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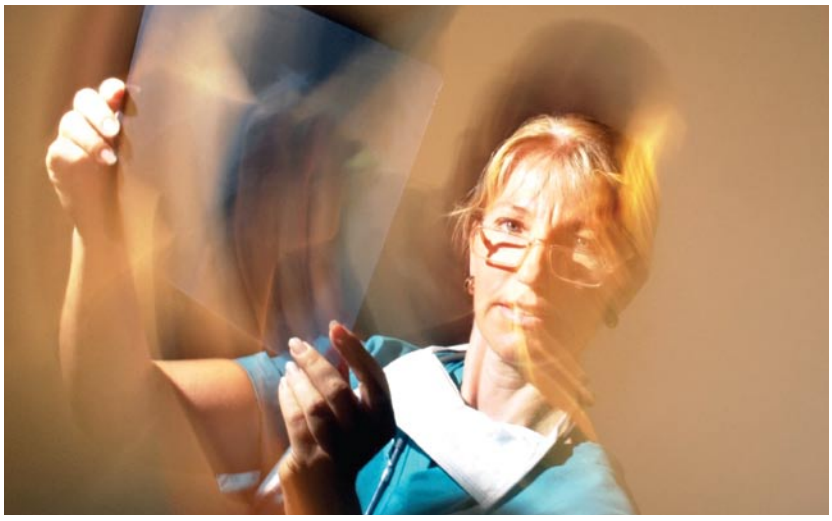


The One Percent Strategy: **Lessons Learned** From Best Performers

2008

13th Annual National Business Group on Health/Watson Wyatt Employer Survey on Purchasing Value in Health Care

Watson Wyatt Worldwide

National Business Group on Health

2008

13th Annual National Business Group on Health/Watson Wyatt Employer Survey on Purchasing Value in Health Care

Table of Contents

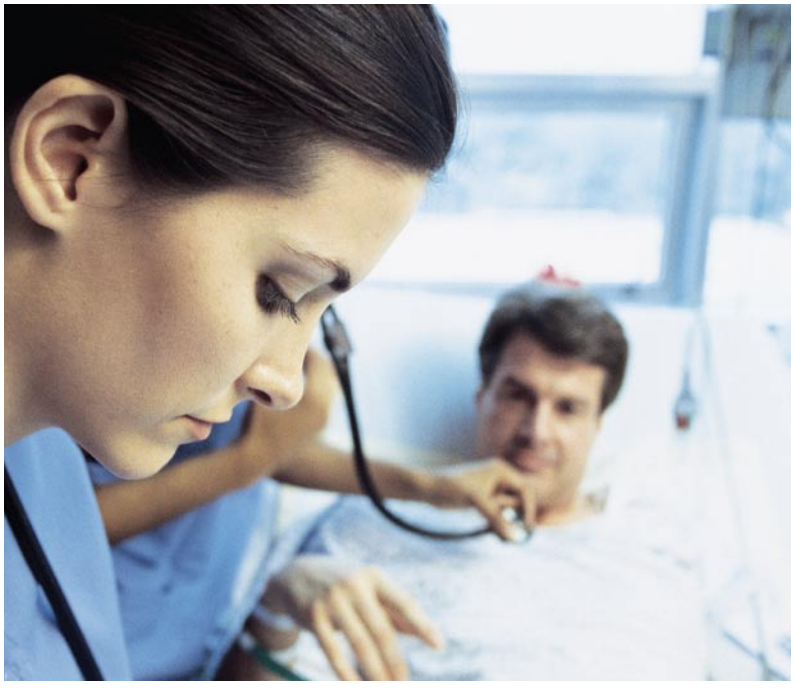
Featured Figures

Executive Summary

Despite a two percentage-point drop from 2006 to 2007, health care costs are increasing at twice the rate of inflation. Thus, more employers are turning to **consumer-oriented health care models** to help them control costs and improve employee health and productivity. These companies **are getting results** by combining consumer-directed health plans (CDHPs) with a broad range of programs designed to more actively **engage employees** and provide them with the services, tools and information needed to make more **informed health care decisions.**

The 13th Annual National Business Group on Health/Watson Wyatt study details current trends and best practices in employer-sponsored health care benefit programs. Key findings include:

- Best-performing companies have a two-year median cost increase of 1 percent, compared with 10 percent for their poor-performing peers. The median two-year increase for all employers is 6.2 percent.



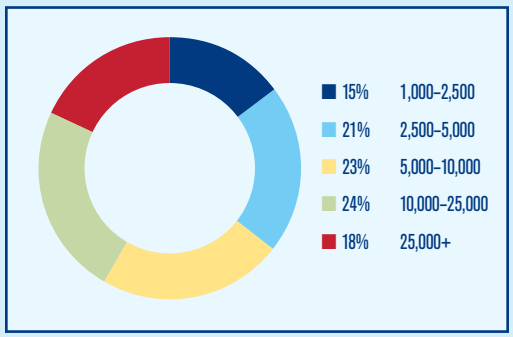
- Companies with a CDHP report a two-year average cost trend that is significantly below that of companies without a CDHP (5.5 percent vs. 7.0 percent). Enrollment rates in CDHPs are also strongly linked to lower health care cost trends. Companies with at least 50 percent of their population enrolled in a CDHP have a two-year trend about half that of non-CDHP sponsors.
- Both CDHP adoption and enrollment rates are increasing. Forty-seven percent of companies now have a CDHP in place – an increase of more than 20 percent compared with 2007. Forty-two percent of these companies have at least 20 percent of their employees enrolled in a CDHP, up from 27 percent of surveyed companies in 2006.
- Best performers and those with consumer-oriented health care models are achieving significant cost savings by implementing programs that use financial incentives; focus on provider quality, data, health and productivity; and provide employees with information to make smarter health care decisions.

About the Survey

The 13th Annual National Business Group on Health/Watson Wyatt *Employer Survey on Purchasing Value in Health Care* tracks employers' opinions and practices and the results of their efforts to provide and manage health benefits for their workforce.

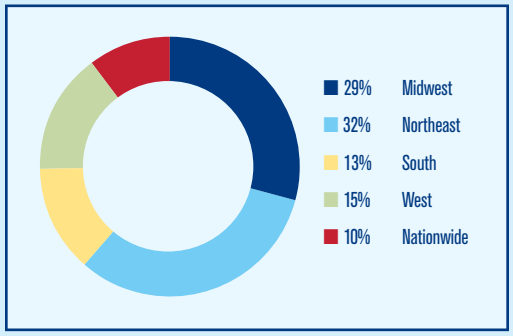
This report identifies the actions of best performers as well as current trends in the health care benefit programs of U.S. employers. The participants include 453 employers that collectively employ 8.4 million employees (**Figure 1**). The responding organizations provide benefits to workers across the country (**Figure 2**) and operate in a variety of major industry sectors (**Figure 3**). Respondents spend on average $7,211 per employee per year (PEPY) on health care costs, which equates to more than $60 billion in total health care expenditures. Their responses, completed between November 2007 and January 2008, reflect their 2007 and 2008 health plan decisions and, in some cases, 2009 strategies.

Figure 1 | Full-Time Employees



Note: Percentages do not add up to 100 percent due to rounding.

Figure 2 | Region Where the Majority of Benefit-Eligible Workforce Is Located



Note: Percentages do not add up to 100 percent due to rounding.

Figure 3 | Industry Groups

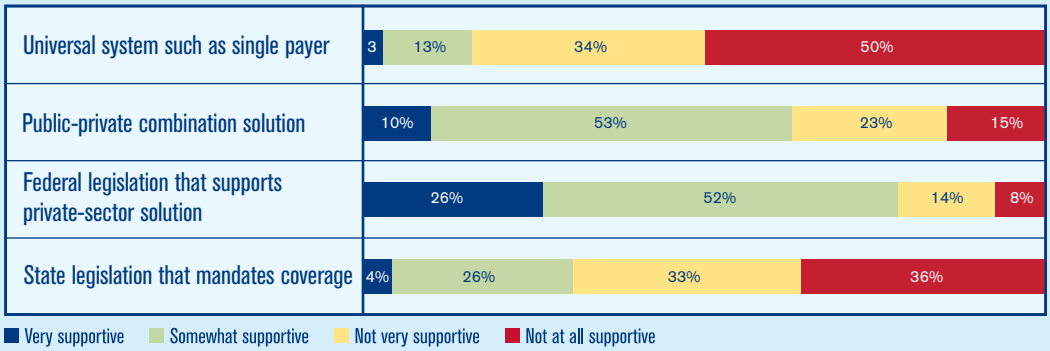
Sector	Percentage of Companies	Median Two-Year Trend (%)	Median PEPY for 2007
Basic materials	1.8%	4.5	$8,650
Finance, insurance and real estate	14.2%	7.0	$6,701
General services	8.6%	5.0	$6,572
Government	4.0%	9.0	$7,982
Health care	12.6%	8.0	$8,000
Information technology and telecommunications	12.0%	6.0	$7,619
Manufacturing	27.7%	5.1	$7,435
Media and entertainment	2.0%	5.5	$7,137
Utilities	4.2%	7.0	$7,975
Wholesale and retail	13.1%	5.7	$5,902
All	**100%**	**6.2**	**$7,211**

Note: Percentages do not add up to 100.0 percent due to rounding.

