Reducing Corporate Health Care Costs

Refocusing the Strategy

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Employers Take the Reins of Health Care Cost Reduction

By Barbara Gniewek
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Employers currently spend more than $390 billion per year on employee health insurance, with annual health care cost increases significantly exceeding the overall rate of inflation. Conventional approaches to dealing with these annual increases – incremental cost shifting through plan design changes and increased employee contributions – have failed to stem the rise in costs. Lacking innovative solutions from other sources, employers are now concluding that they must take the reins of health care cost reduction.

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Employers Take the Reins of Health Care Cost Reduction
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Employers are the nation’s largest purchasers of health care (aside from the government) and the majority of insured Americans currently receive their health care through an employer-sponsored plan, so the employer segment is a crucial focus for health care reform. Employers face shareholder and market pressure to keep costs low to increase profit margins, yet they must also offer comprehensive, competitive medical benefits to attract and retain the most talented employees. This is why employers are becoming receptive to new programs and funding models that offer solid medical benefits and the potential to reduce costs.

Better Late Than Never

Despite years of worsening conditions, employers only recently have started to assume a lead position in the battle against rising health care costs. Their impetus for doing so comes from two major realizations:

1. Managed care has not been working – Managed care was originally intended to be a health care system that controlled the utilization of services, thus ensuring that patients received the appropriate level of care. Instead, it turned into a system that endorsed excessive price cutting and provider negotiations, cost-shifting and ineffective health care management. As a result, consumers as a whole became increasingly disconnected from the real cost of health care. Many also adopted a “use it or lose it” philosophy and became over-utilizers of health care services. Under managed care, employer-sponsored health plan expenditures rose dramatically between 1988 and 2004.

2. Productivity is tied to healthier lifestyles – Many employers have adopted the belief that encouraging employees’ involvement in their lifestyle choices and health care purchasing decisions will make them more rational consumers and healthier, more productive employees. After all, high levels of employee productivity are considered essential to maintaining a positive bottom line. Unfortunately, employers are experiencing declining productivity due, in part, to employee absenteeism and to a condition called “presenteeism.” According to the 2001 report, Presenteeism: A Clear View of a Growing Problem, by Clark Marcus, Amacore Group, Inc., “Presenteeism signifies that a number of employees, even those with perfect attendance records on the job, are nonetheless working with impairments and disabilities that cause them to perform less efficiently. This results in employers’ losing up to 32 times as much productivity from presenteeism as from absenteeism.”

Why Not Just Shift Costs?

Shifting health care costs – increasing employee deductibles, co-pays, premium contributions and other out-of-pocket costs – has been employers’ recent tactic-of-choice to mitigate annual health care cost increases. These short-term fixes, which are understandably unpopular with employees, have become unavoidable for many employers. Yet, cost-shifting tactics are no more than a temporary solution, as they fail to address the actual sources of rising health care costs: America’s aging population, unhealthy lifestyles, high-cost health care technology advances, and inefficient health care delivery and coverage systems. Health care cost shifting can reduce “demand,” but it will not impact or reduce “need.” In a similar vein, increasing employee deductibles also has an adverse impact on health care usage and costs.

“Cost-shifting tactics are no more than a temporary solution.”

In contrast to cost-shifting and deductibles, which produce financial barriers to care, consumer-driven health care (CDHC) is a cost-containment trend that encourages individuals to get the care they need. In response to a plea from employers to help contain or reduce health care costs and a push to drive consumerism in health care, consumer-directed health plans (CDHPs) are becoming a growing part of payors’ product portfolios. According to the Reducing Corporate Health Care Costs 2006 Survey of employers conducted by the Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions (the “Center”), a part of Deloitte & Touche USA LLP, 40 percent of respondents chose a CDHP as the most effective plan design for managing costs and maintaining quality care. With the right CDHP design, patient demand is reduced primarily for discretionary care events and need is reduced for many high-cost and risky inpatient procedures. Furthermore, there are no cost barriers because everyone has first-dollar coverage.
Employer Success Story: Blue Ridge Paper Products, Inc.

When Bonnie Blackley joined Blue Ridge Paper Products, Inc. (BRPPI) as Director of Corporate Benefits, the CEO challenged her with “doing anything [she wants] as long as [she] can save money.” This directive became Blackley’s opportunity to put new ideas for corporate health care cost reduction to the test, including wellness and diabetes management programs, a benefits task force, and a Population Health Management program.

