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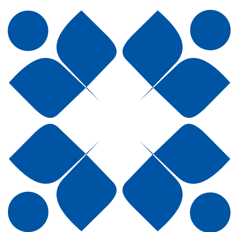

# Consumer Driven HEALTHCARE

## CDHPs have minimal effect on hospital marketing

***But consumerism drives outreach efforts***

CDH is helping create a buyer's market for healthcare services, but most hospital marketing programs haven't responded yet.

Hospitals and health systems face myriad challenges related to CDH. From the collections issues posed by larger up-front, out-of-pocket payments to the increasing demand for cost and quality data, the environment keeps changing.

Given that many consumers now have more say in how they spend their healthcare dollar (be it out of pocket or from an HSA or HRA), it would seem that marketing efforts would change as well. But in most parts of the country, the emergence of consumer-driven healthcare hasn't transformed how hospitals market themselves.

Whereas some are launching new strategies to market services and facilities to consumers (as opposed to only large purchasers and payers), most haven't, says **Anthony Cirillo, FACHE, ABC,** a principal at Fast Forward Consulting in Huntersville, NC. Most hospitals are small, community facilities, he says. "Ask them what they are known for, and they will say—drum roll, please—'compassionate care.' " They aren't specifically targeting the healthcare consumer or differentiating themselves from the competition, he says.

> **"Where do you draw the line between marketing done in response to CDH and marketing the hospital would do anyway? Every facility's answer may be different."**
>
> *—Barb Flitsch*

It may be a matter of being more knowledgeable about the subject, says **Kenneth T. Hertz,** senior consultant at MGMA Health Care Consulting Group in Alexandria, LA, adding that hospitals and health systems are still learning about CDHPs and their potential effect. "We haven't seen, up to this point, much change in marketing strategies or tactics—and in many cases, we really see limited marketing per se."

Instead, he adds, health systems are focusing on service lines, access, patient-friendly service, and other issues.

Some hospitals and health systems are much further along the road. What's unclear, however, is whether such efforts are related to the emergence of CDHPs.

### Innovators and nascent consumerism

Innovative marketing efforts, driven at least in part by consumerism, are under way, says **Barb Flitsch,** a senior consultant at Watson Wyatt in Minneapolis. Such efforts, however, aren't receiving a lot of notice.

Another issue to consider is that even health systems making consumer-focused changes in marketing may not be responding to CDH or CDHPs per se, although it's difficult to determine.

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Change behavior and the attitudes will follow.

## CDHPs

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"Where do you draw the line between marketing done in response to CDH and marketing the hospital would do anyway?" asks Flitsch. "Every facility's answer may be different."

For example, efforts to attract expectant mothers with more amenity-rich maternity wards have been under way for years. Hospital fitness centers certainly predate CDHPs.

But the emergence of the savvier, often cash-paying patient is creating the demand for greater change—change that may be lucrative for hospitals that position themselves well.

### Fabulous Omaha

Flitsch says she is seeing more efforts to market directly to the consumer, and many of the most innovative initiatives are happening in the heartland. Omaha, NE, is a "fabulous example," she adds. She points to Omaha-based Alegent Health, a nonprofit healthcare system that has embraced consumerism internally (with CDHPs) and externally (with outreach and transparency efforts).

It markets itself to consumers and has been at the forefront of finding better ways to engage them in their health and healthcare decisions, she explains, adding that Alegent CEO Wayne Sensor is a prominent advocate of consumerism. Alegent's billboards explicitly tell the passersby that they have choices to make about healthcare, she says.

Perhaps Alegent's most notable effort involves transparency. In January 2007, it launched My Cost, a proprietary tool that lets a healthcare shopper enter information about insurance and procedure type and find out what the total cost is, including what he or she can expect to pay. Those without coverage have access to a list of self-pay prices and information on financial-assistance programs.

In January, Alegent held a forum in which it shared its insights—and its My Cost technology—with interested health systems. The goal was to help other hospitals and health systems move closer toward cost and quality transparency. Attendees came to Omaha from as far away as Florida and New Hampshire.