Health Care Reform

With the U.S. health care system front and center in the 2008 presidential election, considerable attention will be given to whether the United States should follow other advanced economies and adopt a single-payer system (**Figure 4**). However, more than eight in 10 large employers are "not very supportive" or "not at all supportive" of a single-payer system. More than two-thirds of respondents are also not supportive of state legislation that mandates coverage for all state residents. Instead, 78 percent support private-sector solutions such as tax credits, health savings account (HSA) improvements and market reforms. To a lesser extent, respondents also favor some combination of government programs, employer coverage and contributions, and individual requirements.

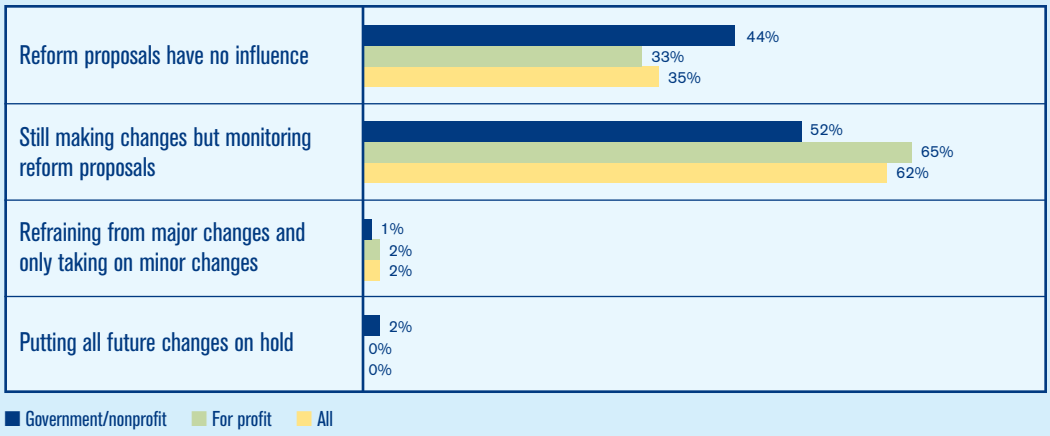
Figure 4 | Companies Strongly Support Private-Sector Solutions Over Single-Payer System



Note: Percentages do not add up to 100 percent due to rounding.

Uncertainty about the U.S. health care system is having little to no impact on companies' decisions to make program changes (**Figure 5**). These results are universal, regardless of the organization type, number of employees or recent health care trend experience. However, most companies are paying close attention to the debates and monitoring the various reform proposals made by the candidates.

Figure 5 | Reform Proposals Are Not Having an Impact on Companies' Decisions to Make Plan Changes



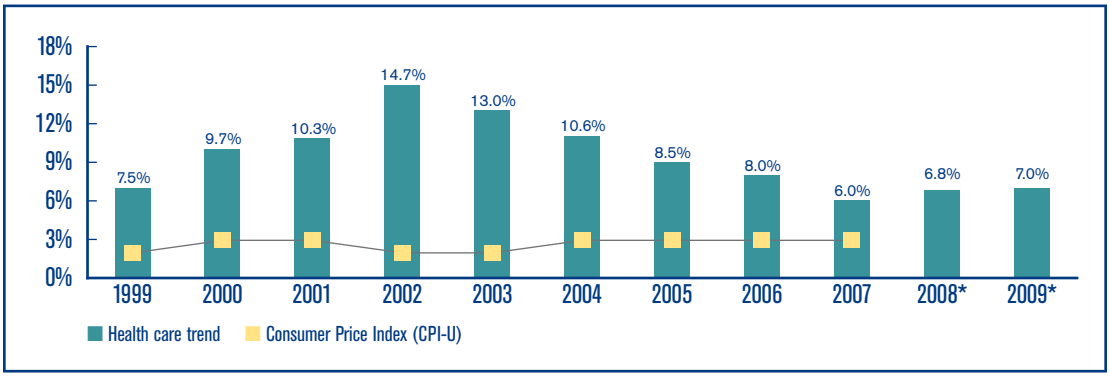
Trends

Annual median cost increases for health care dropped by two percentage points – from 8 percent in 2006 to 6 percent in 2007 – yet are still twice the rate of inflation (Figure 6). While health care trends dropped from 2006 to 2007, they are expected to be modestly higher in 2008 and 2009. However, average trends would have been 9 percent in 2007 without changes to plan design and/or employee contributions. With no further changes in 2008 and 2009, median cost trends are anticipated to be 9 percent and 8 percent, respectively.

As the rate of health care cost increases has slowed, organizations are gaining confidence in their ability to offer health care benefits in 10 years (Figure 7). The slowdown in trends has also helped companies more accurately budget for their health care costs as 85 percent of employers were at or below budget in 2007.

In 2007, the average health care spend per employee was $7,211 and is anticipated to increase to roughly $7,620 in 2008. Companies with workforces in the Northeast face the highest PEPY costs at $8,144 followed by $7,778 in the West (Figure 8). Organizations with nationwide workforces report the lowest per employee annual costs at $6,962.

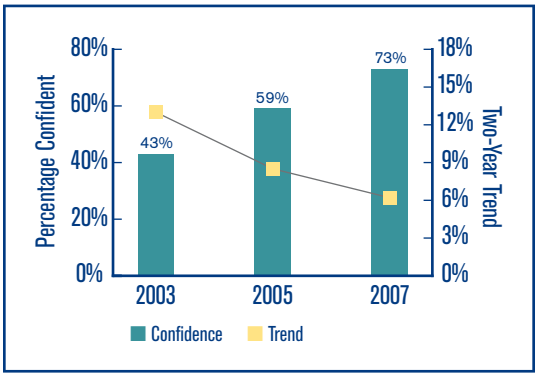
Figure 6 | Health Care Cost Increases Decline[1]



* Estimated

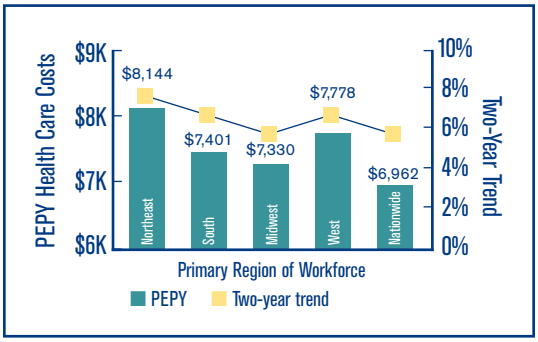
Note: Based on median trend.

Figure 7 | Confidence Is High That Employers Will Offer Health Care Benefits a Decade From Now



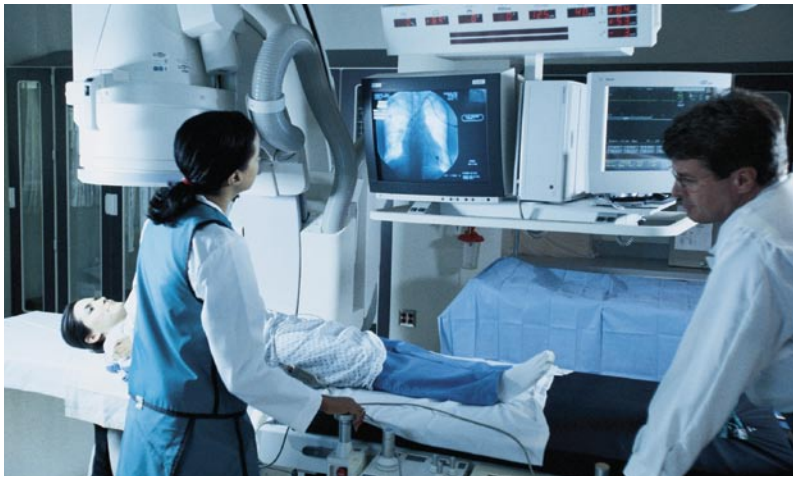
Note: Confidence represents those responding "very confident."

Figure 8 | Companies With Northeast Workforces Face the Highest Cost Trend and PEPY Medical Expenses in 2007



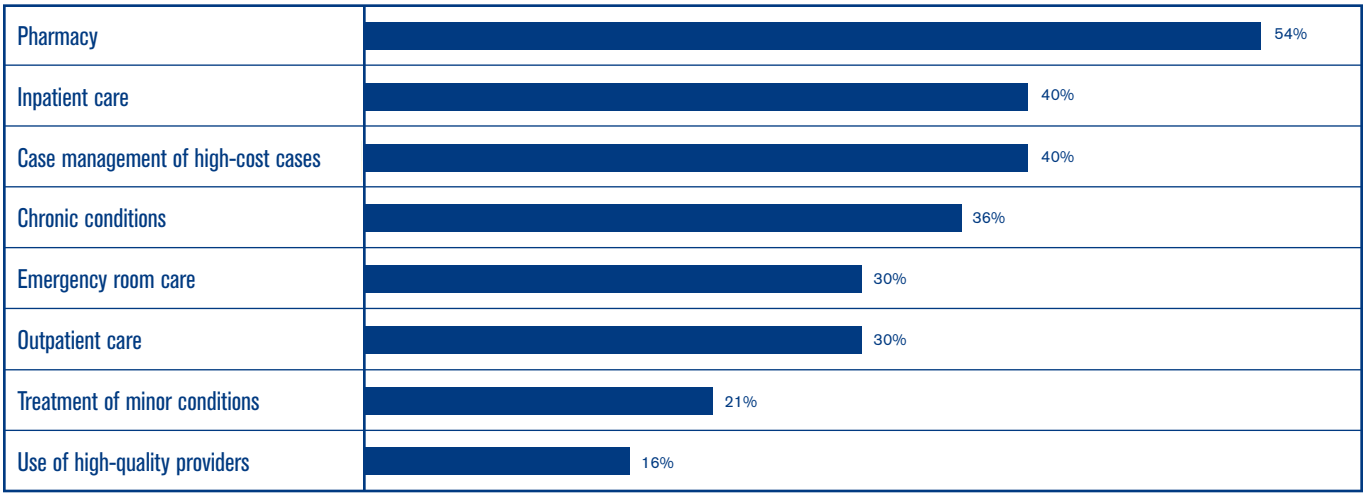
Note: Based on medians.