BRPPI is one of the largest employers in Western North Carolina. Its 2,100 employees, who work 12-hour rotating shifts, are predominantly males over age 45, and have one or more health and/or lifestyle issues. Such an environment was ideal for Blackley to make a profound impact on health status and cost using wellness initiatives.

Wellness and Diabetes Management Programs

On-site wellness and diabetes management programs, instituted in 2001, were among BRPPI’s first initiatives. The programs were adapted from regional hospital and city programs and feature cash rewards for participating and meeting goals. These goals include getting physical and dental exams, attending “lunch and learns,” attaining normal blood pressure, cholesterol and weight levels, and exercising.

The BRPPI diabetes program provides free education classes at a regional hospital, free on-site monitoring, and around-the-clock paramedics trained in diabetes management. A pharmacist that comes to the plant’s medical department performs monthly drug consultations and A1c tests. In exchange for their participation, benefit plan members pay no co-payments for diabetic medications and supplies.

Benefits Task Force

Around the same time that the BRPPI wellness programs were being implemented, Blackley created a Benefits Task Force to redesign the company’s benefits program.

To encourage employee buy-in, she asked for union and non-union volunteers. The task force selected a new third-party administrator, decided on a renewal rating arrangement, installed local networks, and implemented four-tier pharmacy co-pays (with $0 “preferred generics”). The group also spearheaded an extensive employee education and communication program about health care costs.

According to Blackley, “The task force made all the right decisions – I simply provided them with education and information. Because employees were the ones driving our health care delivery, there was complete buy-in. The members even presented their recommendations to senior management with supporting information.”

The Benefits Task Force remains a key component of many BRPPI benefits decisions, such as tiered networks and disease management programs. Senior Management has consistently supported the task force by approving its ideas and recommendations – with positive results. Overall claims costs since 2003 have increased by just half of the national rate. In 2004, costs actually decreased.

Population Health Management Program

One of BRPPI’s most innovative programs is Population Health Management. Employees receive a $100 incentive if they take a health risk assessment. Depending on their score, the employees are then assigned a personal nurse coach, who acts as each member’s health manager. Based on the member’s readiness for change, the nurse coach assists the member with setting individualized health goals, using the following programs and incentives:

- Tobacco cessation
- Weight management
- Annual fitness center program
- Depression management
- Diabetes management
- Other: high blood cholesterol/blood pressure, acid-reflux disease (GERD), chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma and allergies.

The Future of Health Care at BRPPI

BRPPI’s future health care plans include measuring and addressing employee absenteeism and presenteeism costs, health care quality issues, obesity and pain management. Blackley says that the company is very interested in learning more about best practices in the global health care market, where some countries are delivering first class health care for 70-80 percent less than the fees typically charged in the U.S. system.
Employers view the cost of health care coverage as the primary factor driving their health benefits strategy. To control excessive benefits consumption and curb costs, many employers are encouraging employees to adopt a more active and rational approach to managing their health.

Attempts to influence employees’ lifestyle choices and health care purchasing decisions include offering consumer-directed health plans (CDHPs), many of which include high-deductible Health Savings Accounts (HSAs) and other consumer-directed offerings (which can reduce short-term costs), and implementing care management programs (which can lower long-term costs).

According to the Reducing Corporate Health Care Costs 2006 Survey conducted by the Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions, 24 percent of responding large employers offer some sort of consumer-directed health plan (CDHP), and many more believe that CDHPs offer the most effective approach for managing costs and maintaining quality care. This is no surprise given the experience of those respondents who have implemented them. In 2006, cost increases for CDHPs will average only 2.6 percent, compared to about 8 percent for other plan designs. Close to 70 percent of the survey participants are considering a CDHP as an option or replacement for traditional health plans in the next five years.

To complement and enhance their CDHP plans, employers are beginning to provide more care management programs so that their employees maintain healthy outcomes for chronic conditions. Seventy-four percent of the survey respondents offer a disease management program, either through their health plan or through a specialty vendor. Diabetes and asthma maintenance programs are most popular; however, newer programs for lower-back pain and depression are emerging. Corporate wellness programs are also popular – 93 percent of survey respondents indicate that they offer some sort of wellness program. The most popular programs include flu shots, smoking cessation, fitness and nutrition.