Alegent remains an exception, but it's not the lone exception. For example, St. Luke's Health System in Kansas City, MO, has a service through which an individual can call, provide the name of the insurer, and get the price of a procedure, Cirillo says. Another emerging trend is a hybrid: The consumer provides the information online, and someone from the health system calls back with the price.

Flitsch also points to Carol.com, headquartered in Minneapolis. The service, free to consumers and limited to the Minneapolis–St. Paul area, lets shoppers compare healthcare services, practitioner credentials, quality dimensions, and costs with and without insurance. Participating providers pay to participate—a marketing effort in itself.

It's not as sophisticated as the My Cost application, Flitsch notes, but it's another example of how some providers are using marketing tools to appeal to the active, engaged consumer.

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Flitsch adds that, like Alegent, Carol.com has billboards in town promoting choice. One such billboard features a tie and a stethoscope, and the copy says, "You shop for one—why not shop for the other?"

## Are they consumers yet?

Such efforts target the consumer, but Cirillo isn't convinced that many patients have embraced that mantle. "Their consumerism is coming from watching too many drug commercials and pestering their physician or doing really serious Internet research and questioning their physician," Cirillo says. There are always exceptions, but not very many, he adds.

Alternatively, **James M. Goss,** vice president of public relations and marketing at CentraState Healthcare System in Freehold, NJ, is seeing a more involved consumer, one who asks more questions and is willing to invest in health. He doesn't necessarily attribute that to a particular type of plan design, but it's a true trend—one that's had an effect on how CentraState markets itself to potential patrons, he says.

## Cross-fertilization

CentraState recently opened the $48 million Star and Barry Tobias Ambulatory Campus. The 171,000-square-foot outpatient center houses:

- A fitness and wellness center
- A physical therapy/rehabilitation center
- A cardiac diagnostic and cardiac rehabilitation center
- A sleep disorders center
- A health awareness center (including a health awareness center for students and an outpatient diabetes center)

Putting these five programs into a single physical location provides a "tremendous opportunity for cross-referral," he reports. Some of the services are covered and others are self-pay, but they feed into each other.

Flitsch has seen similar efforts at other health systems. It's not a change directly driven by CDH or plan designs, but by consumers taking a more active role in their health, which some would see as a byproduct of the CDH movement.

Health clubs have been common for a while, but now, Flitsch says, she is seeing health club membership opportunities linked to cardiac rehabilitation. She also cites the inclusion of massage therapy and 3-D sonogram imaging for expectant parents in some health systems as active steps taken by healthcare providers to attract consumer dollars. (For a detailed look at similar efforts, see the March 2006 **CDH.**)

## Cultural and (soon) economic

Some hospitals are becoming more consumer-focused, although perhaps not in direct response to CDHPs. CDHPs are "catching the wave of what's been happening for a decade," says **Rick Wade,** vice president of the American Hospital Association. CDHPs add economics to what has been a "cultural wave," he says.

That cultural wave reflects a generational change, driven largely by demanding baby boomers, he explains. From the aforementioned maternity wards to the addition of complementary and alternative medicine to hospice care, baby boomers have pushed healthcare consumerism. (For more information about the effect of boomers, see the January 2006 **CDH.**) HSAs, Wade says, "haven't yet trembled the landscape." But as CDHPs become more common, that will change, he adds.

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### In future issues

- Portable, personalized and potent: Patient-facing medical records make consumerism real, but are there drawbacks?
- Small businesses and CDHP: Smart tactics for special challenges.
- Complementary and alternative medicine: Will CDHP open new doors?
- Case studies: Employers who change behavior and attitudes—and improve the bottom line.
- MedFICO update: A new tool for hospitals to manage debt?

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## CDHPs

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### Leveraging information

Most of those interviewed believe there's still a long way for health systems to go in terms of marketing services directly to patients. Although plenty of data exist to help these efforts, the information often isn't being used. Unfortunately, says Cirillo, hospitals are frequently "woefully inadequate" at collecting data that can be used for marketing.

Even collected data go unused by most hospitals, notes Flitsch, or they are at least not used to their optimal level. Basic demographics, the Patient Activation Measure score, and information extracted from tools used to assess whether patients qualify for charity care all can be used to enhance how hospitals communicate with consumers.

