

LEADING THE WAY

EMPLOYER INNOVATIONS IN HEALTH COVERAGE

2018



TABLE OF CONTENTS

04 INTRODUCTION

06 PAY FOR VALUE

Intel Connected Providers to Focus on Outcomes, Eliminate Waste	7
Identifying High-Cost Claims Led to Successful Carve-Out Program for High-Tech Organization	9
NRECA Implemented a Carve-Out for Specialty Drugs	11
Brokerage Contracted With Shared On-Site/Nearby Primary Care Services Facility to Address Healthcare Cost Trend	14

15 DRIVE TO QUALITY

ARLP Established Direct Contracts to Improve Quality and Manage Cost	16
The Alliance Centers of Excellence/High-Performance Networks Set Quality Criteria for Providers	17
EMO Services Resulted in Better Outcomes and Lower Costs for Princeton University	19

20 PERSONALIZE THE EXPERIENCE

Boeing Opens New Doors to Behavioral Healthcare	21
Princeton University Health-Coaching Program Targeted Chronic Conditions	22
BorgWarner Motivated and Incentivized Employees to Good Health	24
Fortune 50 Retail Organization Targeted Diabetic and Pre-Diabetic Population to Maintain and Improve Health Status	24
Activision Blizzard Supported Its Members to Have Healthier Pregnancies	26

28 EMBRACE DISRUPTION

Walgreens Established Care-Coordination Model Within Carrier Partners	29
AT&T's Full Commitment to Making Consumerism Work	30
PepsiCo Increased Employee Engagement Through Point-Solution Platform	31

33 CONCLUSION

INTRODUCTION: FORGING PATHWAYS TO SUSTAINABILITY

The federal tax incentive encouraging employers to offer health insurance coverage to their workers has often been described as an “accident of history” – an inadvertent byproduct of World War II wage and price controls. Owing to that monumental policy decision generations ago, employers have emerged as the core of the American health insurance system.

According to the US Census Bureau, more than **178 million Americans currently have employer-sponsored health insurance** – more than half the country, surpassing Medicare and Medicaid and dwarfing the number of people covered in the individual market.

Despite employers playing such a significant role in the healthcare market, policy debates have too often ignored them, focusing instead on whether the states or the federal government should have a more direct role in providing healthcare coverage.

The American Benefits Council and Mercer, along with other stakeholders, have argued that employers are more than mere intermediaries. They play a critical role in the healthcare system, leveraging purchasing power, market efficiencies and plan design innovations to provide comprehensive health coverage at a fraction of the cost to government compared to federal programs.

The Affordable Care Act (ACA) and laws preceding it recognized this, plainly building on and around the employer-sponsored system. Nevertheless, misperceptions abound. In discussions with policymakers on this subject, we have encountered a widespread belief that the unlimited tax exclusion is a primary cause of the high cost of healthcare in the US. These academics and policymakers argue

that because health benefits can be provided more cheaply than wages under current tax law, employers provide richer coverage than they would otherwise, prompting employees and their families to use more healthcare than they really need.

We are concerned that some policymakers subscribe to the myth that because healthcare is purchased with tax-free dollars, employers don't feel the need to manage their own healthcare spending. That they don't seek more cost-efficient health plans. That they don't work to ensure quality of care. **That they don't innovate.**

In fact, employers have been innovating since they first began providing health benefits. Thirty years ago, Bell South (now AT&T) created the largest privately negotiated hospital PPO; five years later, Allied Signal (now Honeywell) implemented the first point-of-service plan. These early managed care organizations and others like them reined in soaring cost growth and reshaped the healthcare landscape.

Today, with the total average annual cost of healthcare benefits exceeding \$12,000 per employee,¹ employers know all too well that rising healthcare costs threaten their ability to compete in the global marketplace. Employers are working incredibly hard to slow cost growth while still ensuring employees and their families have access to high-quality care. For years, these efforts have included encouraging employees to be better healthcare consumers and to take care of their health.

Employers have pioneered strategies that directly address the biggest cost drivers in the US healthcare system: the relatively small number of

¹Mercer. *National Survey of Employer-Sponsored Health Plans*, 2017.

high-cost claims that drive such a large percentage of spending, increasing unit prices resulting from marketplace consolidation, misplaced incentives, waste, inefficiency, uneven quality of care and lack of transparency. Many of these experiments have met with startling success and – if scaled and encouraged – have the potential to fundamentally improve healthcare for all Americans.

The American Benefits Council and Mercer have worked with employers and other stakeholders to raise awareness of the harm that could be caused by implementation of the so-called “Cadillac Tax” or erosion or elimination of the individual federal income tax exclusion for employer-sponsored health coverage. These incentives are the foundation of high-quality, affordable coverage that Americans overwhelmingly like and want to keep. And it is to maintain this coverage that employers continually seek to enhance value and improve outcomes for employees through innovation.

This paper is a playbook of some of employers’ most innovative strategies. Mercer has identified four areas where we believe change is most needed to create a more rational healthcare marketplace, called the “Vitals for Change.” We’ve organized the case studies in this paper to show how employers are helping to drive change in all four vital areas:

- Pay for value
- Drive to quality
- Personalize the experience
- Embrace disruption



1

PAY FOR VALUE

Pay for value is about aligning reimbursement with value, not volume. As the ultimate purchaser, employers expect to pay for better patient outcomes, more efficient care and improved member experience. Reimbursement changes are already well underway.

Pay-for-value strategies are steps taken by employers and health plans to move away from traditional fee-for-service reimbursement to give providers meaningful financial incentives to provide high-quality care in the right setting and to avoid wasteful, duplicative or unnecessary services. Successful strategies require collaboration between employers, carriers and providers around provider pay, network design and benefit design. Some very large employers have taken the lead by directly contracting with providers and initiating payment reforms. Although most health plans have incorporated elements of pay for value into their programs, employers now have an important role to play to ensure these strategies are delivering lower cost and better quality, that health plans continue to experiment and evaluate their approaches, and that there is a road map for expansion of the successful approaches.



Case Study

Intel Connected Providers to Focus on Outcomes, Eliminate Waste

The issue: Intel's health benefit program had long been focused on all three elements of the triple aim: quality, cost and user experience. The company had previously implemented high-deductible health plans, biometric screenings and on-site primary care, strategies that helped achieve a consistent low single-digit trend, nearing zero — until costs began to rise again.

The solution: As a company that deals in data, Intel undertook a deep analysis of claims in 2011 and found that although it was spending \$500 million per year on healthcare for 132,000 people, just 800 people accounted for \$100 million. These high-cost individuals were managing chronic conditions (often multiple conditions), engaging with multiple doctors and specialists and managing multiple prescriptions. But the program was lacking coordination of care to help these employees navigate the system, avoid wasted spending and achieve improved health outcomes. To address this issue, Intel went out

to the marketplace in locations where they had a critical mass of employees and forged partnerships with health systems, essentially creating their own Accountable Care Organizations (ACOs). These arrangements were structured around pay-for-performance based on measures supporting the triple aim. In this new Connected Care system, physicians keep in touch with the patients and coordinate with other service providers associated with the patient — including Intel's on-site primary care clinics. Secure data sharing between providers was a key component of the program.