Care management programs (whether for wellness or disease management) are positive signs that employers are beginning to understand the benefits of investing in innovative and effective ways to control costs and improve health conditions. The key challenge of care management, however, is to measure, manage, and realize results. More than half of the respondents (53 percent) with care management programs are anticipating positive savings with the next five years. However, 71 percent of those respondents do not measure any annual savings to demonstrate that their expected outcomes are being realized. This is not surprising; measurement of consolidated clinical and financial information can be challenging, and tracking and using data from many different components or sources can be complex.

With a talent shortage looming, transformational health care programs can be a key ingredient for focused workforce retention. Yet, obstacles remain. Sixty-two percent of the survey respondents believe that their biggest hurdle to adopting change in their current health care purchasing model is employee resistance and/or entitlement to coverage. An effective transformation, therefore, will be one that leverages leading practices in integration of the various elements of benefits and compensation with organization and HR strategy to support an organization-wide change initiative.
Employee Success Story: Pitney Bowes

Pitney Bowes has a straightforward health care philosophy, which it calls “Creating the Culture of Health.” The company believes that it will only be as effective as its employees. Unless these employees are healthy and able to come to work, Pitney Bowes cannot achieve business success.

Pitney Bowes positions itself as a health care partner to its employees. It gives them comprehensive information and shares the best health care resources available, based on the belief that employees can make appropriate health care decisions by themselves and that preserving employees’ health will decrease costs. This philosophy has proven to be extremely successful for the company, which has realized millions of dollars in savings from plan design changes, on-site health clinics and wellness programs. For example, Pitney Bowes’ move to high-deductible, consumer-directed health plans generated concerns that plan members were using preventive options and exams less frequently than in the past. To counteract this, company executives decided to give employees free preventive medicines, and found that health care costs subsequently went down.

Pharmacy Plans

Pitney Bowes has adopted an innovative approach to its pharmacy plan design: “We don’t care whether you’re taking a generic or a brand name, we just want you to take the medication.” The company has eliminated the standard “managed care” tools for cost control (e.g., mandatory generics, mandatory mail order, step therapy and therapeutic substitution) but maintains the co-insurance levels so that employees see the “real cost” of medications. Under this approach, Pitney Bowes found that the utilization of many maintenance drugs went up and employees increased compliance. Interestingly, the company discovered that the migration between brands also increased – suggesting that cost exposure provided employees with the incentive to make efficient choices.

On-site Clinics

Pitney Bowes operates seven on-site health clinics, with plans for an eighth location by the end of 2006. These clinics provide free, low-level primary care to employees and have saved the company $1.3 million in health care costs since their inception. Offerings include physical therapy, sports medicine, allergy treatments and OB/GYN services. Use by employees is steadily increasing, with more than 34,000 patient encounters in the past year.

Cost Savings and Future Plans

The health care industry tends to view costs as being carved into segments – with employers managing the cost of each segment. Pitney Bowes, in contrast, looks at its health care costs and their management as a whole. Sometimes this means over-investing in one of its tools or programs because it results in better outcomes. Pitney Bowes’ pharmacy program, for example, may not be the most cost-advantageous of potential management options but the company feels that it produces the best results in chronic disease management.

Pitney Bowes’ future health care cost management plans include better integration of the on-site clinics with employees’ primary care providers and other levels of care. Currently, data is warehoused for all clinic encounters. If employees need this data for their primary care doctors, it can be faxed or delivered. The company is investigating a new system that will bring it much closer to integrating this information with other levels of care.
Reducing Corporate Health Care Costs

Consumer-driven Health Care: What If Employers Could Have It All?

By Shane A. Heiser and Rita Zabat
Deloitte Consulting LLP

With the return of climbing health care costs and waning confidence in managed care’s ability to be effective, consumer-driven health care (CDHC) has emerged as a new – and increasingly popular – approach to modernizing employer-based health plans.

According to the Reducing Corporate Health Care Costs 2006 Survey conducted by the Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions “(the “Center”), a part of Deloitte & Touche USA LLP, close to 70 percent of responding large employers are considering a Consumer-directed Health Plan (CDHP) as an option or replacement for traditional health plans in the next five years.