Although marketing begins with data collection, it's about more than just medical data itself; it's also about discovering what the individual's interests and influences are, says Cirillo. He offers an example of why interests matter: A grandmother has a grandson on a local soccer team sponsored by a hospital that focuses on growing relationships. This provides her with an additional reason to choose that hospital when the need arises.

Learning about influences can offer insight into which bloggers and online communities are helping form consumer opinions. Hospitals with this information will know where to go to have the strongest effect on the online healthcare shopper, says Cirillo.

"Hospitals that start a conversation with consumers, collect information, and start [customer relationship management] initiatives have the best shot at directly communicating to their prospects and communicating knowledge that will help them build a relationship and create tipping points for choosing them," he explains.

Some hospitals are drawing consumers to their site and getting them to opt in, often by providing something of value in return, he says. With that data, hospitals can tailor the outreach accordingly.

"It is really about having a culture of data collection, whether it be cold hard facts and figures or observational and anecdotal information on prospects' needs, wants, and desires," he says.

### Down the road

Hospitals have many legitimate concerns about consumerism, and, innovators notwithstanding, change is going to be slow. "It's a huge learning curve," says Flitsch.

It may take a while for health systems—and for providers in general—to understand the effect of CDH and CDHPs, but once they do, the marketing efforts will follow, Hertz says. "It would seem to me that as we better understand consumer behavior and drivers, we will see changes in the strategies and tactics employed by both our larger systems and smaller private practices—but that's down the road a piece," he adds. ■

### The new ambassadors

Interestingly, although many hospitals aren't directly appealing to potential self-pay patients through formal marketing and public relations (PR), increased patient responsibility is creating new de facto marketing and PR opportunities, or pitfalls, depending on how one views it.

Those opportunities are in accounts receivable (A/R) and collections—not areas most think of as the cutting-edge of marketing.

"It used to be that accounts receivable was a backroom operation that got down in the dirt with insurance companies over payment. Well, now those people are calling consumers asking for payment, and that directly reflects on the brand," says **Anthony Cirillo, FACHE, ABC,** a principal at Fast Forward Consulting in Huntersville, NC.

It's not an overt marketing tool, he says, but the nuances of CDHPs and the new role of the consumer will necessitate training. The PR and marketing folks will have to be involved in that effort, demonstrating how the A/R and collections effort connects to the overall brand, he says. It's basic customer service, but it takes on a far greater role in the emerging CDH environment.

The account representatives are the face of the hospital, he says; they are "the new PR ambassadors."

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# How top companies win with CDHPs/ABHPs: Towers Perrin report identifies best practices

Employers who succeed at account-based health plans set objectives, provide leadership, communicate value, and help employees understand and manage risk.

That's one of the crucial messages from *Account-Based Health Plans: What Works—and Why*, released recently by Towers Perrin. The report is based on a survey of 350 large U.S. employers (150 offering account-based plans) and a second survey of 1,000 employees (500 of whom were enrolled in account-based plans). Account-based health plans (ABHP) are Towers Perrin's designation for what is often known as CDHP—an HDHP accompanied by an account.

It's the first time the firm has released a report combining employee and employer responses. The results were enlightening—and a bit disappointing. (Many echo the findings of the first phase of the firm's research: 2007's *Towers Perrin Study on Account-Based Health Plans,* detailed in the August 2007 **CDH.**)

Enrollment in these plans (and in the attendant accounts) remains low; employers and employees alike seem to be missing what the plans can offer. For example, the report notes most participants don't yet see the account as a way to prepare for future healthcare costs.

The study finds an odd dichotomy. Employees in ABHPs want something different, but at the same time many remain hidebound in their thinking. "Relatively few ABHP participants are responding in ways that suggest they're looking beyond their prior experiences with traditional plans," the study states.

## Ah, the good old days

Many ABHP enrollees are less satisfied than their counterparts in traditional plans. In particular, they compare their ABHPs unfavorably to traditional plans. The catch is that these traditional plans are changing, too, so such comparisons are often inapt. (See "CDH helps contain healthcare costs, Mercer survey finds" in the January 2008 **CDH.**)

It's an over-romanticized perspective on traditional programs; in effect, it's a pining for the way things used to be, says **Jay Savan,** a principal at Towers Perrin in St. Louis. "The facts are that the cost-sharing and premium requirements of traditional plans, as illustrated by the *2008 Towers Perrin Health Care Cost Survey*, are changing in a manner that continues to shift cost and responsibility to participants," he says.