[1]A company's medical benefit expenses for insured plans include the premium paid by the company and, for self-insured plans, include all medical and drug claims paid by the plan, company contributions to medical accounts (FSA/HRA/HSA) and costs of administration minus employee premium contributions. The annual change in costs is based on costs for active employees after plan and contribution changes.



The traditional ways of managing costs continue to drive medical cost trend management. Companies have been most successful at managing costs around pharmacy, inpatient care and high-cost cases, but they struggle with getting employees to use high-quality providers and avoiding overtreatment of minor conditions (Figure 9).

Figure 9 | Companies Doing Best at Managing Pharmacy Costs but Struggle With Quality



Note: Percentage responding their organization has been "very effective" or "moderately effective" at managing the costs of active employees in these areas.

Retiree Medical Coverage Continues to Decline

Just 24 percent of companies will provide traditional medical coverage for employees under 65 who retire this year, and 23 percent will provide such coverage to retirees who are eligible for Medicare. Last year, 28 percent offered coverage to employees under 65, and 26 percent did so for employees eligible for Medicare. Today, only 15 percent of new hires are offered retiree medical coverage compared with 18 percent last year.

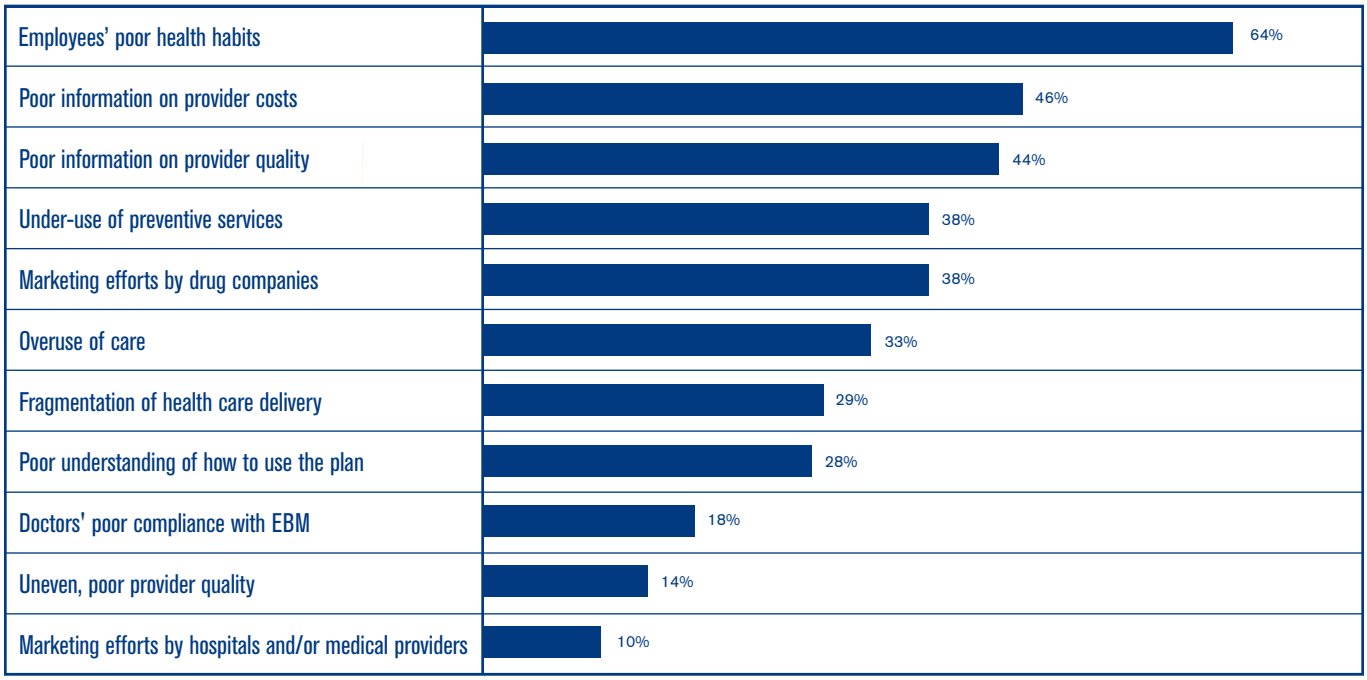
Twenty-nine percent of companies that currently offer retiree medical support use a VEBA for funding their program and another 8 percent are planning or considering it. Organizations with more than 35,000 employees lead the way as 39 percent currently use a VEBA and nearly 13 percent are planning or considering it in the future.

The biggest health care coverage challenge that companies face is the poor health habits of their employees – identified by nearly two-thirds of respondents as a considerable challenge to managing their health care costs (Figure 10). Companies also struggle with the lack of information on provider costs and quality. However, there appears to be less concern among employers that the quality of care received by their employees is poor or that doctors are not complying with evidence-based medicine (EBM) guidelines.

Rewards vs. Penalties

Today, 31 percent of employers offer rewards for health status factors, while 6 percent penalize employees for poorly managing their health condition(s). However, best-performing companies report they are more than 40 percent more likely to use penalties in the next two years than poor performers (19 percent vs. 13 percent).

Figure 10 | Top Challenges Employers Face to Maintain Affordable Benefit Coverage



Note: Percentage responding to a "very great extent" or "great extent."

On the Rise/On the Slide

During the last few years, there has been a considerable transformation in employer-sponsored health care programs. With the evolution of the consumer-oriented health care model, the future portends even more significant changes. Figure 11 shows the rising, stagnant and declining trends in health care programs over the last three years.

Rising

The good news is that we are seeing positive trends around provider quality, programs that address lifestyle-related risks such as weight management and health risk appraisals, and the use of metrics and data analysis. Some strides have also been made to provide reliable access to information via the Internet and through more personalized models such as a health coach.

Figure 11 | Programs and Strategies on the Rise and Slide

	Programs	2008	2007	2006	Percentage-Point Change
On the Rise	Offer health risk appraisals	83%	72%	65%	18%
	Currently use provider quality	30%	25%	13%	17%
	Offer weight management program that focuses on reducing obesity among employees	74%	66%	59%	15%
	Audit or review eligibility and enrollment in your health plan	73%	59%	58%	14%
	Participate in quality/value initiatives outside of plan offerings	45%	38%	34%	10%
	Implement lifestyle behavior change programs purchased separately through specialty vendor(s)	56%	54%	47%	9%
	Currently use lost workdays	18%	11%	10%	8%
	Offer Internet resources for tax-impact modeling	42%	38%	34%	8%
	Implement data warehouse	51%	48%	44%	8%
	Offer health coach	60%	57%	53%	7%
	Offer Internet resources with side-by-side coverage comparisons	64%	61%	58%	5%
	Offer Internet resources with provider pricing	19%	16%	15%	4%
	Offer Internet resources for provider quality comparison tools	29%	29%	26%	4%
	Participate in purchasing coalition	27%	28%	24%	4%
	Offer onsite health center	29%	29%	27%	3%
	Integrate health care, disability, work/family, EAP and other health-related benefits	37%	40%	34%	3%
	Implement disease management programs purchased separately through specialty vendor(s)	36%	40%	38%	–2%
	Based decision on health outcomes	9%	10%	12%	–3%
On the Slide	Implement disease management programs purchased through one or more of your health plans	76%	74%	79%	–3%
	Structure plan design partially based on employee compensation levels	26%	29%	32%	–5%
	Implement lifestyle behavior change programs purchased through one or more of your health plans	56%	60%	62%	–6%
	Select medical vendors or price plan options based on risk-adjusted costs	10%	11%	18%	–8%
	Based decision on vendors' estimates of ROI	39%	48%	47%	–8%

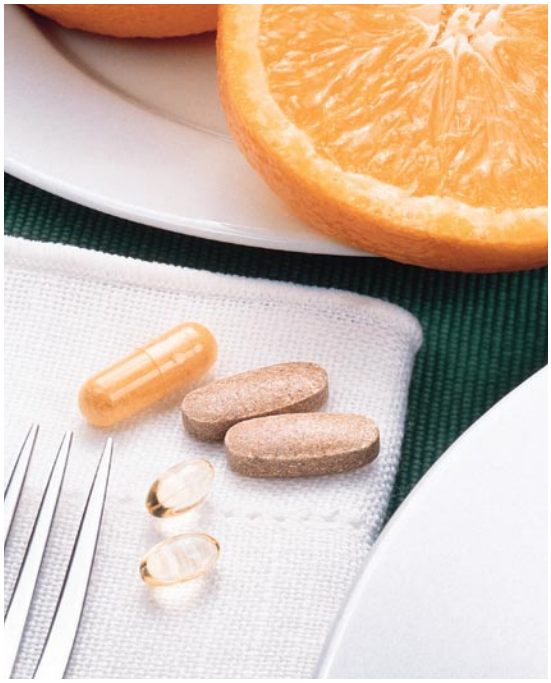
Note: Percentages represent programs currently in use or planned for next year. Due to rounding, percentages in the right column might not be equal to the difference between percentages in the 2008 and 2006 columns.