Consumer-driven health care is about changing behavior, not simply shifting costs. While managed care was designed to do just that – manage patient care – it has been watered down (mostly due to public demand) to concentrate on increasing efficiency on the supply side of the health care equation; dealing with provider contracting, unit costs and minimal volume controls. Consumerism, in contrast, addresses health care demand by giving people the necessary information and tools to be good consumers of health care. Behavior change is at the core of CDHC – encouraging individuals to move from passive patients to engaged health care consumers. The concept can be illustrated as a chain reaction: Change Behavior → Reduce Demand → Decrease Utilization → Lower Cost → Improve Health.

Adoption rates for consumer-driven health plans are on the rise, yet many employers remain skeptical about their ability to meet employee needs and control costs. There are several reasons for this skepticism, including limited performance data, a propensity to maintain the status quo, employees’ entitlement mentality, and fear of change.

Another key roadblock to wholesale acceptance of CDHPs is the belief by many employers that their workforce will not understand or effectively leverage the elements of a consumer-driven environment. This might be a legitimate concern; however, 20 years ago, many employers did not think employees would understand managed care.

Plan design alone will not promote measurable change. Without implementing a defined strategy that includes education, communication and change management, and incorporating an integrated, reward-based health improvement program, employer-based, consumer-driven care is only moderately effective. Fortunately, with the right approach, employers can have it all: They can use CDHC to significantly control and reduce costs while measurably improving the health and productivity of their workforce. Potential benefits for employers include:

- Cost savings from year one
- Cost avoidance (lower cost increases in future years)
- Simplified plan administration
- Satisfied and engaged workforce
- Increased retention
- Increased productivity.

Potential benefits for employees include:

- First-dollar coverage for preventive and wellness programs, and sometimes chronic care programs
- Choice of providers
- Opportunity to save for retiree-status health expenses (with HSAs)
- Access to tools and resources to make informed health care decisions
- Improved health – the ultimate goal.

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Employers need to view information. Successful CDHC programs focus on:

- Changing behavior: Shifting health care costs to employees provides only limited long-term relief. Ultimately, any change initiative must address responsible employee health care utilization.
- Engaging and empowering employees: Consumer-driven health care is not about insulating employees from the true cost of health care. It is about engaging and empowering employees to make informed health care purchase decisions.
- Instilling accountability: Employers hoping to encourage the adoption of consumer-driven health plans by enabling employees to become efficient and accountable health care consumers must themselves become accountable for success by limiting existing cost-shifting practices. Also, employers should drive provider accountability through price transparency or quality-based purchasing programs (pay-for-performance).
- Reducing Need: Traditional cost-saving strategies that typically employ cost shifting (through plan design or contributions), have focused on managing the supply side of health care through provider reimbursement levels. This approach fails to impact many of the basic sources of health care inflation and will not impact or reduce utilization. CDHC, on the other hand, encourages employees to take advantage of wellness programs and other plan offerings to address current health issues/conditions and reduce future need.
- Rewarding efficiency: Providers who offer high-quality, low-cost services should be rewarded. An example of this is a tiered payment system. These networks can recognize efficiency indirectly, using quality measures as in many value-based purchasing programs, or directly, based on cost-effectiveness, as has been implemented for the State of Minnesota.
- Integrating care management: Employers need to view care management not as a voluntary plan add-on but as an incentive-based program to protect those with chronic conditions. Also, employees who complete health risk assessments should be encouraged to share results with their physicians when discussing any health issues or lifestyle changes.
- Creating incentives: People sometimes need incentives to do the “right thing.” Rewards can include a cash bonus to take a health risk assessment or reduced premiums for completing a smoking cessation program. However, CDHC plan success does not have to rely solely on rewards. A plan design that encourages wellness and care management and that includes account-based reimbursement can elicit the right behaviors.