**Roy Ramthun,** president of HSA Consulting Services in Silver Spring, MD, says that the traditional plan, with its low premium, is not sustainable. "Apparently, people are not reading the studies suggesting that healthcare spending will double to $4 trillion within 10 years," he says.

Ramthun notes that the real option isn't between a traditional plan and a CDHP/ABHP; it's a CDHP/ABHP or nothing. "From the company's perspective, it might be the only plan they can afford. Otherwise, they might drop coverage entirely. Would people prefer that? We are certainly seeing that play out in the small business market—coverage continues to decline," he says.

And there's something else going on, says Savan: It's not just about satisfaction with a particular plan design, it's about satisfaction with healthcare coverage in general. Although there's higher dissatisfaction with CDHPs, there's plenty of discontent to go around. (See Figure 1 on p. 6.)

"These data are hardly an endorsement of the status quo, and they suggest people aren't making rational comparisons," says Savan. For example, the same networks generally apply to ABHPs and traditional plans, but participants score the plans differently when it comes to helping them find quality doctors and hospitals.

This is a common theme in other surveys. **Barb Flitsch,** a senior consultant at Watson Wyatt in Minneapolis, says that her firm's research finds that much of the dissatisfaction relates to higher out-of-pocket costs, which should not be surprising. Moreover, Watson Wyatt found

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## Best practices

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dissatisfaction with health coverage across the board, as did Towers Perrin.

Another reason why traditional plans are not an appropriate comparison is that they are fundamentally different. Traditional plans represent a term-insurance model, whereas ABHPs present an "equity-accumulating cash-value model," Savan explains.

But for all the differences, comparisons are inevitable, he says. Accordingly, it's important to help consumers understand the differences and take full advantage of the ABHP.

### Winning hearts and minds

The report suggests that focusing on hearts and minds, not merely on the mechanics of design and implementation, is the key to success.

"Plan design and vendor management are important, but it's also necessary to build a new mind-set around healthcare, with a broad commitment from both the organization and employees," the Towers Perrin report states.

Communication is, of course, crucial. "It's trite to say it because it's been established as an industry truism, but the best-designed plan isn't worth anything if people don't appreciate and understand it," says Savan. Ramthun, too, attributes some of the employee dissatisfaction with lack of education.

But the reverse is true, too: Education and communication won't help a poorly designed plan. And there is often both poor design and inadequate education, Savan says.

But through education, tools, and effective plan designs, employees can move from a renter mind-set to that of an owner, Savan says. They will "stop viewing their health coverage purchase as a series of transitory 12-month episodes and start viewing it as a durable investment in the most precious, longest-lasting economic asset they possess: their physical, mental, and emotional health."

Savan readily acknowledges that's easier said than done. "Changing behavior and attitudes isn't rocket science; it's much more difficult," he adds.

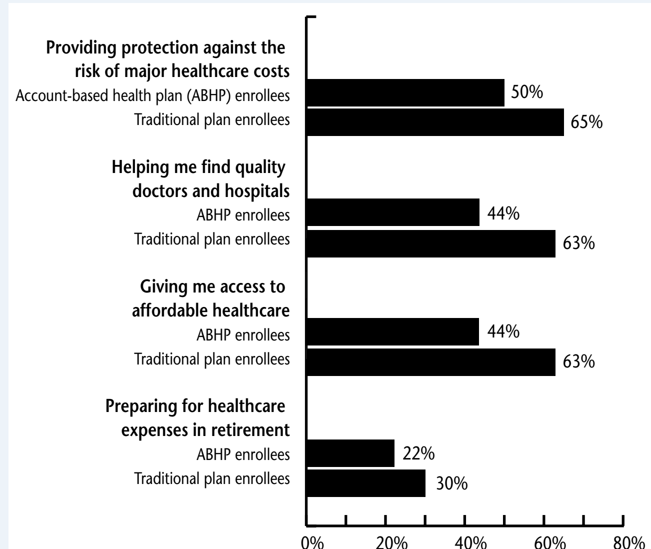
Employers can bring about change in one of three ways, he says. They can do things:

- **To employees** (this has been the approach over the past couple of decades, with cost-shifting and network constriction)
- **With employees** (e.g., offering wellness programs)
- **For employees** (e.g., providing tools that "enable thoughtful consumption" to help them financially prepare for future needs, including retirement)

Savan advocates the second and third options, combining thoughtful program design with progressively disclosed, transparent communication and education (in digestible portions, over time). But to do this, employers may need to better understand their workers, as the study reveals that

**Figure 1: Satisfaction with current health benefit program**

Percent responding "very satisfied" or "satisfied":




*Source:* Account-Based Health Plans: What Work—and Why, *Towers Perrin, 2008.*

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employers don't really understand what employees think about their health coverage. (See Figure 2 below.)

## Why it matters

High-performing companies[1], on average, have more than twice the voluntary enrollment in ABHPs than do low-performing companies (29% versus 12%), and they are more likely to report positive behavior change (89% versus 58%).

"The overall performance differential suggested by these key metrics indicates that, when designed, communicated, and executed effectively, ABHPs are a formidable tool in the quest for a healthier workforce and lower health care costs," the report concludes.

And yes, the companies are saving money. For the first time in more than a decade, high-performing companies are keeping healthcare-cost growth near the cost growth of the consumer price index.

## What high performers do that others don't

The report is teeming with best practices; one thread connecting the best practices is that managers drive change. The survey found that 73% of high-performing companies leverage support from managers and supervisors to drive healthcare changes, versus 50% of low-performing companies. "Support from the managers who directly influence employee attitudes and behavior every day can go a long way toward engaging employees in change."

The following is a look at several other practices outlined in the report that are associated with the top-performing employers. These employers:

- **Set clear, broad, and realistic objectives.** Objectives may vary by employer, but, generally, these top performers know what they want out of the ABHP. (Such planning indicates a firmer commitment to change, the study states.) And what about employers who haven't set objectives? "Without trying to be overly critical, the absence of objectives is inexcusable," says Savan.
- **Aren't driven by cost cutting.** Although ABHPs help employers cut costs, it's not a primary objective for top performers. "High performers realize that if they design programs that encourage and support good health, demonstrate a sincere interest in participant well-being, build a sense of shared responsibility, and reward positive behaviors, the almost-inevitable result is lower operating cost," says Savan.
- **Are involved in health management.** The survey found that 72% of high performers (compared to 33% of low performers) say their company plays a significant role in employee health management. High performers recognize the value of identifying health risks in the employee population, building programs to address those risks, and reaching out to engage employees in managing their health.
- **Understand the lay of the land.** This finding may tie back to setting objectives. High performers know what they are getting into when they launch an ABHP. They "are thorough and accurate in assessing the organizational climate—the appetite for change, the level of trust, and employee characteristics," the report

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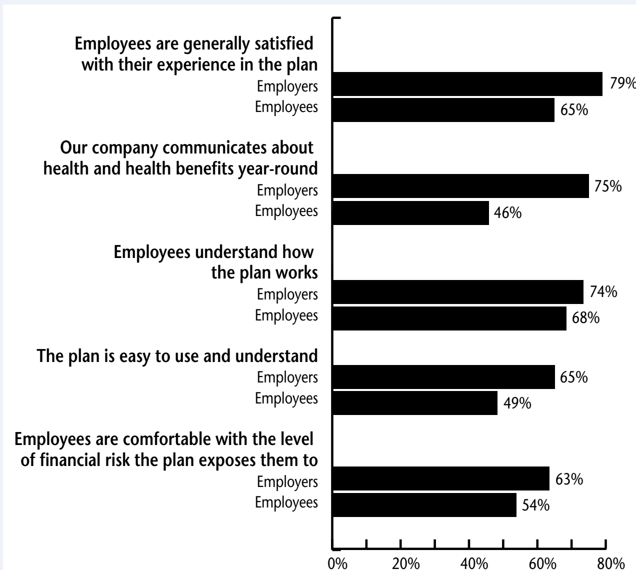
## Figure 2: Worker satisfaction with current benefit health plan

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## Best practices

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states. For example, they are more likely than low-performing companies (75% versus 45%) to try to understand the health risks in their employee population.