The results: Compared to the other Intel plans, Connected Care plans are achieving better outcomes and higher member satisfaction and are already showing a slightly better year-over-year trend, with overall lower total cost per member — especially higher-risk members. Increased efficiency, improved outcomes and happier patients add up to a clear win.

KBR, Inc. was one of the first employers to participate in the Aetna/Memorial Hermann ACO, which provides better overall care for the employee and has reduced costs for KBR. They also participate in a program that brings together a surgical center of excellence with enhanced care coordination. For employees in KBR's PPO who use the program, surgery is cost-free; for those in the HSA plan, it's free after they've met their deductible. This is a benefit that employees love — with lower cost to KBR as well as to patients.

SPOTLIGHT ON DATA

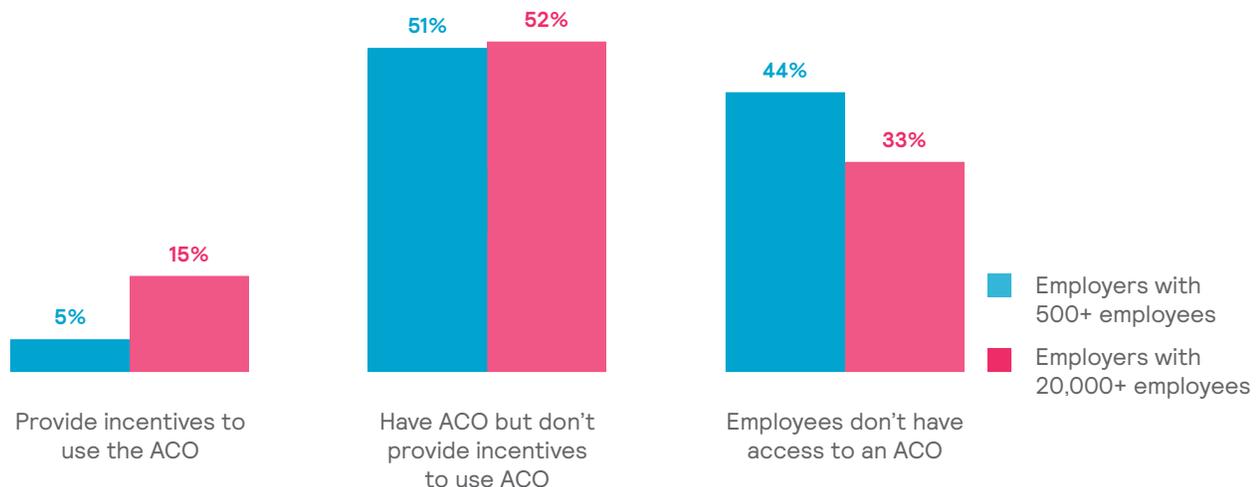
For many organizations, the first step in trying to determine the approach to take to address their population's health issues is delving into their data. One American Benefits Council member has used its data analysis service to:

- Examine the efficacy of high-deductible health plans (quantified cost-avoidance over the past three years)
- Develop scorecards by location for high use of ER versus urgent care, low use of generics and communication of preventive benefits
- Study outcomes of employees who have had biometric screenings that revealed high blood pressure

ACCOUNTABLE CARE ORGANIZATIONS

ACOs are perhaps the most visible vehicle for delivering value-based care. An ACO is an affiliation of providers who work together to treat an individual across care settings (for example, doctors' offices, hospitals and long-term care facilities), with payment tied to achieving cost, quality and satisfaction targets. A small number of mostly very large employers have contracted directly with providers to form an ACO; in addition to Intel, early adopters include Boeing, Walmart and other leading-edge organizations. Health plans have moved quickly to incorporate them and ACOs are increasingly being offered through employer-sponsored health plans. Some employers are now taking the step of changing plan design to give employees an incentive to seek care from ACO providers.

Figure 1: Accountable Care Organizations: The Largest Employers Are Providing Incentives



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2016

Case Study

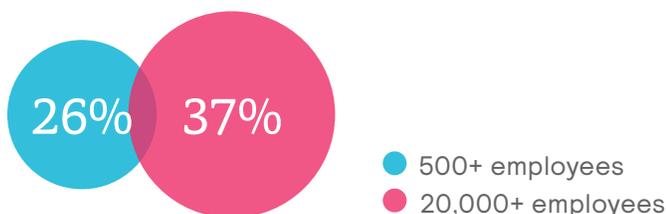
Identifying High-Cost Claims Led to Successful Carve-Out Program for High-Tech Organization

The issue: A large high-tech organization analyzed its de-identified claims data to look for ways to address high maternity costs. The company found that users of infertility services had a much higher rate of high-cost newborn claims, including multiple births, pre-term births and “avoidable C-sections” compared to nonusers of infertility services.

The solution: The organization explored insurance carrier solutions but ultimately decided to carve out all infertility services to a specialty vendor focused solely on outcomes, a great user experience, and reduced costs. Instead of simply shifting costs to employees, this solution worked on reforming the delivery system for infertility services by covering the right services (for example, making single-embryo transfer the standard and covering genetic testing of embryos as a standard benefit); providing a customized, curated network of facilities that align with the principles of the organization; and creating a unique patient-centered advocate experience to guide employees through the process.

The results: Since the implementation of this program, the organization has seen a substantial reduction in multiple-birth pregnancies among employees (less than 3% of users of this service versus a national average of 22%), around a 60% success rate with in vitro fertilization (IVF) (versus a national average of 45%) and a net promoter score of +86. Employees rate their experience with the network of doctors at 4.8/5 and their experience with the specialized benefit and support at 4.9/5. The higher IVF success rate has given employees what they told the organization they want most: a single healthy baby. Given the cost of a multiple birth is about \$145,000 on average (whereas the cost of a healthy single birth is about \$17,000), even factoring in spending more on infertility services (which the firm needs to do just to remain competitive), the service leads to increased savings while also improving women’s and newborns’ health.

Figure 2. Employers Providing In Vitro Fertilization Coverage



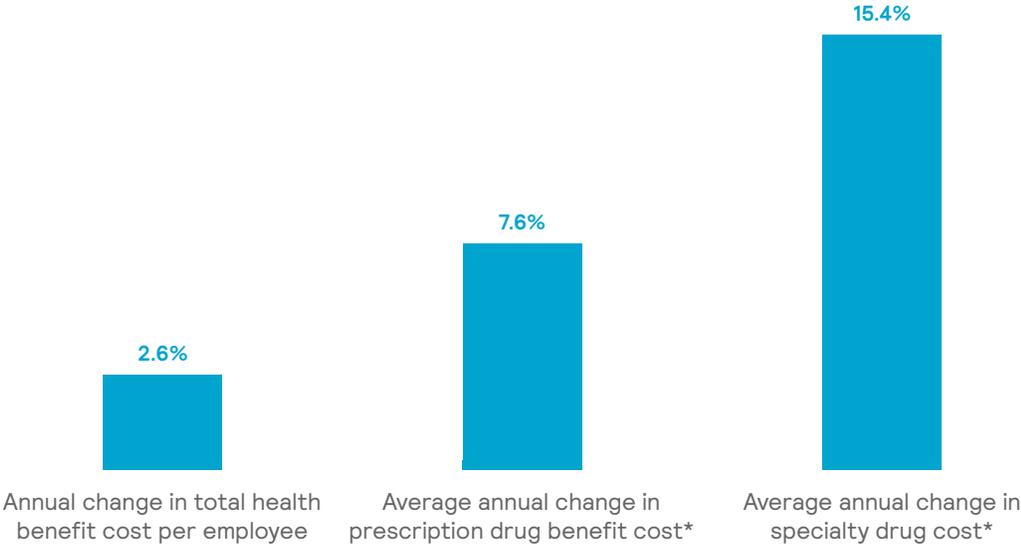
Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017



SPECIALTY RX MANAGEMENT

Prescription drug cost is rising faster than overall medical cost, driven by sharp increases in cost for specialty drugs. The most common cost-management approach, used by about half of all large employers, is simply to steer employees to a specialty pharmacy to fill prescriptions for specialty medications. But applying pay-for-value strategies may have more potential for cost savings. By carving out specialty drug management, employers can address the misalignment of incentives by separating distribution and management, and gain greater flexibility in formulary, clinical and plan design features.