Slow Growing

Companies have been slow to invest in online provider quality tools and to offer information on provider pricing. This may reflect the slow response by the marketplace to provide credible solutions in these areas. The number of organizations using purchasing coalitions has also stayed consistent. Moreover, progress has stalled around the integration of health care, work loss and other health-related benefits.

Declining

Organizations are more hesitant to use measures from vendors in their decision making. They are basing fewer decisions on health outcomes and are much less likely to use vendors' estimates of return on investment (ROI). While the use of lifestyle management programs purchased from specialty vendors is on the rise, companies have become less willing to purchase lifestyle programs from their health plans. Also, the number of employers purchasing disease management programs from both specialty vendors and health plans has declined from 2006 to 2008.[2]



Plan vs. Specialty Vendors

Best-performing companies now favor health plans over specialty vendors for their information tools and are almost evenly split on whether they use their plans or specialty vendors for disease management (**Figure 12**). This reverses a long-standing trend where best-performing companies more heavily relied on specialty vendors to provide these services. However, these top performers are continuing to use specialty vendors more than plans for lifestyle programs.

Figure 12 | Best Performers Are Choosing Their Health Plan(s) for Disease Management and Information Tools

	Program Offered Through:	Poor Performers	Average Performers	Best Performers	Ratio Top to Poor
Provide employees with decision-making tools	Plan	77%	81%	88%	1.13
	Vendors/independent	58%	58%	60%	1.05
Provide employees with information/ tools on provider quality	Plan	66%	69%	76%	1.15
	Vendors/independent	31%	27%	27%	0.89
Implement lifestyle behavior change programs	Plan	53%	56%	57%	1.09
	Vendors/independent	57%	54%	60%	1.06
Implement disease management programs	Plan	77%	80%	77%	1.00
	Vendors/independent	37%	40%	34%	0.93

[2]Twenty-one percent of companies do not currently have a disease management program in place.

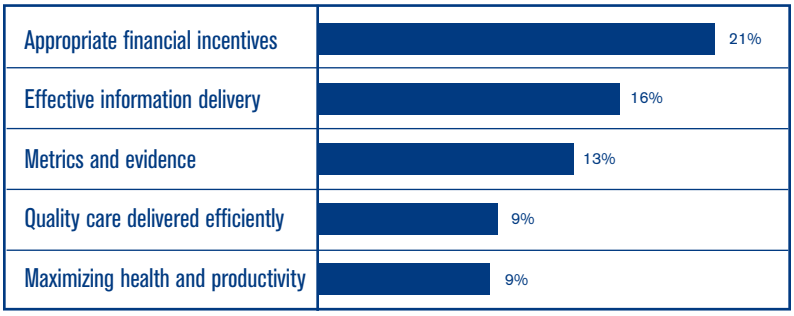
Top Performers

Some organizations have been much more successful at controlling their health care cost trends than others. While the median two-year trend (for 2007 and expected for 2008) for all organizations is 6.2 percent, best-performing companies have realized significantly lower cost trends. The best-performing companies – those with a median two-year average cost increase in the lowest quartile among all respondents – have a median two-year trend of 1 percent (Figure 13). Conversely, poor-performing companies – those in the highest quartile – have a cost trend of 10 percent. The gap between the best and poor performers has widened in recent years. In 2004/2005, the average trend for poor performers was three times the trend of top performers (15 percent vs. 5 percent). Today, the gap has grown to 10 times.

Figure 13 | The Gap in Median Trend Grows Between Best and Poor Performers

Survey Year	Best Performers	Average Performers	Poor Performers
2007/08	1.0%	6.2%	10.0%
2006/07	2.5%	8.0%	11.0%
2005/06	3.0%	8.0%	11.5%
2004/05	5.0%	10.0%	15.0%

Figure 14 | Key Drivers of Best Performers



Note: Percentage that best performers are more likely to implement programs with these features as compared with poor performers.

The best-performing companies are getting results by incorporating programs and initiatives in five key areas (Figure 14):

- Appropriate financial incentives
- Effective information delivery
- Metrics and evidence
- Quality care
- Maximizing health and productivity

Best-performing companies are clearly differentiating themselves from poor performers through greater use of financial incentives, effective information delivery and use of metrics and evidence. These companies are also making bigger investments to enhance quality and to maximize health and productivity.

Our research used multivariate regression analysis to estimate how changes in the five key program areas have affected health care trends, controlling for confounding factors such as industry, region and average age of the organization.

Our estimates show that a company with a current cost trend of 6.2 percent that elevates its use of programs and initiatives in each of the core areas commensurate with the top 10th percentile is associated with a reduction in cost trend to 3.2 percent – a 3 percentage-point decline (6.2 percent vs. 3.2 percent). However, a company with low program use – such that its use of the five core program areas is equal to the bottom 10th percentile – is anticipated to have a cost trend of 8.2 percent. Altogether, that represents a trend differential of 5 percentage points (Figure 15). For an organization with a $100 million annual health care spend, that translates to roughly $5 million in savings.

A key finding in this year's study is that companies with consumer-directed health plans are at the forefront in developing a consumer-

oriented model – and it is paying dividends in terms of lower health care costs.[3] In fact, best-performing companies are almost 50 percent more likely to offer a CDHP than poor performers (50 percent vs. 34 percent). But these companies are doing more than adopting a high-deductible health plan. As we illustrate in the next section, CDHP companies, especially those with high enrollment, are more focused on providing their workforce with tools and information to help manage their own health care and navigate through the health care system.

But non-CDHP companies have also been successful at managing their health care costs by embracing the principles of consumerism. The best-performing non-CDHP companies use financial incentives (other than higher deductibles); focus on provider quality, data, health and productivity initiatives; and provide employees with essential information to manage their health to a much greater extent than their poor-performing peers (see "Success Extends Beyond High Deductibles," next page).

Figure 15 | Predicted Trends for High and Low Levels of Program Use

Program	Predicted Trend Under Low Program Use	Predicted Trend Under High Program Use	Decline in Trend by Moving From Low to High Program Use
Baseline Trend = 6.2%			
Appropriate financial incentives	6.5%	4.9%	–1.6%
Quality care delivered efficiently	6.7%	5.7%	–1.1%
Maximizing health and productivity	6.7%	5.7%	–0.9%
Effective information delivery	6.6%	5.8%	–0.8%
Metrics and evidence	6.5%	5.9%	–0.7%
Significant improvement in all factors	**8.2%**	**3.2%**	**–5.1%**

Note: High program use represents the 90th percentile and low program use represents the 10th percentile. Predicted trends are based on multivariate regression analysis, and values represent a movement in trend from a baseline of 6.2 percent. Due to rounding, percentages in the right column might not be equal to the difference between percentages in the low and high program use columns.

[3] We define a consumer-directed health plan (CDHP) as a plan with a deductible of at least $1,000 for employee-only coverage, offered together with a personal account that can be used to pay a portion of the medical expense not paid by the plan. CDHPs typically include decision-support tools that help consumers better manage their health, health care and medical spending.

