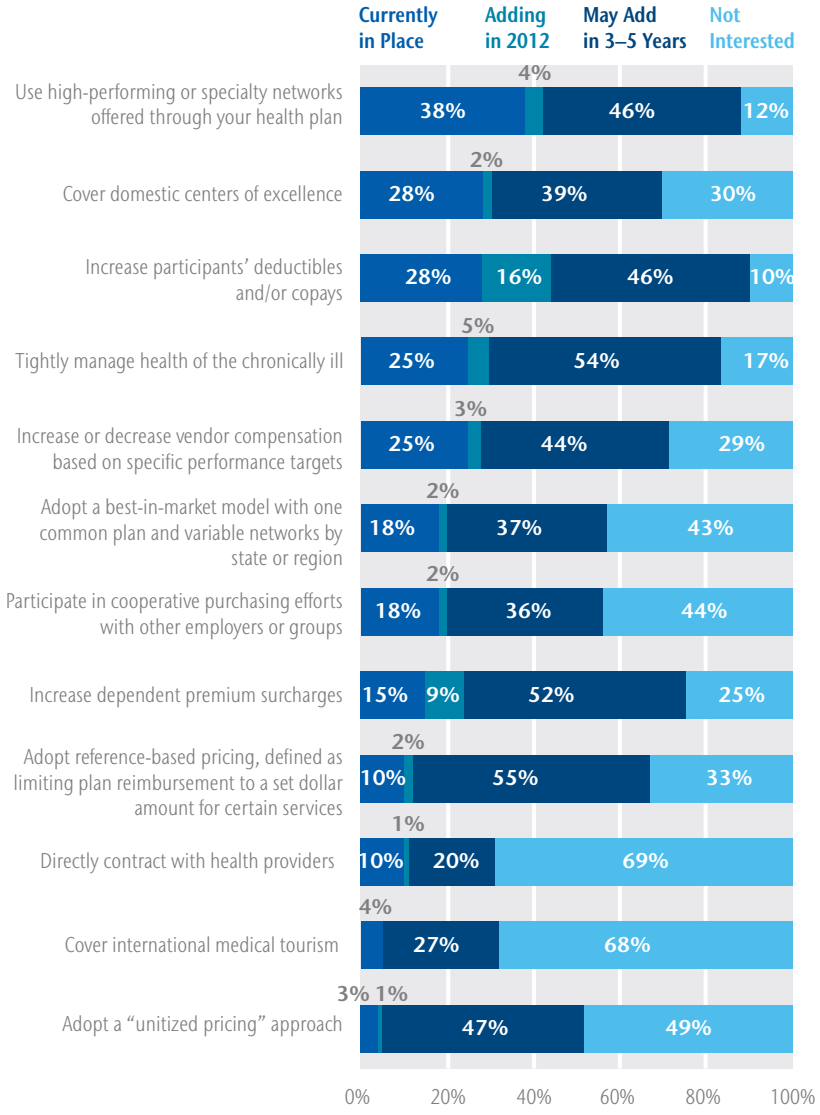
Covering the Right Individuals

Employers typically spend as much on dependents as they do on employees, with some organizations spending a greater amount on individuals who do not work for the company than they spend on those who do. One tactic deployed to address this is the use of surcharges for adult dependents. In 2011, 15% of employers increased dependent surcharges. In 2012, another 9% are increasing surcharges, and in the next 3 to 5 years another 52% may adopt this tactic. To reinforce this message many employers are turning to dependent eligibility audits as a way to make sure they are covering only those people the plan is intended to cover.

Maximizing Purchasing Efficiency

In an effort to manage their largest item of health care spend, employers continue to investigate options for optimal vendor purchasing. The adoption of a best-in-market approach with a common plan and variable networks by state/region is offered by about a fifth of the population, with another 37% of the respondents considering this in future years. Over 50% of employers are currently participating in coalition-based purchasing (20%) or are considering it in the next 3 to 5 years (36%).

Managing Cost/Reducing Unnecessary Expense



Aon Hewitt Point of View

Employers have deployed, and will continue to use, traditional cost savings tactics. Increasing deductibles, copayments, and the cost of dependent coverage are all being implemented in an effort to curb the rate of increase in projected health care costs. While these levers will continue to be foundational for the next several years, employers are also beginning to embrace more aggressive techniques that focus on innovative network options and improved care management.

Plan sponsors increasingly will require enrollees to use specialized networks and will mandate condition management for their chronically ill members. One thing is clear when it comes to reducing unnecessary expenses: Change will be the constant for the foreseeable future. New care delivery models will emerge and new reimbursement models will be presented. Employers can do one of the following:

- Continue to sponsor a medical plan, but migrate from a traditional "managed trend" approach to a "house money/house rules" (HMHR) approach that is more requiring of plan participants and integrates a pay-for-performance philosophy into their benefit programs.

- Change from plan sponsor (defined benefit) to coverage facilitator (managed defined contribution). Private and government-run health care exchanges will introduce new strategic options that plan sponsors owe it to themselves to evaluate.

Consumer Mindset: Make It Personal

Our consumer research tells us that employees are worried about health care affordability. They want to save money without sacrificing their own or their families' health. Cost, treatment, and provider decisions are highly personal and emotional. To drive the "right" behaviors, employers must move beyond communication to a "marketing" model that highlights more than just the numbers. Employers can do this by making the message personal:

Personalize health and cost information. To help consumers reduce the amount they're spending on health care while maintaining good health, give them a personalized health plan that includes information like their individual health conditions, health risks, specific actions they should consider, and how to take those actions efficiently.

Make succinct information available at the point of need. Consumers want help getting quality care, when they need it, and for the best possible price. However, many aren't sure where to go for help.

Guide consumers to smart choices in quality and cost-effectiveness. In consumers' minds, there is often a belief that higher cost equals higher quality. Of course, this isn't always the case when it comes to health care.

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About Aon Hewitt

Aon Hewitt is the global leader in human resource solutions. The company partners with organizations to solve their most complex benefits, talent and related financial challenges, and improve business performance. Aon Hewitt designs, implements, communicates and administers a wide range of human capital, retirement, investment management, health care, compensation and talent management strategies. With more than 29,000 professionals in 90 countries, Aon Hewitt makes the world a better place to work for clients and their employees.

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