Figure 3: Annual Cost Increases of Specialty Drugs Are Driving Overall Increases in Prescription Benefits Spend



*Employers with 500+ employees
Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017

Figure 4. Employers Are Taking Steps to Steer Employees to Specialty Pharmacies



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017

Case Study NRECA Implemented a Carve-Out for Specialty Drugs

The issue: The National Rural Electric Cooperative Association (NRECA) administers health benefits that are available to more than 900 consumer-owned, not-for-profit electric cooperatives, public power districts and public utility districts in the US. NRECA recognized that specialty drugs were an ever-increasing proportion of healthcare spend, representing 35% of total pharmacy spend. And pharmacy spend accounted for roughly \$100 million out of \$500 million in total annual claims paid, so action was needed to target this high-cost area.

The solution: Beginning in January 2016, NRECA began requiring that specialty medications be paid through the pharmacy benefit rather than the medical benefit. In this way, it not only took advantage of the deeper discounts available through its PBM, but also connected patients with the PBM’s specialty pharmacy team. This team provided assistance and information to patients who were on specialty medications to improve adherence. The team also helped align the site of care to ensure that medications were being dispensed in a cost-effective setting – for example, at a patient’s home rather than a provider’s office – which in many cases also resulted in a better patient experience.

As part of its initial pharmacy claims analysis, NRECA's vendor identified the members with the highest drugs claims. Before the new program was implemented, the vendor communicated with each of these patients and their providers to ensure that patients with serious health conditions were transitioned into the new program appropriately and without any gaps in care.

The results: NRECA estimates the plan saved approximately \$1.3 million in 2016 by carving specialty medications out of the medical benefit and providing site-of-care alignment services.



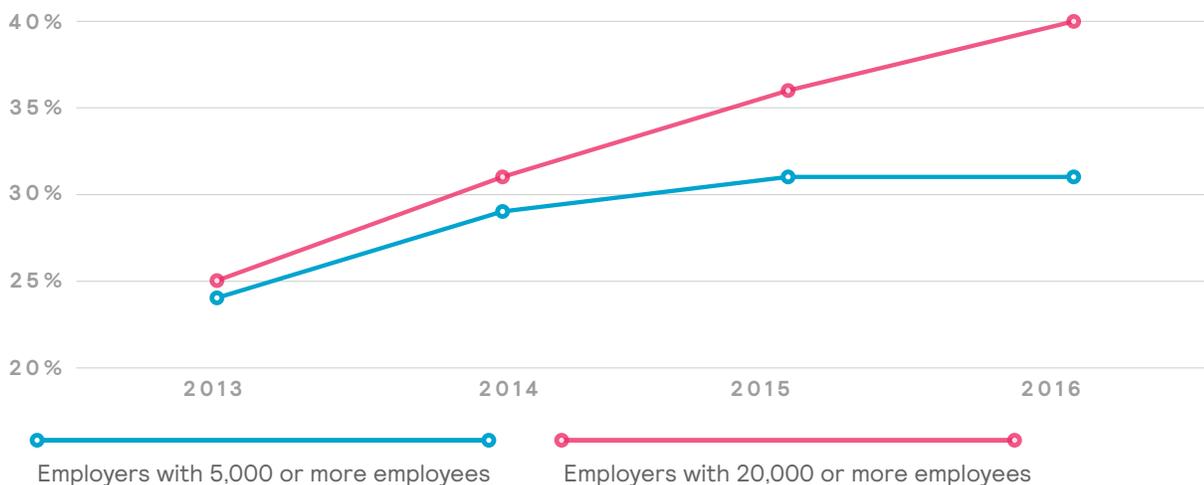
ON-SITE MEDICAL CLINICS

Worksite clinics were once focused on treating work-related illnesses and injuries, but employers are increasingly using them to provide a wide array of primary care services. Although these offerings range in scale from a single nurse to comprehensive primary care and pharmacy services, the most robust clinics are designed to support workforce health and productivity and reduce overall medical spending — without shifting undue cost to workers.

Employers that offer HSA-eligible plans and provide on-site care face unique challenges. Under rules for HSA-eligible plans, only preventive services can be provided at no cost; employees need to pay the full cost of a nonpreventive visit before they satisfy the plan deductible. As enrollment in HSA-eligible plans rises, these rules are an impediment to employers and employees who also want to offer or use worksite health clinics, where care is often at low or no cost. Clouding the picture further is an IRS notice released in February 2015 suggesting that a portion of the cost of care received through the clinic must be counted in the ACA's excise tax calculation.²

Establishing a new clinic, or expanding an existing occupational health clinic to provide general medical services, is one way employers can ensure that their employees — and, in some cases, employees' dependents — have timely access to quality care. In a survey of clinic sponsors by the National Association of Worksite Health Centers, nearly all respondents said that their onsite clinics met the objectives of increasing employee satisfaction and improving productivity.²

Figure 5. Growth in Offering of On-Site or Near-Site Medical Clinics for Primary Care Services



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2016

² Internal Revenue Service. "Guidance on the Application of Code 4980D to Certain Types of Health Coverage Reimbursement Arrangements," 2015, available at <https://www.irs.gov/pub/irs-drop/n-15-17.pdf>.

Case Study

Brokerage Contracted With Shared On-Site/Nearby Primary Care Services Facility to Address Healthcare Cost Trend

The issue: An insurance brokerage wanted to address its escalating and unsustainable healthcare cost trend. In examining its claims, the company found that many services being utilized by members were “steerable” to lower-cost alternatives; for example, to a convenient care clinic rather than an urgent care facility or emergency room. But with a growing shortage of primary care physicians in the US, accessing a primary care physician is not always easy, which was compounding the problem.

The solution: The employer contracted with an on-site/nearby primary care services facility (which provided the opportunity to share services with other employers whose population size did not justify having an on-site facility). The facilities were available 24/7 and members were given free

access to a broad scope of primary care services, including on-site pharmacy (generic dispensing) for employees and their dependents. The cost to the employer was a fixed fee per member per month (with an average of less than \$100 per member per month). The on-site/nearby primary care center did not balance bill to the insurance coverage.