How to Spot a Successful CDHC Program

Leading a company through a strategic transformation to consumer-driven health care can be challenging. It requires that an employer assemble an artful combination of success drivers: the “right” plan design (one that offers effective financial incentives), the “right” vendors (ones that offer consumer-focused tools and information), and targeted employee education and financial information. Successful CDHC programs focus on:

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Building Blocks for a CDHC Program

While CDHC programs vary by organization, successful initiatives typically share these key elements:

1. A Formal Change Management Plan – Transforming a company’s health care program into one that embraces consumerism requires an organization-wide change initiative. This formal plan should include developing a new health care strategy and implementing robust internal communications and employee training to support the transformation. Textron, for example, implemented a full-replacement CDHC program five years ago. According to Human Resources Director George Metzger, the organization focused on communications to ensure program success. The campaign strategy included the clear message that Textron is a “co-financier” of an employee’s health care plan and that achieving success is a joint responsibility. When asked what advice Textron has for companies considering a CDHC program, Metzger responded:
   - Think through your CDHC strategy so that you can articulate it crisply.
   - Live your message. Make sure that all program components support your overall message.
   - Communicate consistently and clearly. Your message needs to come through on all channels. “You won’t find a Textron employee who will talk to you about health care without also talking about quality care, healthy outcomes and evidence-based medicine. That’s how clear our message is,” Metzger explained.

2. Account-Based Plan Design – The most effective way to change behavior is to make workforce members accountable for their health care utilization by leveraging an account-based plan design. While there are many vendor health plan options that flaunt the term “consumer-driven,” adopting one that features an account-based plan design is essential. This can be accomplished through either a Health Reimbursement Account (HRA), a Health Savings Account (HSA), or – in some situations – a combination of the two.

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Employer Success Story: Fannie Mae

Fannie Mae has been recognized by the C. Everett Koop Awards for its Partnership for Healthy Living Program, which has saved Fannie Mae $1.5 million in medical costs and $1 million in employee absences from 1994 to 2000, through innovative tactics such as offering health assessments and incentives to encourage employee participation in the program.

The goals of this innovative program include helping employees improve their health and reduce risk factors through early detection and disease prevention; encouraging healthier lifestyles through behavior modifications and interventions; and heightening health awareness through education. Here’s how it works:

Fannie Mae employees are encouraged to participate in a health assessment that includes a complete set of bloodwork, a lipid profile and thyroid study, as well as an osteoporosis screening and body fat analysis. Additionally, employees are asked to complete an online health assessment. Results from the online assessment and lab tests are combined to create a living health profile document that employees can share with their physicians and modify as risk factors change.

The health assessment helps to identify high-risk employees, who are subsequently referred to an intervention program called “Partnership for Healthy Living.” The program invites these employees to work with a nurse for 12 weeks to try and change their behaviors in order to make significant changes to their health. Incentives are used to encourage employee participation in the program. For example, all employees who complete an online assessment and participate in all of the testing are given a Healthy Living Day Off. To date, 50 to 70 percent of Fannie Mae employees have chosen to participate in the health assessment. The organization also uses an innovative method to measure cost savings and overall program success. Each employee health profile is assigned a “health age,” which indicates the individual’s health status. For the time period in which the program is in place, the change in average “health age” is measured along with medical claims data. Decreases in health age correlate to decreasing claims numbers.

Currently, Fannie Mae’s program is run by Health One, a third-party vendor that houses the health data, and then assigns nurses for high-risk members. Opportunities exist for Fannie Mae to leverage that data for other disease management programs and employee outreach efforts.

Consumer-driven Health Care: What If Employers Could Have It All?

3. Best Practice Care Management Programs – One of the most critical component of a CDHC program, integrated care management can help employees prevent certain health care conditions, improve their overall health status and manage existing chronic and acute conditions.

Care management refers to a spectrum of programs designed to improve employee health and productivity, enhance clinical quality, and optimize the efficiency of health care delivery (Figure 1). It encompasses all aspects of health care and all ages of employees, from a healthy 22-year-old to a 62-year-old with multiple chronic conditions. Care management programs may include:

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<th>Figure. 1: Best Practice Care Management Program Components</th>
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<td><strong>Health Promotion</strong></td>
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Although some traditional health plans utilize various aspects of care management, they often are not targeted/coordinated and thus fail to materially impact the 20 percent of members who typically comprise 80 percent of costs. This creates gaps and missed opportunities to identify and manage a number of chronic conditions. In contrast, companies that utilize an integrated, best-practices approach to care management can help to significantly improve employee health status and control costs for certain conditions.