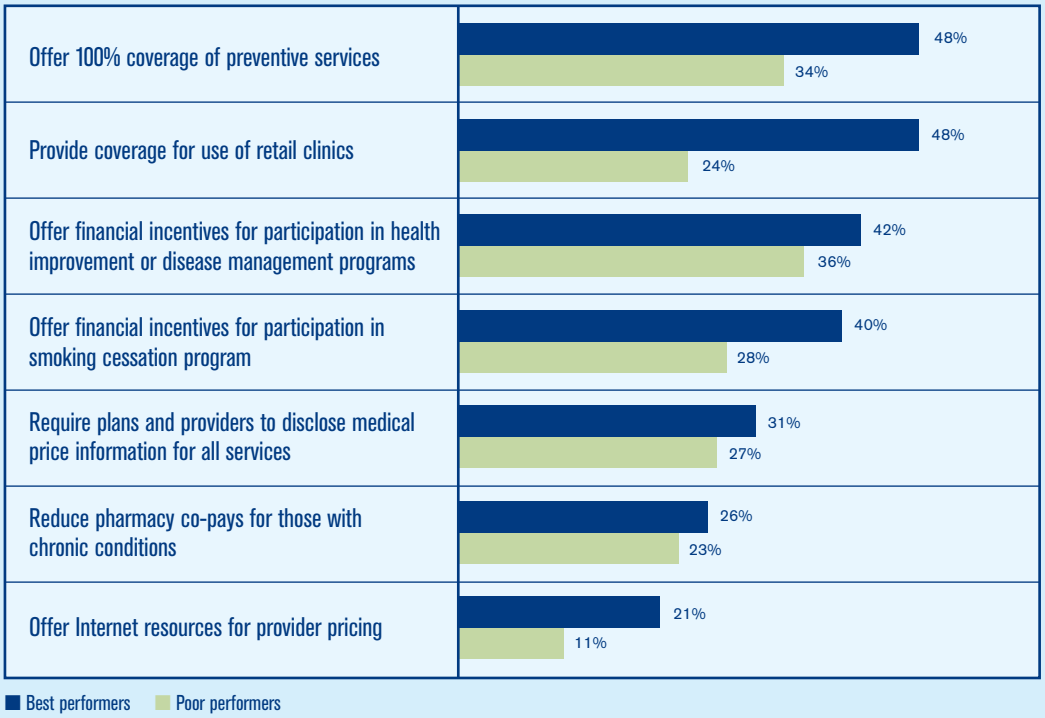
Success Extends Beyond High Deductibles

While there has been substantial growth in consumer-directed health plans over the last few years, a number of companies have been slower to embrace the high-deductible health care model. Whether it is for business reasons or fear of negative employee reactions, these companies have maintained their course and have not meaningfully empowered their workforce with greater responsibility to better manage their own health care. Or have they?

In fact, the best-performing non-CDHP companies are doing many of the same things to engage employees in managing their own health care as CDHP companies are doing. This includes use of financial incentives to influence appropriate health care decisions among employees. It also includes a greater focus on provider quality, data and evidence, maximizing health and productivity, and more effective delivery of health care information to employees.

While higher deductibles are not a primary plan design feature of non-CDHP companies, the best performing of these companies are much more likely to use other types of financial incentives. For example, the best-performing non-CDHP companies are twice as likely to offer coverage for the use of a retail clinic (**Figure 16**). These companies are also more likely than their poor-performing counterparts to offer financial incentives to participants of health management programs and to encourage the use of preventive services.

Figure 16 | Non-CDHP Companies Use Financial Incentives to Deliver Cost Savings



Note: Responses for companies that do not currently have a CDHP in place.

Case Study: **Land O'Lakes**

Lowering Trend Through CDHP Enrollment

Land O'Lakes, one of the best-performing companies in this year's study, reduced its health care cost trend from 13 percent in 2006 to negative 5 percent in 2007. The company achieved this amazing reduction through a significant plan redesign, which featured the introduction of a CDHP. What's more, 72 percent of Land O'Lakes employees enrolled in the CDHP in 2007, the first year it was offered.

With full support from senior management, the company cut back from 12 self-insured plan offerings and nine fully insured plans in 2006 to three plans in 2007 – the CDHP and two PPO plans. All three plans were similarly subsidized and offered the same level of co-insurance and pharmacy provisions. The CDHP also included an HRA (as opposed to an HSA), which the company felt better matched the demographics of its production-heavy employee population. At the same time, the company beefed up its disease management initiatives for cardiac care, diabetes, asthma and back pain as well its health management initiatives including a weight loss program with Weight Watchers. Land O'Lakes also continued its membership in a data warehouse through the National Data Cooperative and strengthened its use of metrics.

Land O'Lakes attributes the enormously successful enrollment to its honest and open communication with employees as well as helpful information and tools. In 2005, the company began paving the way for the plan by informing employees that the company was on a health care journey to continue to provide competitive and comprehensive coverage, but at a more reasonable cost. In 2006, Land O'Lakes added more detail on the new plans. It held meetings around the country with employees and sent out DVDs which showed concrete examples of how much low-, medium- and high-level health care users would likely spend under each of the three plan offerings, showing how the CDHP compared to the traditional PPO plans. Employees were also given access to a set of robust tools which allowed them to see how their use of specific drugs or medical services might be affected under each plan. And, employees could also contact a call center to answer their questions before and during the enrollment period began.

For 2008, Land O'Lakes instituted a health risk assessment incentive of $50 and other minor changes to its health care plan (e.g., dependent audit, renegotiated with pharmacy vendor), yet was still able to slightly increase its CDHP enrollment. However, because it expects trend to drift upwards again, the company is planning another big plan design change in 2009 – offering the CDHP on a total replacement basis. The company feels that this is the natural evolution of its health care transformation and another essential part of a multi-year strategy begun in 2005. It's a strategy that will continue to focus on open communication and one that has so far produced very impressive results.

Case Study: **General Mills**

Earning Results Through a Broad-Based Approach to Health Care

General Mills has taken a broad-based approach in managing its health care programs for many years, and the strategy is clearly paying dividends. Its five-year health care cost trend has been less than 3 percent and its trend in 2007 was 1.6 percent. General Mills is a best performer using all of the following tactics to improve health benefit performance: a keen focus on plan design, communication, health management, quality, data and metrics.

Design

The company offers employees four health care options – two PPOs, an EPO and a CDHP. Employee enrollment in the CDHP, first offered in 2005, has risen steadily over the last three years, from 17 percent in 2006 to 32 percent in 2008. General Mills has encouraged participation in its CDHP by offering 100 percent preventive coverage and a higher lifetime maximum than in its non-CDHPs.

Communication

General Mills also has maintained an effective stream of communication to encourage behavior change, including pre- and post-enrollment employee meetings, easy-to-understand print materials and flash videos. The company supports these programs with a robust set of enrollment tools that help employees analyze their potential costs and evaluate how they would fare under each health care option. General Mills also seeks employee feedback on a frequent basis. The company conducts frequent health surveys. For example, the company is currently conducting an extensive survey to understand whether employees are satisfied with their personal health and availability of wellness and prevention programs. They are also asking employees whether they believe the company is invested and committed to improving their personal health.

Health and Wellness

Improving the health and wellness of its employees is a hallmark of General Mills' total health approach. The company has maintained onsite fitness centers at its corporate office and in certain plant locations for many years, providing access both to employees and their families. General Mills has a health care clinic at their main headquarters, as well as nurse practitioners and physician assistants at some of their plant facilities. General Mills promotes preventive care and offers wellness programs at all of their worksites.

Quality

General Mills pays close attention to improving the quality of its providers. Although this can be especially challenging in rural areas, the company visits physician groups even in more remote locations, educating physicians directly about the use of evidence-based medical practices. In addition, the company aggressively manages its high-cost cases, holding monthly phone calls with vendors to review planned courses of action. This case-specific approach helps ensure that the patient is receiving the best care available and has all the resources necessary to achieve the best possible outcome.

Data and Metrics

General Mills is a founding member of the National Data Cooperative and has used metrics to drive many of its health benefit decisions. Scorecards for each of its significant business locations are created and analyzed to monitor that location's specific health and health care experience.

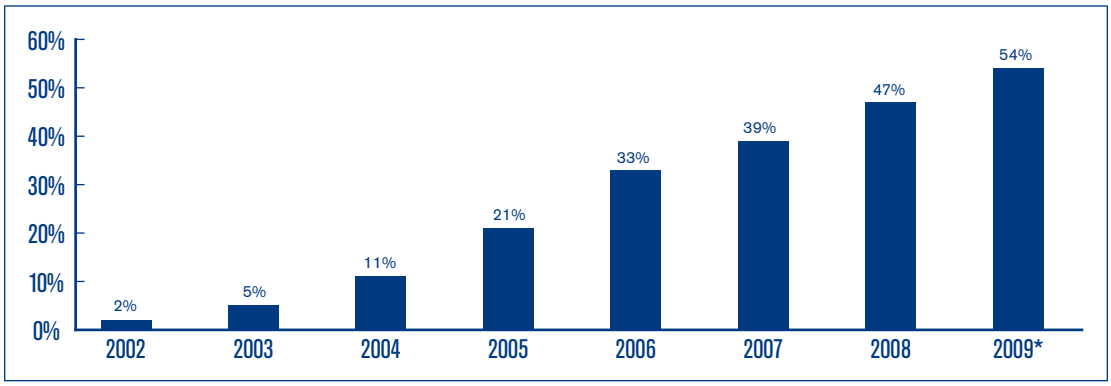
General Mills understands that effective health care programs lead not only to enhanced bottom-line results, but also to happier, healthier employees who are more likely to stay with the company. With its broad-based approach to health care, General Mills has made both of those outcomes a reality.

Consumer-Directed Health Plans

Organizations have been steadily adopting consumer-directed health plans. Today, 47 percent of companies have a CDHP in place – an increase of 8 percentage points since 2007 (Figure 17). This trend is expected to increase as some respondents without a program today expect to adopt a CDHP in 2009, bringing the total to 54 percent.