The results: The programs have been well-received by employees – particularly the \$0 copay for 24/7 access to primary care for all family members. The employer has realized significant savings in actual healthcare spend (10%–30%) from the initial reduction in convenient care, urgent care and “steerable” emergency room services. Over a three- to four-year period, savings have been maintained year over year.



2

DRIVE TO QUALITY

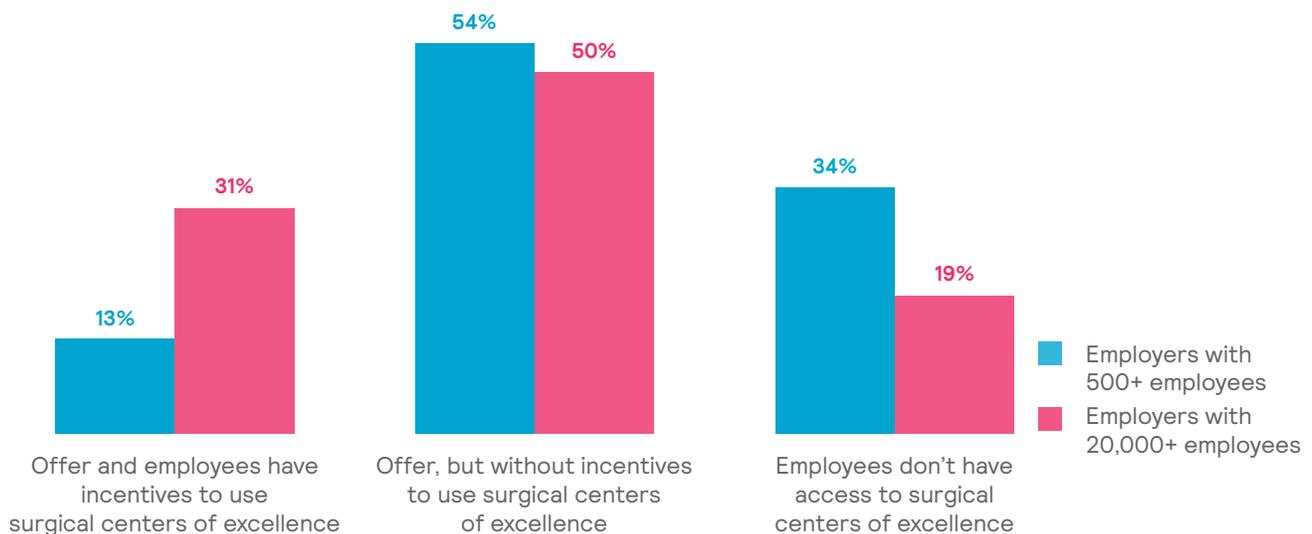
Improving the quality of care is the most desirable way to lower healthcare spending. That means the right care is delivered at the right time, in the right setting, error-free. Better outcomes eliminate waste and improve care.

Though most, if not all, health plans have incorporated quality improvement into their own programs as well as their contracts with healthcare providers, employers have an important role to play to ensure these strategies are delivering better care and outcomes and that health plans continue to experiment and evaluate their approaches and build on their successes.

CENTERS OF EXCELLENCE

One approach being embraced by some large employers is a “centers of excellence” strategy – and nearly a third of jumbo employers now provide employees with a financial incentive to use a surgical center of excellence.

Figure 6. Surgical Centers of Excellence: The Largest Employers Are Providing Incentives



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2016

Case Study

ARLP Established Direct Contracts to Improve Quality and Manage Cost

The issue: ARLP, a diversified coal producer and marketer, was facing increasing costs and was concerned about a lack of transparency and poor outcomes from healthcare providers. The company had implemented primary care interventions, but wasn't seeing continued cost reductions.

The solution: The first step in trying to manage cost trend was to understand the price of the various procedures in the claims data. The company began by moving to a third-party administrator that agreed to provide price-per-procedure codes, instead of averaging out claim costs for similar procedures. This allowed ARLP to drill down and identify major cost drivers. What it found was stunning: 4% of its members were driving 50% of its claim costs. This explained why primary care interventions hadn't helped to bring down costs — the top cost drivers were patients with intensive health issues being handled by multiple specialists and hospitals. The patients were often critically, chronically ill with low disease knowledge and limited therapy management and coping skills.

ARLP then sought partnerships with facilities that were willing to disclose prices before interventions and work with the plan and its population for better health outcomes. One such partnership was with a facility that had proven outcomes for knee replacement surgery. A more sensible solution, both from a financial and a patient-care perspective, was to pay for a member to travel 300 miles to get a knee replacement at an outpatient surgical center that performs the operation routinely for a contracted price, rather than send that patient to a nearby hospital.

The results: As it turns out, convenience can be costly. ARLP's direct contractors for full knee replacements charged less than \$27,000, whereas other facilities charged more than \$87,000. ARLP Direct Contract facilities have demonstrated better outcomes for the participant, better prices for the plan and lower rates of complications. With the implementation of this program, ARLP has seen negative cost trend growth.



Case Study

The Alliance Centers of Excellence/ High-Performance Networks Set Quality Criteria for Providers

The issue: The Alliance (a not-for-profit employer-owned cooperative), through its QualityPath™ program, combines centers of excellence/high-performance networks with benefit structures for steerage. A patient experience manager assists enrollees through the process.

The solution: QualityPath asks all stakeholders (providers, employers and enrollees) to do something differently so that all stakeholders benefit. Providers must meet quality criteria that apply not just to enrollees in the QualityPath program, but to their entire patient base. Employers implement plan designs that provide financial incentives for employees to use the program, and employees who choose QualityPath providers work with the patient experience managers who coordinate their care. The program includes prospective payment bundles for a variety of services, including joint replacements, coronary artery bypass grafting (CABG), CTs and MRIs. Colonoscopies will be added to the program in 2018.

The results: The feedback from employees has been positive – they have a richer benefit that is optional, not required. In addition, some employees scheduled for joint replacements with surgeons outside of the program ended up avoiding surgery by trying more conservative care or receiving a different diagnosis from the QualityPath surgeon.

The feedback from employers has also been positive. Joint replacement surgeries through the QualityPath program cost an average of \$12,000 less than the standard price (including the network discount). Imaging prices are 20% less than the average price (including the network discount).

EXPERT MEDICAL OPINION PROGRAMS

Expert Medical Opinion (EMO) programs enable individuals struggling with a medical decision to have their medical case reviewed by experts to confirm the diagnosis and treatment plan, or to offer an alternative diagnosis and/or treatment approach. This solution aims to prevent unnecessary procedures and therefore save on costs. Most importantly, it empowers the individual through easy access to experts, education and coordination with treating physicians, when appropriate.

Figure 7. The Most Important Objectives for Offering EMOs

Steer patients to high-quality providers	80%
Assist patients who have complex conditions	78%
Lower medical plan costs	74%
Expand access to care	53%

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2016 Supplement for employers with 5,000 or more employees.





Case Study

EMO Services Resulted in Better Outcomes and Lower Costs for Princeton University

The issue: When examining its claims, Princeton University found that physicians were referring patients to out-of-network, hospital-based facilities, which are often more expensive than independent facilities. It also found that patients would generally follow their physician's recommendation without researching other options or seeking other medical opinions, especially for major surgical procedures.