To strengthen their overall CDHC program, employers should think about ways to make their current care management offerings more effective and meaningful for employees. According to Textron, “word of mouth” and “community” are very powerful tools to accomplish this. Fostering and promoting “affinity” groups (e.g., diabetics, asthmatics) will allow for support networks and self-made references. Textron has actively encouraged these types of programs, by, for example, inviting an oncologist to speak in a chat room where participants remain anonymous.
4. **Reward-Based Incentives** – A well-structured, reward-based incentive program aligns and integrates each of the care management elements (prevention, health promotion, condition management) with account-based plan design and helps transition employees to CDHPs. Without proper education/communication, a CDHP’s high deductibles can look like cost-shifting. However, with a reward-based incentive program, companies can neutralize this perception and help employees feel good about the benefits provided through their employer. Note that it is imperative that the rewards should encourage a change in employee behavior that leads to improved health. Typical incentives include:
- Cash for completing health risk appraisals or participating in certain wellness initiatives, such as weight loss or smoking cessation
- HRA contributions
- Points toward cash
- Gifts/prizes.

More progressive incentives may include:
- Paid-time off
- Dental/vision benefits
- Supplemental HRA contributions (for specific condition management initiatives).

**Example A:** Flexible Rewards Program – Employees earn points for certain actions, such as completing a health risk appraisal (20 points), getting a wellness exam (20 points), attaining fitness levels (20 points), achieving health status improvements (20 points), registering on the health plan web site (10 points), completing health awareness training (10 points), or meeting with a nutritionist (10 points). Employees then claim rewards after reaching certain point totals, such as additional PTO days (1-5 days), HRA/HSA contributions ($100 - $500), post-retirement HRA contribution, limited-purpose dental/vision HRA/FSA contribution ($100 - $500), subsidized dental/vision plan ($100 - $500), and cash rewards (lower than tax-advantaged rewards).

**Example B:** HRA Funding Requirements – Employees are required to complete certain actions, such as completing a health risk appraisal and having a preventive care exam, for the employer to make any contributions to their HRA or HSA.

5. **Best-in-class Vendor Selection and Focused Vendor Management** – There are many vendors that administer CDHPs. While all claim to have a consumer-focused platform with robust tools and resources to engage their members in health care management, not all vendor tool sets are created equal. Health care transformation requires much more than a plan design and a web site. There are many elements that must work together to transform passive patients into engaged consumers. For those program elements that do not meet desired standards, best-in-class specialty vendors may be integrated with the health plan administrator.

Focused vendor management, both during implementation and on an ongoing basis, is critical for many CDHP elements and components. Initiatives to assess and manage vendor operations and performance can make the difference between an effective and a flawed health care transformation initiative.

6. **Data Integration Across Program Elements** – Leveraging data across all program components is critical to identifying and managing health risks. However, tracking, integrating and using data from each CDHP component can sometimes be difficult, but shouldn’t be a barrier to implementation. Numerous specialty vendors have data integration tools for employers that can make this task easier.

7. **Defined Measures for Success and Program Improvement** – The concepts and theories behind health care transformation may sound promising to an employer but lacking specific success measures, a CDHC program’s effectiveness will never be known. Companies should establish measures for:
- Consumer engagement
- Utilization impact
- Employer cost control
- Health status improvement
- Workforce financial impact
- Workforce productivity
- Employee/member satisfaction.

Once success measures are defined, the employer must monitor and tweak the program as needed to make sure the objectives set out on the CDHP strategy are being met. This is an important, ongoing process that can encourage long-term employee support for a company’s CDHP.

Employers’ demands to control health care costs and improve the quality of care have been the driving forces behind CDHC. Health care benefits’ migration into managed care over the last twenty years has resulted in employees being insulated from both health care decisions and health care costs. In fact, health care has become one of the few things for which people don’t necessarily shop for value before they make purchases. CDHPs have the necessary ingredients to combat rising health care costs, while improving the overall quality of employee health care. Giving employees the tools they need to make consumer-style decisions about selecting the right health care, at the right time, in the right setting – and giving them the financial incentive to make those decisions – will improve both an individual’s quality of health and their satisfaction with their health benefits.

CDHPs are not just an employer-based phenomena. Consumerism is poised to be much more far-reaching, attracting individual members from the private sector with HSAs and federal initiatives such as value-based purchasing in Medicare. Consumerism is a trend that will reshape our health care system for the foreseeable future.
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