- **Recognize that ABHPs are different—and help employees recognize it, too.**
- **Educate and reinforce.** The survey found that 60% of high-performing companies provide year-round education, communication, and access to healthcare information (versus 39% of low-performing companies).
- **Help workers understand risk.** (See "Risky business: Overcoming anxiety" below for details.)
- **Know that vendor management matters.** High performers carefully select vendors, closely manage them, and regularly assess their performance.
- **Evaluate program effectiveness.** Whereas 84% of high-performing companies analyze data to manage their healthcare programs, only 34% of low-performing companies do. "By evaluating program effectiveness—rigorously and regularly—and using the results to build performance improvement plans—you can ef-

### Risky business: Overcoming anxiety

One of the most important—and complex—issues raised in a Towers Perrin's report, *Account-Based Health Plans: What Work—and Why,* relates to risk. Employees are anxious about the risk of account-based health plans (ABHP).

Asked about the statement "I am comfortable with the level of financial risk my health plan exposes me to," 54% of ABHP participants agree or strongly agree, compared to 76% of those in traditional plans.

It's a big difference reflecting a big concern. But, says **Jay Savan,** a principal at Towers Perrin in St. Louis, the concern is largely misplaced.

#### A primer in risk

Savan says that there are two types of risk presented in an insurance environment: overinsurance and underinsurance.

"When participants express anxiety over financial risk, we contend they are focused on the latter, to the exclusion of the former," he says. Insurance premiums essentially represent a fixed risk, whereas cost-sharing elements (e.g., deductibles, copays, and coinsurance) represent variable risk—risk that's incurred only when there's a claim.
So as cost-sharing elements such as deductibles and copays are reduced, premiums are increased.

Savan cites the 80/20 rule. "Applied to healthcare, this rule observes that, in any given year, 80% of claims are incurred by 20% of participants. Thus, 80% of the time, a participant will find himself in the majority of claimants who only incur 20% of all costs," he explains.

So, he says, one could argue that overinsurance (paying higher premiums than needed during the 80% of one's life when they are in the low-cost cohort) is a greater financial mistake than underinsurance. "That is, incurring excess fixed risk 80% of the time is worse than being exposed to larger-than-desired variable risk 20% of the time."

Moreover, with traditional term insurance, one can't leverage the 80% "good years" against the 20% "bad years."

That shifts in an ABHP environment. "We assume greater variable risk in order to accumulate during our lower-cost years such that we can offset the greater variable exposure in our higher-cost years."

This is a new concept to consumers, at least in terms of health insurance. But it's a concept employees and employers must grasp to truly appreciate ABHPs.

#### Why it matters

Once consumers understand and are comfortable with the risk, their satisfaction increases and they are more likely to behave like consumers. They are also more ready to take on greater healthcare cost and management responsibilities, the report says. "In fact, ensuring employees understand how to manage financial exposure seems to be the gateway to getting them to embrace the new responsibilities inherent in ABHPs," the report states.

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ficiently achieve optimal results without major disruptions or frequent program overhauls," the study says.

- **Provide tools.** Two-thirds of high-performing companies provide employees with support tools for decisions about providers and services (versus 35% of low-performing companies). Half offer financial modeling tools (versus 28% of low performers).
- **Monitor resources.** Top performers are more likely than poor performers to monitor employees' use of resources and tools to ensure they're achieving the desired effect (82% versus 54%).
- **Focus on health.** Although 65% of high-performing companies say they're committed to building and maintaining a culture of health, only 33% of low-performers do. Most (56%) high-performing companies communicate the benefits of enhanced health (versus 21% of low performers). About two-thirds of high-performing companies offer health improvement programs and access to condition-management assistance; less than half of low performers offer either. Moreover, 38% of high performers work with vendors to create customized care-management programs targeted to the specific needs of their employees.

The report states that not only do these best practices create a road map for other employers, they also provide a glimpse into the future.