The solution: Princeton implemented an EMO program that provided a resource for employees to seek other options, whereas before they might not have known where to start to get a second opinion. To encourage participation, employees with treatment plans that involved surgery received \$400 if they obtained a second opinion through the program.

The results: Since program implementation, Princeton has found that two-thirds of members who get a second opinion get a new treatment recommendation, and 20%–30% end up with a new diagnosis. Also, the number of back, hip and knee surgeries has gone down for two years in a row. With these results, the incentive provided to employees is well worth it, with savings of \$500,000.

Other American Benefits Council members utilizing EMO services include a high-tech organization that has seen a 20% change in medical diagnosis and a 70% change in medical treatment plans over 2 1/2 years, resulting in a 2:1 direct medical cost ROI.

3

PERSONALIZE THE EXPERIENCE

Relevant, personalized and timely health information fuels action and enables shared accountability. As we see in so many internet-based businesses, data and technology can now help us reach individual employees with the information they need, in the way they want it, to make a bigger impact than ever before.

Health assessments, lifestyle coaching and disease management have become the mainstays of employee health and well-being programs. As the view of what constitutes employee health and well-being continues to expand, we are seeing employers adding a range of “point solutions” that address specific health issues, such as sleep disorders, or help employees better manage stress.

Figure 8. Percentage of Employers Offering Programs

	500+ Employees	20,000+ Employees
Disease management	80%	87%
Health assessments	79%	85%
Telephone or web-based health/lifestyle coaching	68%	83%
Health advocate services	54%	58%
Resiliency program/stress management programs	41%	50%
Face-to-face health/lifestyle coaching	35%	38%
Sleep-disorder diagnosis and treatments	33%	33%

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2016

BOEING OPENS NEW DOORS TO BEHAVIORAL HEALTHCARE

When your goal is a healthy and productive workforce, there is always more that can be done – and, at Boeing, innovation is often the byproduct of looking for the next barrier to overcome. In the critical areas of mental and emotional health and substance abuse, access to care can be a barrier – not just for Boeing’s population but for the country as a whole. Why? Behavioral health problems can be hard to recognize and diagnose, leading to delays in getting proper care – mental health professionals are in short supply, and stigma can prevent people from seeking help. Boeing has been actively partnering with its ACOs to integrate behavioral health into the primary care setting in order to address all three of these issues – with a new initiative in development with one ACO.

Boeing’s long-term strategy to improve access to treatment for behavioral health and substance abuse issues recognizes that many different doorways to care are needed. Several years ago, the company placed Employee Assistance Program counselors in onsite occupational health clinics that offer an array of services and are well-utilized; employees can see a counselor without concern that others will know the type of service they are receiving.

Another doorway can be a patient’s visit to a primary care physician (PCP) – but only if the PCP recognizes the problem and knows what

to do about it. Led by one of Boeing’s senior ACO partners, a simple, ingenious solution was pioneered for Boeing ACO members, giving all PCPs in the network the ability to consult directly – and in real time – with a psychiatrist’s office to discuss concerns or questions arising during a patient’s office visit. The program is based on clinical evidence indicating that the collaborative care model is twice as effective as standard care for people with depression and anxiety. Over two years, patient symptoms improved (and held steady), and they had a higher level of satisfaction with their care. This program has now been implemented in three other cities where Boeing offers an ACO. Importantly, the approach benefits not just Boeing employees and family members, but all patients of the PCPs participating in the ACO.

The newest ACO initiative will provide yet another door. Unlike the standard process for triage or intake today, the program is based on the premise that the first stop for a person with concerns about a behavioral health issue should be with the most qualified professional to ensure he or she gets the right guidance at the first contact. The program will provide ACO members with same-day telephone or video access to a psychiatrist or doctoral psychologist for free. Whether it’s a new concern, confusion or dissatisfaction with current treatment, or help coordinating care with other doctors, members will get expert support and follow-up. The pilot is targeted for a summer 2018 launch, with the expectation to roll out a refined model more broadly in 2019.



Case Study

Princeton University Health-Coaching Program Targeted Chronic Conditions

The issue: Princeton University data analysis revealed that chronic conditions had a major impact on both workforce health and program cost. Diabetes was the biggest cost driver, with claims averaging \$13,000 annually per member.

The solution: Princeton implemented a “My Health Coach” program with the help of a specialty coaching program vendor. To encourage participation, members with diabetes were offered the incentive of a medication copay waiver to engage in health coaching to manage their condition; in the following year, they were offered an additional one-time \$250 incentive.

The results: With the initial copay waiver incentive, Princeton saw participation in the My Health Coach program rise from 2.9% to 4.9% of the population with diabetes. The monetary incentive the following year doubled participation, and currently 11% of the diabetic population (based on claims data) is

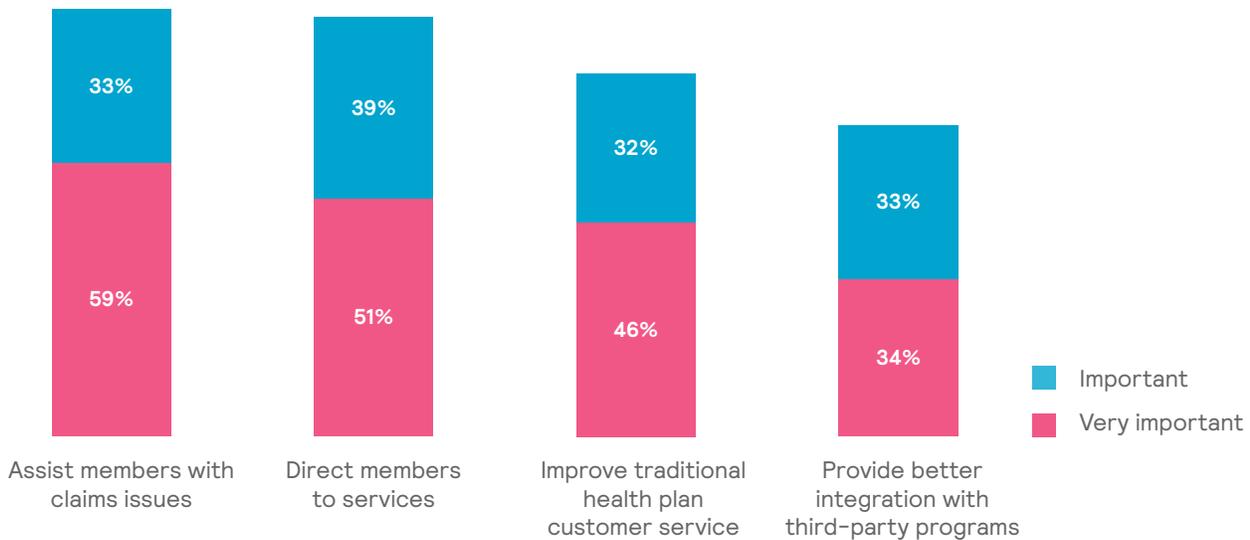
engaged in the program. Continued engagement is required to maintain the medication copay waiver and 76% of those who enrolled at any point are still engaged with their coach. Clinical outcomes for members in the coaching program are encouraging: 66% of the population reduced hemoglobin A1c levels, translating to a 60% reduction in cardiovascular risk. Of those participants with high hemoglobin A1c levels prior to the program, 43% reduced their values to a target level, and 10% to pre-diabetes levels.