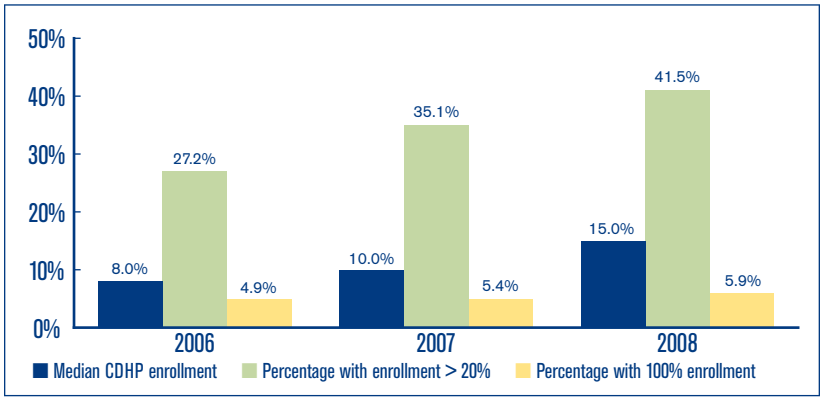
Enrollment rates in CDHPs are also increasing. In 2008, roughly 15 percent of employees at organizations with a program are enrolled in the CDHP compared with 8 percent in 2006 and 10 percent in 2007 (Figure 18). Few employers have been willing to migrate their entire workforce to a CDHP. Similar to findings from the previous two years, less than 6 percent of companies have 100 percent enrollment in a

Figure 17 | CDHPs Are Steadily Climbing



*Note: * Indicates planned for 2009.*

Figure 18 | CDHP Enrollment Rates Are on the Rise



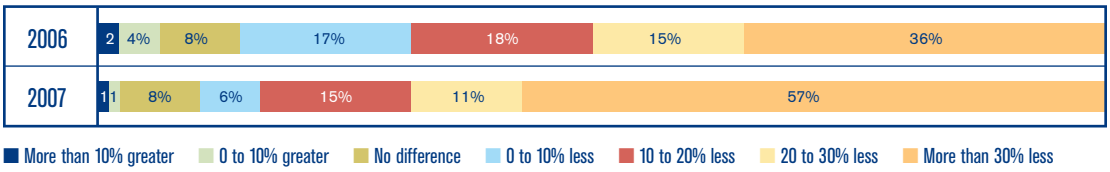
Note: 2006 data is based on the 12th Annual National Business Group on Health/Watson Wyatt Survey.

CDHP. However, the percentage of companies with at least 20 percent CDHP enrollment rose to almost 42 percent in 2008 compared with 27 percent in 2006 – an increase of more than 50 percent.

To encourage enrollment in CDHPs, a large number of companies offer significantly lower premiums for CDHP enrollees. Nearly 60 percent of companies offer CDHPs with a contribution that is lower than their traditional co-pay plan by 30 percent or more (Figure 19). This is a dramatic increase compared with last year, where 36 percent of companies provided more than a 30 percent premium differential. In essence, companies have tried to boost enrollment rates in CDHPs by significantly lowering premiums. However, our research did not find any meaningful connection between enrollment increases in CDHP options and premium differentials that were 30 percent or more lower than those for the traditional plan options.

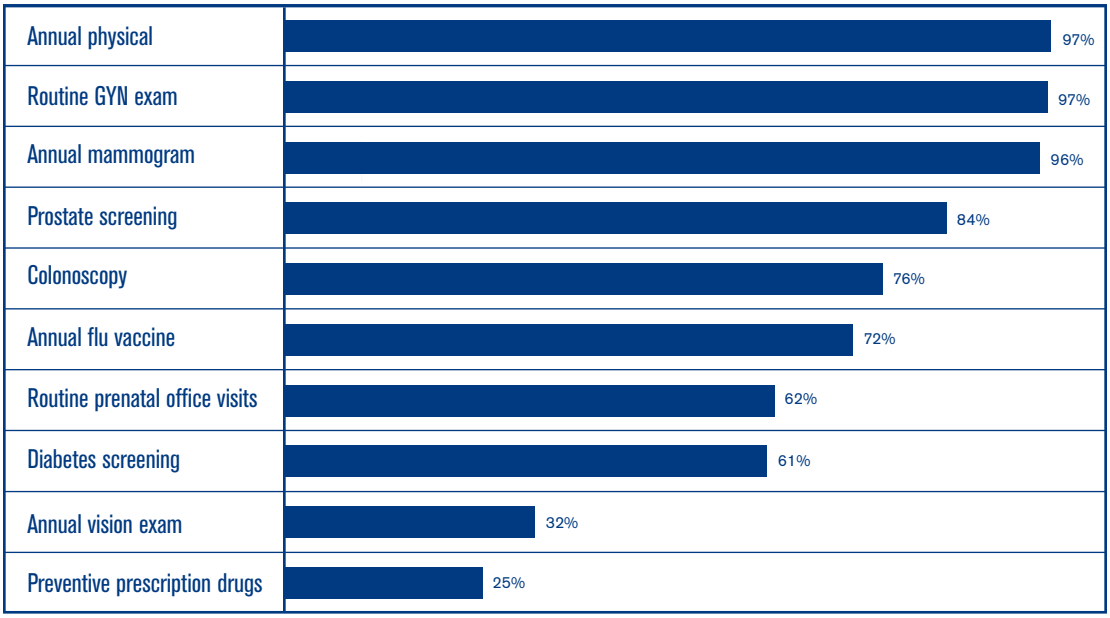
Many companies with a CDHP provide 100 percent coverage of the most common preventive services. Nearly all companies provide first-dollar coverage before reaching the deductible for an annual physical and female cancer screenings (Figure 20). Three-quarters or more also provide other cancer screenings and more than two-thirds cover flu vaccination. Slightly fewer companies offer first-dollar

Figure 19 | Companies Offer Significantly Lower Premium Costs for Employees Enrolled in CDHPs



Note: Percentages do not add up to 100 percent due to rounding.

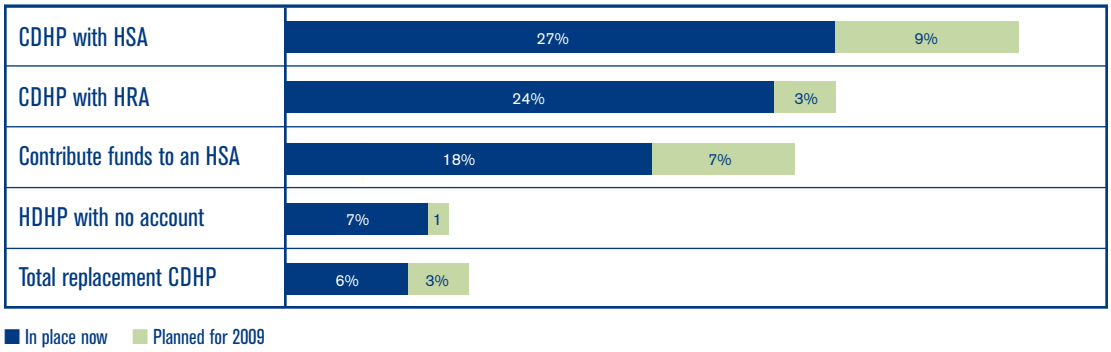
Figure 20 | Many Preventive Services Are Covered Under CDHPs Before the Deductible Is Met



coverage for prenatal office visits (62 percent) and diabetes screenings (61 percent). And only 25 percent of companies currently offer preventive drug coverage.

For account-based programs, HSAs lead the way – offered by 27 percent of companies today (Figure 21). Health reimbursement accounts (HRAs) are also popular with 24 percent of companies. However, employers are three times more likely to add an HSA in 2009 (9 percent) than an HRA (3 percent). Up to this point, companies have been slow to adopt total replacement programs. Today, 6 percent of employers offer a total replacement CDHP for any segment of their workforce. However, that rate could reach almost 9 percent by 2009 if companies follow through with their current strategy plans.

Figure 21 | CDHPs With Health Savings Accounts Are the Most Popular Account-Based Plans



Work Loss

Companies have increased their use of work-loss data by more than 60 percent compared with last year (18 percent vs. 11 percent), but very few companies use the data to make decisions (5 percent). In addition, only 6 percent of companies currently integrate time-off programs with their health care data, although another 10 percent plan to do so in 2009.

Companies with a CDHP report a two-year median cost trend that is significantly below companies without a CDHP (5.5 percent vs. 7.0 percent). Enrollment rates in the CDHP are strongly linked to lower health care cost trends. In fact, companies with at least 50 percent of their population in a CDHP had a two-year trend about half that of non-CDHP sponsors (Figure 22). Health care trends for companies that adopted a CDHP in 2006 or after are lower than those companies that adopted in 2005 or earlier (5.0 percent vs. 6.0 percent). This could reflect a higher than normal reduction in cost trends in the first several years after adopting a CDHP program. It might not reflect a sustainable trend.

However, companies with a CDHP program are doing much more than merely increasing deductible levels. They are highly focused on programs and initiatives in areas of quality, metrics, effective information delivery, and health and productivity. The high-deductible plan is part of a much broader strategy for changing the way their workforce uses and interacts with the health care system. These actions are positioning CDHP companies for long-term success.

Although consistent and reliable provider quality information is still developing, companies with CDHPs have made it a centerpiece of their health care strategy. Specifically, CDHP companies use limited and high-performance networks based on price and quality more frequently than other companies (Figure 23). CDHP companies are 50 percent more likely to use (or plan to use) centers of excellence for treatments other than transplants and 46 percent more likely to participate in quality/value initiatives outside of plan offerings. They also more often use online provider quality comparison tools that direct employees to high-quality providers.