"What leading companies are doing today, in fact, provides a picture of what success could look like over the next few years," the report states. ■

### Reference

1. "Performance," for purposes of the report, is defined by several factors, including reported per-employee costs; the extent to which the program manages employer and employee costs, enhances efficient purchasing of healthcare services, and enhances employee understanding and engagement; and employee satisfaction, attraction, and retention.

## More keys to CDHP success

Aetna, too, has come up with its own best practices, and, not surprisingly, they echo some of the themes of Towers Perrin's report, *Account-Based Health Plans: What Work—and Why.*

The Hartford, CT–based insurer recently released the results of a five-year study of healthcare claims and utilization for members of its Aetna HealthFund consumer-directed plans. The study of 1.6 million members (205,000 in an Aetna HealthFund plan) identifies the four keys to success that help employers succeed in implementing a consumer-directed benefits strategy.

1. Foster a culture of healthcare consumerism among all employees, beginning with senior executives
2. Implement a focused employee communication and education campaign
3. Offer wellness programs, incentives for healthy behaviors, and 100% coverage for preventive care
4. Carefully construct a benefits package that includes appropriate levels of member responsibility


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# Focus on changing behaviors, not attitudes, says expert

Many employers are taking a piecemeal approach to employee health; as a result, they are not driving the behavior necessary to reduce healthcare costs, notes **Randy Gebhardt,** president and chief operating officer of Columbus, OH–based Quantum Health. Moreover, he says, too much effort is spent trying to change attitudes when the focus should be on behaviors.

Gebhardt is calling for an integrated social architecture to support employee health. Health promotion can't be separate from plan design, and neither can it be separate from the culture of the workplace, he says.

In that context, CDHPs are an important part of the foundation, but they are not the entire structure, he says. CDHPs "are completely consistent" with an integrated approach to health and healthcare, but "none that I have seen creates an integrated system for managing health and care."

Gebhardt made his case in a presentation ("Accepting the Healthy Life: Guideline to Behavior Modification for Employees & Employers") at the Consumer Health World meeting in Washington, DC, in late 2007; he recently spoke with **CDH** about his presentation.

## Beyond changing attitudes

Gebhardt, who comes from the world of retail consulting, takes issue with the conventional wisdom that changing consumers' attitudes alters their behavior. In fact, he says, it's the other way around. "You have to change behavior and the attitudes will follow," he says. "Humans don't live as we think; we think as we live."

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It's a philosophy that dates back at least to William James, but Gebhardt arrives at it from his work in retail. "In retail, we don't even care if attitudes change; we want behavior to change."

Attitudes often don't parallel behavior, he says. "Consumer research very clearly and convincingly showed that Americans would never use automated teller machines," he adds. But consumers' behavior defied that attitude.

Likewise, consumer attitudes about health and wellness don't always translate into action. "The reality is, we all know what we're supposed to know," he says. But we don't make the necessary changes to transform knowledge into practice.

## A job for the employer

The first step, Gebhardt says, is to create "a social architecture" that encompasses benefit design, workplace culture, and wellness initiatives. And that architecture begins with the employer-based health plan.

That seems to be where consumers want to start, too, according to Gallup research presented during the same session. (The findings were drawn from a survey of 37,000 Americans that addressed health- and weight-related issues.)

Most Americans are in favor of strong interventions within the school. But beyond that, there isn't a consensus, says **Kevin McConville,** regional managing partner at The Gallup Organization in Washington, DC.

Consumers are more open to and have higher expectations of employer-based initiatives than other approaches. Seventy percent of those surveyed indicated that they thought providing discounts on insurance premiums for those who are healthy (the term wasn't defined) and not obese would be an effective strategy. (See Figure 3 on p. 11.)

Other options, ranging from tax credits related to body mass index to employer-subsidized health club memberships, didn't fare as well, McConville says.

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Thus, for employers and others seeking to drive behavior change, the Gallup research seems to support Gebhardt's contention that the employer-based health plan is a good place to start. (Gebhardt notes, however, such consumer attitudes are "directional" and not an absolute predictor of behavior.)