One American Benefits Council member — a consortium of automotive, hospitality, entertainment, golf and adventure companies — has included on-site wellness coaches as part of its program. The company uses a general fitness coach with a physical fitness and nutritional background, and a registered nurse as a health coach on-site to address chronic illness.

HEALTH ADVOCACY

Health advocacy is a “high-touch” telephonic program with integrated customer service and clinical teams. Advocacy programs are emerging as one of the most important ways to personalize an employee’s experience with their health benefits. In 2016, 54% of large employers provided advocacy services.³ In the best programs, employees have a dedicated health advocate who can advise them, wherever they are on the health spectrum. For example, the advocate could help someone who wants to improve lifestyle habits to decide which of the many programs offered by the employer would be the best fit – whether a coaching program, a digital nutrition tracker, healthy coupon perks or even resources in the community. And if a serious health issue arises, the advocate is trained to help the member navigate the system to get to the right providers and even take on reconciling medical bills to ensure everything has been processed appropriately.

Figure 9. Employer Objectives for Implementing a Health Advocacy Program



Source: Mercer National Survey of Employer-Sponsored Health Plans – Supplement for Employers With 5,000 or More Employees, 2016

³ Mercer National Survey of Employer-Sponsored Health Plans, 2016 Supplement for employers with 5,000 or more employees.

Case Study

BorgWarner Motivated and Incentivized Employees to Good Health

The issue: BorgWarner — a producer of key technologies for combustion, hybrid and electric vehicles — sought to improve nutrition and weight management programs for its employees in order to minimize conditions that were leading to diabetes and cardiac issues.

The solution: To motivate its US workforce, BorgWarner created a holistic approach to health and wellness that united health assessments, rewards, clinical programs, coaching and workshops into an integrated benefits strategy. Each enrolled employee was given access to a health advocate to be the first and primary point of contact whenever the individual needed health and wellness support. The program also evolved into an outcome-based incentive design under which employees can earn points toward reducing their medical premium contribution.

The results: Risks associated with weight, although still problematic, have improved by 4% among BorgWarner's employees; cholesterol has improved by 6%. Overall, the strategy has lowered the percentage of high-risk members by 4% and improved the count of low-risk members by 7%.

The rate of engagement with the health advocates is 53%, saving the company \$3.8 million per year based on its annual matched-case peer comparison. BorgWarner has experienced a 3.7% year-over-year trend since 2007. When comparing per-member claims per year to its vendor's book of business, BorgWarner's members avoided 5% more in claims.

Case Study

Fortune 50 Retail Organization Targeted Diabetic and Pre-Diabetic Population to Maintain and Improve Health Status

The issue: Diabetes was identified by a Fortune 50 retail organization as a major cost driver in 2014, with spend per diabetic member increasing more than 20% between 2013 and 2015. The employer decided to target the problem both by assisting members who were currently living with diabetes and by helping to prevent other members from becoming diabetic.

The solution: The organization launched its diabetes management and prevention initiatives with pilot groups from the employee population. To address prevention, the company partnered with a digital behavior-change vendor and targeted members with metabolic syndrome. Within three months, roughly 3,000 employees applied to be accepted in the program. For diabetes management, the organization partnered with a specialty chronic-condition management vendor and initially targeted 7,000 employees in 2015. The program was designed for cross-integration between the two specialty vendors. The digital behavior-change vendor referred members who already had diabetes to the chronic-condition management program. Conversely, the chronic-condition management vendor offered education on the behavior-change program to members who might call in and are not diabetic, but may be pre-diabetic. Engagement was also supported and driven by navigators — trusted healthcare advisors who advocate for the member and don't work for either the employer or the insurance carrier — to direct members to the correct program.

The results: Though both specialty vendor programs were initially launched for subsets of the organization’s employee population, due to their success, they were later expanded to larger portions of the population in 2016 and 2017. The chronic-condition management program has had sustained engagement over the last two years of around 35% of the target population. The program has helped members comply with their prescriptions, and the percentage of diabetic members who are filling maintenance medications increased 4% in 2016 over 2015. Between 2013 and 2015, the organization saw its diabetes claims spend per claimant rise 20%, but from 2015 to 2016, this dropped to 5%. And obesity claims spend per claimant actually decreased 16% between 2015 and 2016.

Portico Benefit Services wanted to look at creative ways to contain costs or attempt to “bend the trend” while also increasing member engagement. Although its carrier was providing case management and utilization management services, the company saw a significant delay when outreach occurred many times due to waiting on claims to be processed. Portico moved to a navigator model combined with personalized programs that allow it to take a more hands-on approach. It also partnered with an outside vendor and utilized its care-coordinator model to help drive members to more cost-effective providers. Portico has seen high engagement levels with the program: 65% of sponsored members have been connected with care coordinators through Q2 2017, and members have expressed high levels of satisfaction with the program.



HEALTH AND WELL-BEING TECHNOLOGIES

Technology is playing an important role in the evolution of health and well-being programs, allowing employers to personalize the employee experience with novel, intuitive programs or apps. Two-thirds of employers use some form of technology-based resource to encourage employees to become more engaged in managing their health. There were sharp increases in the use of smartphone apps and gamification programs (37%, up from 30% in 2015) and wearable devices and apps to monitor activity (31%, up from 24%). Some employers provide devices to employees to transmit health measures, such as blood sugar level, to providers (5%).⁴

Figure 10. Technology-Based Resources

	Employers with 500+ employees	Employers with 20,000+ employees
Mobile apps	37%	52%
Wearables/apps to monitor activity	31%	43%
Devices to transmit health measures to providers	5%	16%
On-site kiosks	9%	15%
Other web-based resource/tools	42%	69%

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2016

Case Study

Activision Blizzard Supports Its Members in Having Healthier Pregnancies

The issue: Maternity and newborns are the top cost drivers of Activision Blizzard's (AB) medical costs (14% of total spend). The relatively young population of the interactive entertainment company (average member age is 27) falls right into prime childbearing years; approximately 150 babies are born to the self-insured population year over year. Historically, NICU babies or complicated pregnancies constitute nearly a third of high-cost claimants, and the company saw very little member engagement in its traditional maternity management program.

⁴ Mercer, 2016.

The solution: In 2014, AB took a closer look at the engagement levels of its medical carrier’s standard maternity management program. The program was attracting engagement from less than 10% of the moms, and no reported outcomes were available. It was time to repurpose the fixed-cost per employee per month for that program into a targeted maternity solution. The benefits team evaluated two digital app options and sought member feedback through a small pilot program. Through the use of a specialty vendor, a maternity benefits program launched live across the population in August 2015. In addition to an AB-customized vendor pregnancy app, the solution also included a fertility program through the specialty vendor that supported pregnancy via natural means. Both programs were integrated into AB’s wellbeing program and members were able to earn incentive points for engaging in different activities.