Our previous studies showed that the use of data and measurement was a key component of the best performers' approach to making decisions about their health plans. This year we again find that metrics and data analysis are a central part of companies' CDHP strategies. In particular, CDHP companies are much more likely than other organizations to have a data warehouse in place and use its claims analysis to make decisions about their health plan (Figure 24). However, there is no such link to the use of claims reports developed by plan administrators.

Figure 22 | Median Trend Significantly Declines for Companies With Higher CDHP Enrollment

Median Trend for Companies With a CDHP of 5.5%

Figure 23 | Quality

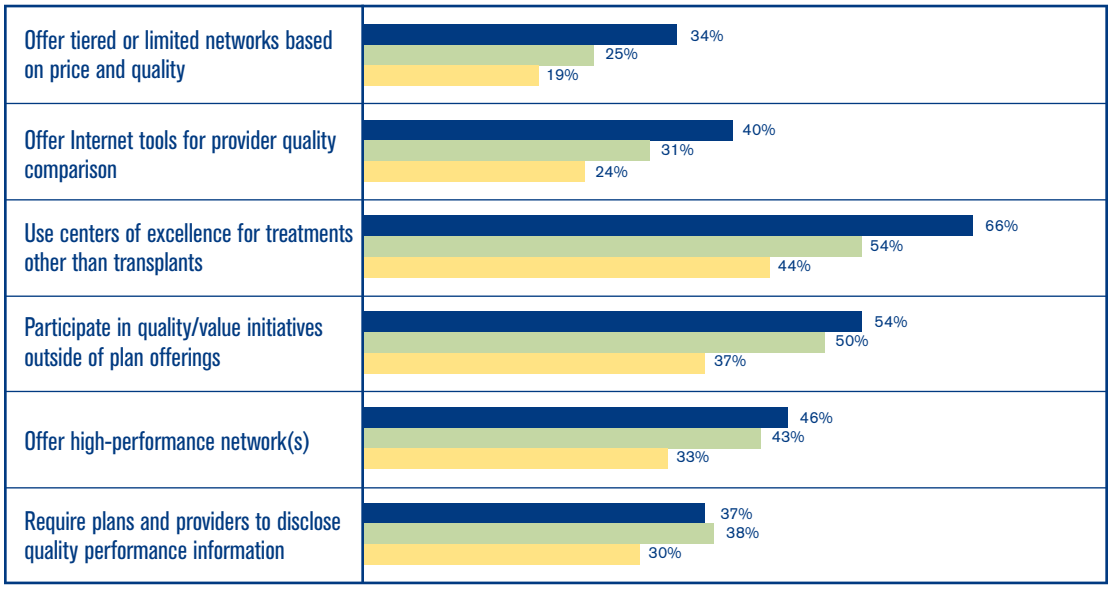
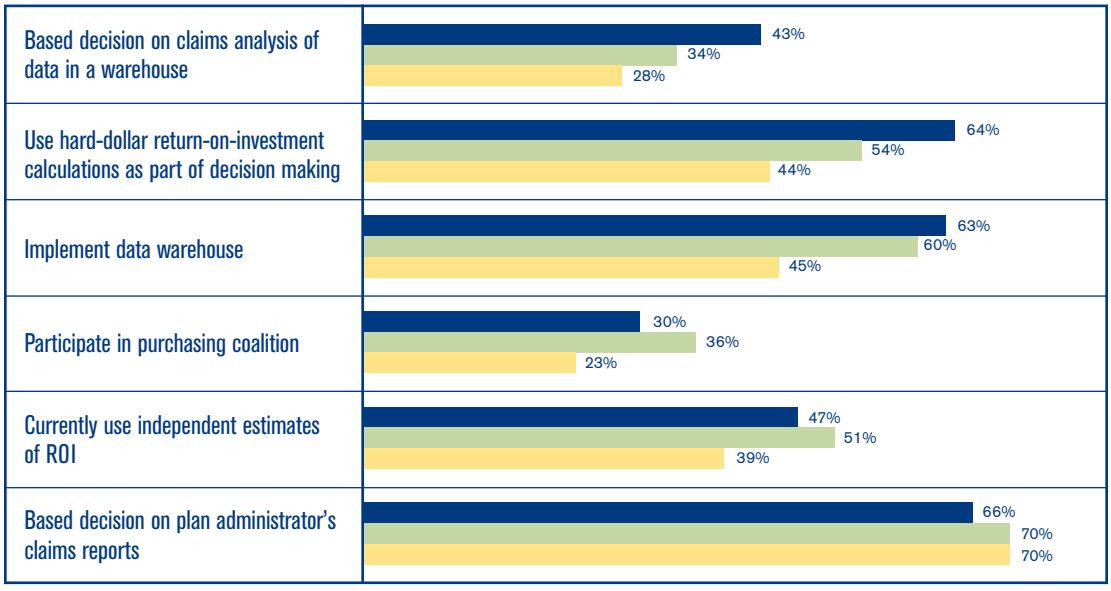


Figure 24 | Metrics



Health Management Program Participation

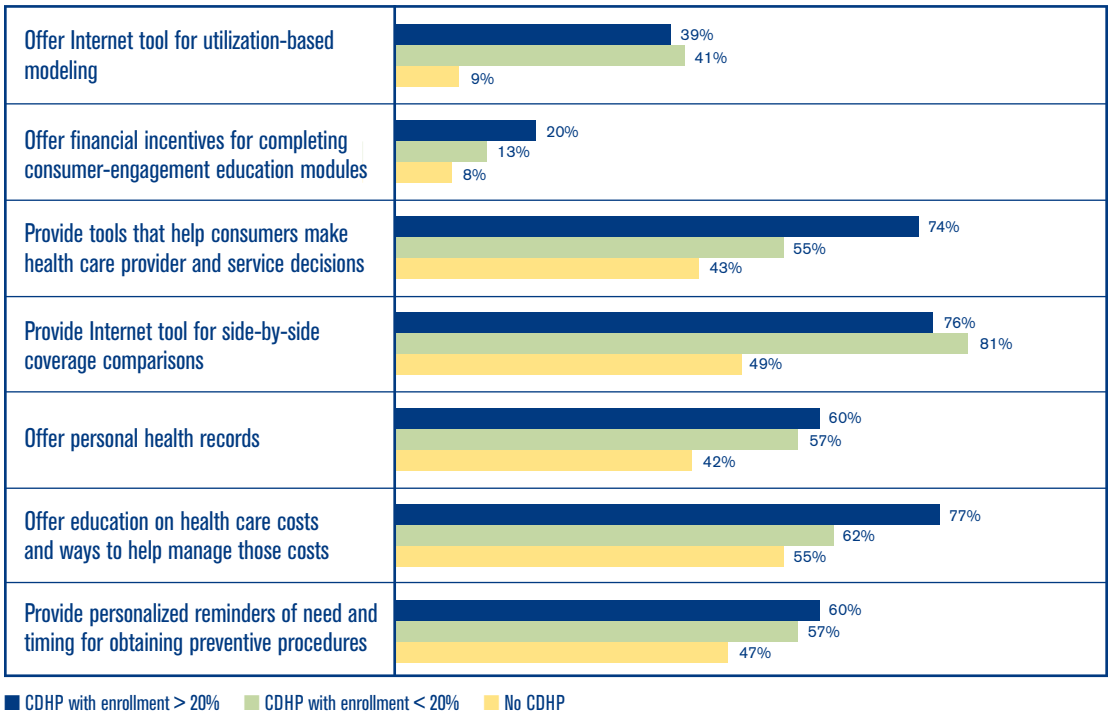
Nearly 20 percent of companies report more than 50 percent participation in their health risk appraisals and 15 percent report that participation level for worksite biometric screening (**Figure 25**). Participation in other health management programs such as the nurse line, health coach and lifestyle behavior change is comparatively low. Many companies do not receive information about the utilization of their programs. This is especially true of provider cost and quality.

Figure 25 | Companies Struggle With Tracking Participation in Their Health Management Programs

	0–10%	11– 30%	31–50%	More Than 50%	Don't Know
Health risk appraisals	22%	24%	15%	19%	20%
Disease management programs	39%	28%	5%	5%	24%
Worksite biometric screening	21%	22%	9%	15%	33%
Health coach	38%	18%	4%	4%	36%
Nurse line	33%	25%	2%	2%	37%
Lifestyle behavior change programs	33%	19%	4%	4%	40%
Personal health records	27%	10%	2%	4%	57%
Online symptom checkers	15%	13%	4%	2%	65%
Physician cost ratings	26%	5%	1%	2%	67%
Hospital cost ratings	27%	3%	1%	2%	67%
Physician quality ratings	25%	4%	2%	1%	67%
Hospital quality ratings	25%	5%	1%	2%	68%

Note: Percentages do not add up to 100 percent due to rounding.

Figure 26 | Effective Information Delivery



Many companies struggle to measure the ROI of their health care initiatives, particularly around their health management programs. Despite these challenges, CDHP companies are almost 50 percent more likely than non-CDHP companies to use hard-dollar ROI calculations to make decisions and they more often draw on independent sources for those estimates.