The results: Initial engagement results have exceeded what the carrier maternity management program achieved by a factor of four. The AB-customized specialty vendor maternity app has 105 registered members, of which 48 are categorized as high risk. These members average 38 sessions each and 42 data points provided (biometrics, symptoms, etc.) on a monthly basis. From AB’s data warehouse findings, highly engaged program members are the right members, meaning they are the ones with a higher percentage of complicated deliveries and highest risk scores. And the costs of this high-risk population are being contained.



4

EMBRACE DISRUPTION

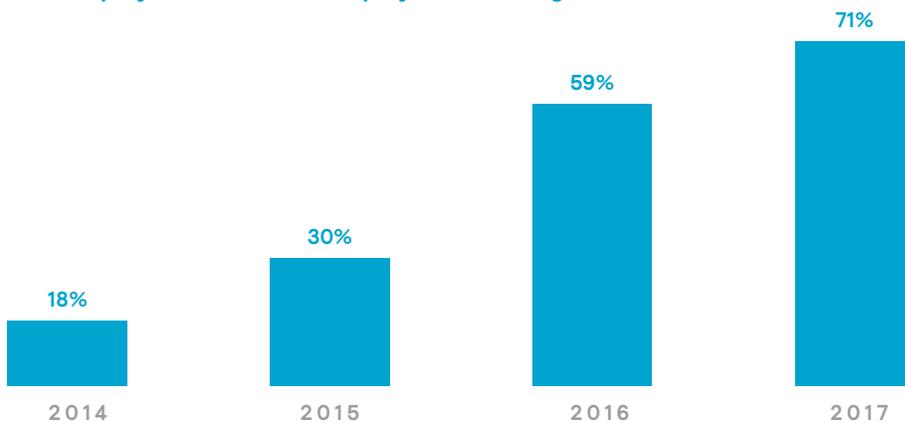
Rapid advances in technology, along with changing consumer preferences and higher expectations, have led to an explosion of new entrants to the healthcare system. Embracing disruption means leveraging constant changes in the system – with internal stakeholders and external partners – to the best advantage of your employees and your organization.

Embracing change can no longer be the province of a small subset of trendsetting organizations. The US healthcare market is in a state of flux – the changing roles of the market stakeholders and new entrants to the market are leading to increased complexity, new opportunities and both potential savings and potential new costs.

Potential carrier and pharmacy benefit manager (PBM) consolidations (such as CVS and Aetna) and the entry of nontraditional organizations (such as Amazon) could disrupt the pharmaceutical market as we know it. New technologies and the rapidly increasing adoption of telemedicine services by health plans are affecting how care is delivered. And while healthcare vendors are merging to gain efficiencies and leverage, so are some employers – witness the recent announcement that Amazon, JPMorgan Chase and Berkshire Hathaway will create an alliance dedicated to improving health benefits for their employees.

Though the direction of healthcare reform at the national level remains uncertain, employers clearly need to continue their efforts to keep cost growth at sustainable levels. And that will require bold – sometimes disruptive – action.

Figure 11. Employers With 500+ Employees Offering Telemedicine Services



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017

Case Study

Walgreens Established Care-Coordination Model Within Carrier Partners

The issue: Like many employers, Walgreens had used a range of strategies to address the cost of insurance. But for self-insured plan sponsors in particular, care delivery is central to cost, so Walgreens turned its attention to improving efficiency in care delivery both to bring down cost and provide better service to members.

The solution: Walgreens implemented a care coordination model that included incentives for both plan carriers and plan members. The company worked directly with its carriers to establish care coordinators, which replaced the typical carrier customer service as the “hub” of care direction. To ensure that these coordinators got involved when providers referred members for care, pre-authorization was required — initially for a defined set of services, but ultimately virtually all referrals would require authorization. Care coordinators were given access to select providers that met in-network and quality standards. The coordinators could see what the costs of using those providers would be. If a member was referred to certain provider to get an MRI at a cost of \$2,000, the coordinator could refer the member to another quality provider that charged only \$1,000. When members were directed to a more cost-effective provider, they could earn a cash incentive of up to \$250. To ensure that the carriers had a stake

in the success of the program, it was built on a shared-savings model — the carrier was to receive a percentage of savings relative to an agreed market trend. This way, both carriers and members stood to benefit when plan providers and patients considered cost at the time of referral.

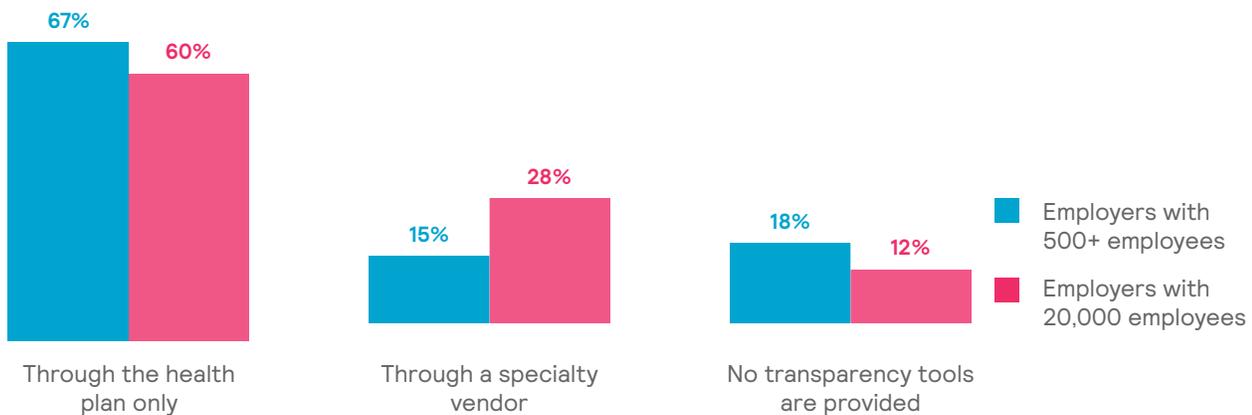
A unique aspect of this program was that it took the burden of price comparison away from the consumer and put it on the carrier, via the care coordinators. Even a savvy consumer is more likely to go with a doctor’s recommendation than to go online to comparison-shop, particularly for serious diagnoses or intense treatment programs. But the care coordinator model ensured that there would always be a provider evaluation and comparison process, regardless of whether the member opts to utilize available transparency tools.

The results: In its first year of operation, the care coordination program is expected to save up to 4% of total medical claims. Seventy percent of the total annual budget allocated for employee incentives for those choosing more cost-effective care has been given out through the first eight months, suggesting that employees are actively engaged in the program. The potential for savings will increase when the program extends pre-authorization to all medical services.

CONSUMERISM AND TRANSPARENCY TOOLS

Employers are increasingly offering tools to deliver price and quality information about specific healthcare providers or service to employees. Employees often access tools online, telephonically or via mobile applications.

Figure 12. Offer Transparency Tools



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017

Case Study

AT&T's Full Commitment to Making Consumerism Work

The issue: AT&T believes the consumer can best defend against the high cost of healthcare — but only if they have the proper tools and support. An early adopter of high-deductible, consumer-driven health plans, the company soon discovered by examining claims and plan selections in tandem that many employees were not choosing the plan that made the most sense for them, from both a cost and coverage perspective. Employees needed more help in navigating the healthcare system to find high-quality, cost-effective providers.