As companies increasingly embrace a consumer-directed model, they increase their employees' accountability for health care decision making. To successfully manage this responsibility, participants must be familiar with the health care system and understand their health care options. CDHP companies are much more likely to provide employees with the education and tools needed to become informed health care consumers (Figure 26). These companies are especially focused on providing online tools to employees to critically evaluate the health plan alternatives that best meet their needs during the enrollment process.

On an ongoing basis, CDHP companies are also providing tools with information about the quality of health care providers and costs of medical services. They are more likely to provide employees with information targeted to their specific needs such as personal reminders around preventive care visits and personal health records.

Previous studies have shown that the best-performing companies take a holistic approach to addressing the health care issues faced by their workforce. This includes a mix of programs that encourage the use of preventive services for those at low risk for serious medical conditions as well as targeted initiatives to encourage employees with chronic health problems to receive the most appropriate care.

Incentives

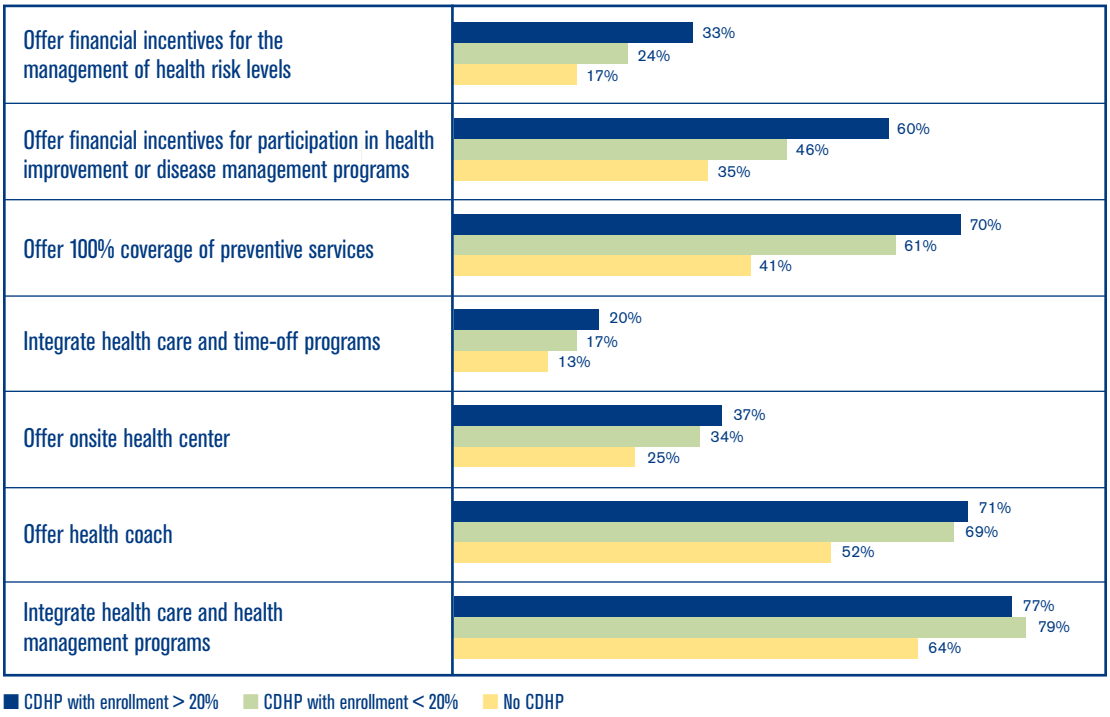
More than half of all employers use financial incentives to encourage employees to participate in one or more types of health improvement activities and 24 percent more plan to do so in 2009 (**Figure 27**). Coverage differentials are most often used to encourage the use of preventive services. However, companies are more likely to use cash or other monetary gifts to promote participation in health management programs.

Figure 27 | Financial Incentives to Encourage Participation in Wellness Programs Are on the Rise

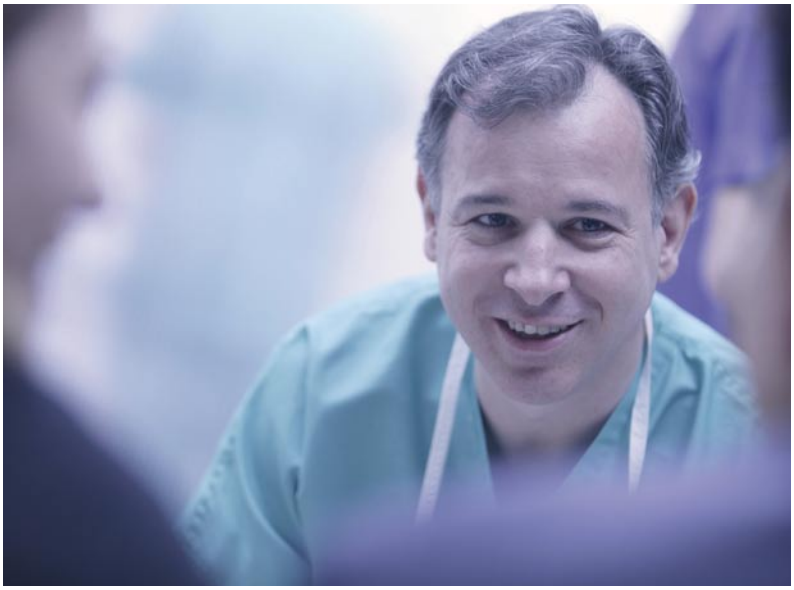
	Coverage Differentials	Premium Differentials	Cash or Equivalent	Other	None
100% coverage of preventive services	37%	1%	6%	9%	47%
Completion of a health risk appraisal	3%	12%	32%	7%	47%
Participation in health improvement or disease management programs	7%	4%	22%	11%	59%
Participation in smoking cessation program	5%	6%	18%	12%	60%
Participation in weight management program	2%	2%	19%	9%	69%
Management of risk levels, such as cholesterol, blood pressure and weight	3%	2%	9%	7%	79%
Completing consumer-engagement education modules	1%	2%	7%	3%	88%
Maintaining a personal health record	0%	0%	5%	2%	93%

Note: Percentages do not add up to 100 percent due to rounding.

Figure 28 | Health and Productivity



However, many companies struggle with engaging employees to more proactively manage their health care. To overcome this inertia, CDHP companies are more likely to offer financial incentives that encourage employees to participate in health improvement programs and manage their risk levels such as cholesterol, blood pressure and weight management (Figure 28). CDHP companies are also more likely to coordinate their data by integrating their health management programs with their health plan and time-off programs. Onsite health centers are a key way to help coordinate care and promote greater workforce productivity; they are almost 50 percent more likely to be offered by CDHP companies.



Value-Based Pharmacy Design on the Rise

All signs point to further growth of value-based pharmacy designs, as almost 20 percent of respondents plan to reduce or eliminate co-pays for chronic conditions by 2009.

Currently, only 12 percent of companies reduce or eliminate pharmacy co-pays for enrollees with chronic health conditions such as diabetes and high blood pressure. In particular, best-performing companies are almost 30 percent more likely than poor performers (16.1 percent vs. 12.5 percent) to cut pharmacy co-pays for participants. CDHP companies use this strategy more frequently than non-CDHP companies (38 percent vs. 26 percent).

Conclusion

As the rate of health care cost increases has slowed, employers' ability to budget for increases and their confidence in offering health care benefits in the future has improved. However, even at the current trend of 6 percent, health care cost increases are significantly impacting employers' bottom lines.

To effectively manage health care costs, employers are transforming their health care strategies. In addition to making plan design changes, they are addressing the root causes of health care costs by taking a broad approach to consumerism that encourages healthy behaviors and makes employees more accountable for their health care decisions.

Many best-performing companies have adopted CDHPs, but for most, this is just one component of a larger consumer-oriented model. These companies also use a combination of tactics that incent desired behaviors, deliver effective information, encourage the use of high-quality care, maximize employee health and productivity, and leverage data and metrics to make decisions about their health plans.

The results and cost savings are impressive for both best performers and CDHP companies with 20 percent or more enrollment. However, employers still face many challenges. Changing employee behavior and obtaining accurate and comprehensive information on provider costs and quality are not easy tasks. A large number of employers still do not track or measure the use or effectiveness of their programs.

The success of the best performers shows us that it is possible for employers to stabilize their health care spending. They have built consumer-oriented models that effectively manage costs and help improve employee health. Their success is worthy of emulation.

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Watson Wyatt is the trusted business partner to the world's leading organizations on people and financial issues.

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Our consultants bring fresh thinking to client issues, along with the experience and research to know what really works. They deliver practical, evidence-based solutions that are tailored to your organization's culture and goals.

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For more information on how Watson Wyatt can help you control health care costs and improve employee health, call 800/388-9868 or visit watsonwyatt.com.

About the National Business Group on Health

The National Business Group on Health is the nation's only non-profit organization devoted exclusively to representing large employers' perspective on national health policy issues and providing practical solutions to its members' most important health care and benefits related issues. Business Group members, primarily *FORTUNE 500* companies and large public sector employers, include the nation's most innovative health care purchasers who provide health coverage for more than 55 million U.S. workers, retirees and their families. The Business Group fosters the development of a safe, high quality health care delivery system, works to achieve transparency and make scientific evidence of effectiveness the standard for care, and shares best practices in health benefits, health and productivity, related paid time off and work/life balance issues.

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