The solution: AT&T implemented an integrated benefits platform, “Your Health Matters,” to give employees access to decision-making tools and other health benefits resources in one place. The platform evolved since implementation to integrate a cost-comparison tool and a second-opinion program. All of AT&T’s health plans are HSA-eligible, and three levels are offered: Gold, Silver and Bronze. However, ongoing analyses showed that some employees remained over-insured. On the new platform, employees’ actual claims experience was imported into the decision-making tools to help employees pick the right plan, based on their past healthcare use. Employees also completed a questionnaire to establish their risk tolerance and the results produced a score for each plan, ranking them in order of “best match” for the employee and their healthcare needs. To encourage appropriate migration into lower-cost plans, AT&T matched employees’ HSA contributions for the Bronze plan, up to \$500 for individuals and \$1,000 for family coverage.

The results: Employees have more choice and more financial responsibility – and more support. The new decision-making support tool, along with the HSA matching contribution, resulted in a 30% increase in enrollment in the Bronze plan in the first year. In the upcoming plan year, when the match will be doubled for the Bronze plan and a new match added for the Silver plan, AT&T expects a similar increase in Bronze plan enrollment and a 20% increase in Silver plan enrollment. Though the program was initially designed to be cost-neutral, AT&T’s medical trend has dropped below the national trend.

Case Study

PepsiCo Increased Employee Engagement Through Point-Solution Platform

The issue: PepsiCo has long been committed to helping its employees maintain a healthy lifestyle. Though the company had implemented several programs aimed at improving employees’ health and well-being over the years and providing them with tools to navigate the complex healthcare system, engagement levels with these programs were not at the desired level.

The solution: PepsiCo partnered with an engagement platform aimed at increasing participation in PepsiCo’s programs with a highly personalized and targeted approach. This engagement vendor acted as a hub for all of PepsiCo’s health plan point solutions, consolidating access in one location. The vendor received data feeds from health plans and point-solution vendors and used the information to customize outreach to members. Based on claims data, it identified

appropriate programs for employees using an algorithm that calculated the probability that a member would need a specific type of care.

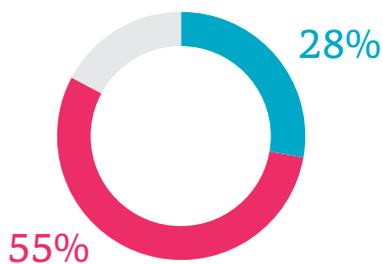
The approach to engagement was subtle: When a member logged into the portal, typically to find information about his or her health plan (for example, spend against the deductible), the page was customized to highlight the programs the employee was most likely to need. Did this “soft sell” approach work? The numbers say yes. One of the specific programs PepsiCo was looking to increase engagement in was the transparency tool. Prior to implementation, there were 18,000 total visits from January to June 2016; after implementation of the engagement vendor, total visits increased by 61% to 29,000 visits from January to June 2017.

The results: After the first six months of the program, around 32% of eligible employees and around 6% of eligible spouses were registered, and engagement in some programs increased: average telemedicine visits per month increased 25% and average monthly registrations for the telemedicine program increased 33% during the first six months of 2017, compared to the same period in 2016. The percentage of members completing a wellness questionnaire and a wellness screening increased 4% and 2%, respectively, during the first six months of 2017, compared to the same period in 2016.

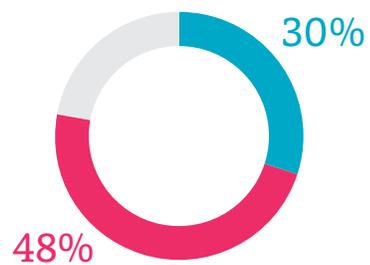
The engagement vendor was also used to target messaging to members who enrolled in a diabetes-management program but who had not activated their program-specific glucometer. Within three weeks of launching a targeted campaign, 38% of these members activated their device and began to utilize the program.

**Figure 13. Strategies for Advancing the Triple Aim Over the Next Five Years
(Based on Employers With 5,000+ Employees)**

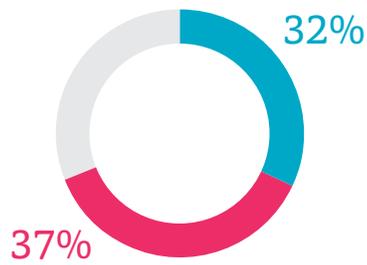
Focused action to manage cost for specialty pharmacy



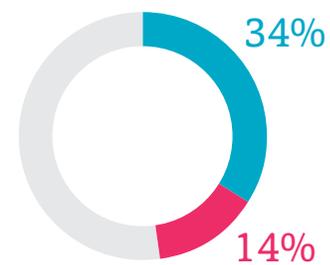
Monitoring/managing high-cost claimants



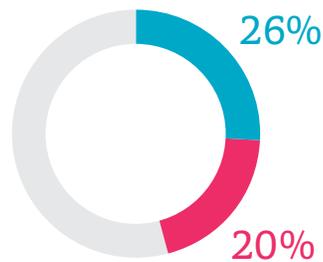
Focused strategy for creating a culture of health



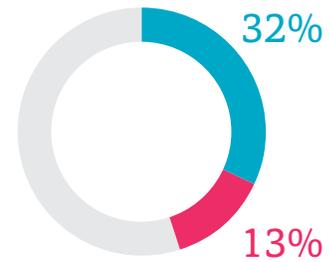
Point solutions: high tech/high-touch support for physical/mental/financial



ACO/other high-performance network strategies



Offering employees more plan/benefit options with decision-support tools



● Percentage of employers rating strategy "important"

● Percentage of employers rating strategy "very important"

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017

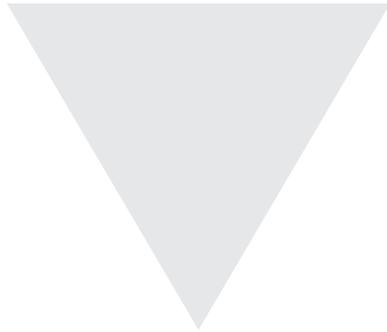
CONCLUSION

In Mercer's 2017 *National Survey of Employer-Sponsored Health Plans*, employers were asked to rate the importance of strategies they will be using over the next five years to advance the triple aim of lower cost, higher quality and a better member experience. The top two won't be a surprise to anyone responsible for managing a health program: taking action to manage high-cost claims and spending on specialty drugs. A number of the stories in this paper have described innovative approaches to these burning issues. It's interesting, too, that about half of these employers say that high-performance networks and alternative provider reimbursement models will be important strategies over the next five years — that kind of concerted effort from employer-purchasers has the potential to transform the way healthcare is delivered in the US.

The third item on the list — a focused strategy for creating a culture of health, which over two-thirds of employers rated as very important or important — is a good reminder of why employers are in the business of providing healthcare, and why it makes sense for them to be supported in this role. Employers have a vested interest in securing the health and well-being of their workers. They recognize that helping their employees thrive has a measurable impact on virtually every aspect of their business. That's why they invest in innovative strategies to provide their employees with effective and sustainable health benefit programs.



For further information, please contact your local
Mercer office or visit our website at:
www.mercer.com.



6001680-HB
Copyright 2018 Mercer LLC. All rights reserved.