## Building a better framework

The employer-based health plan is the framework, Gebhardt says. It supports the social architecture of a healthy workplace. Gebhardt identifies several crucial elements of this structure, including the following:

> *continued on p. 12*

## Figure 3: Attitudes about the effectiveness of giving premium discounts for being healthy and not obese

| | | Total | Gender | | Age | | | Generation | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | Male | Female | 18–39 | 40–54 | 55+ | Gen Y | Gen X | Baby Boomers | Traditionalists |
| Total | Unweighted (n) | 37775 | 16632 | 21045 | 5210 | 11255 | 21310 | 2051 | 4758 | 17143 | 13823 |
| | Weighted (n) | 37775 | 16632 | 21045 | 5210 | 11255 | 21310 | 2051 | 4758 | 17143 | 13823 |
| | Mean | 2.94 | 2.92 | 2.96 | 2.99 | 2.97 | 2.91 | 2.98 | 3.00 | 2.97 | 2.88 |
| | Std Dev | 0.94 | 0.93 | 0.95 | 0.96 | 0.94 | 0.94 | 0.96 | 0.95 | 0.93 | 0.95 |
| **1** Not at all effective | | 3751 | 1651 | 2092 | 506 | 1038 | 2207 | 207 | 438 | 1550 | 1556 |
| | | 9.9% | 9.9% | 9.9% | 9.7% | 9.2% | 10.4% | 10.1% | 9.2% | 9.0% | 11.3% |
| **2** Not too effective | | 6755 | 3000 | 3738 | 889 | 1976 | 3890 | 348 | 827 | 3044 | 2536 |
| | | 17.9% | 18.0% | 17.8% | 17.1% | 17.6% | 18.3% | 17.0% | 17.4% | 17.8% | 18.3% |
| **3** Fairly effective | | 15216 | 7035 | 8144 | 1962 | 4475 | 8779 | 771 | 1792 | 6925 | 5728 |
| | | 40.3% | 42.3% | 38.7% | 37.7% | 39.8% | 41.2% | 37.6% | 37.7% | 40.4% | 41.4% |
| **4** Extremely effective | | 12053 | 4946 | 7071 | 1853 | 3766 | 6434 | 725 | 1701 | 5624 | 4003 |
| | | 31.9% | 29.7% | 33.6% | 35.6% | 33.5% | 30.2% | 35.3% | 35.8% | 32.8% | 29.0% |

| | | Children in Household | | Marital Status | | Income | | |
|---|---|---|---|---|---|---|---|---|
| | | Have kids | No kids | Married | Not married | < $35K | < $35K – < $75K | $75K+ |
| Total | Unweighted (n) | 6645 | 31130 | 25870 | 7159 | 7035 | 13464 | 17264 |
| | Weighted (n) | 6645 | 31130 | 25870 | 7159 | 7035 | 13464 | 17264 |
| | Mean | 2.98 | 2.93 | 2.96 | 2.91 | 2.82 | 2.94 | 2.99 |
| | Std Dev | 0.93 | 0.95 | 0.94 | 0.97 | 0.99 | 0.94 | 0.92 |
| **1** Not at all effective | | 588 | 3163 | 2455 | 780 | 948 | 1313 | 1487 |
| | | 8.8% | 10.2% | 9.5% | 10.9% | 13.5% | 9.8% | 8.6% |
| **2** Not too effective | | 1198 | 5557 | 4808 | 1362 | 1366 | 2460 | 2926 |
| | | 18.0% | 17.9% | 17.4% | 19.0% | 19.4% | 18.3% | 16.9% |
| **3** Fairly effective | | 2608 | 12608 | 10565 | 2761 | 2738 | 5415 | 7060 |
| | | 39.2% | 40.5% | 40.8% | 38.6% | 38.9% | 40.2% | 40.9% |
| **4** Extremely effective | | 2251 | 9802 | 8342 | 2256 | 1983 | 4276 | 5791 |
| | | 33.9% | 31.5% | 32.2% | 31.5% | 28.2% | 31.8% | 33.5% |

*Source: Prepared for* Consumer-Driven Healthcare *by The Gallup Organization.*

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## Changing behaviors

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- **The primary care physician.** If the plan is the framework, the primary care physician (PCP) is the foundation. If you want to ensure prevention, increase awareness of risk factors, and drive participation in appropriate disease management programs, make sure each employee has a PCP. Those with a PCP have 33% lower costs than those without one, he says, citing *The Journal of Family Practice* (1998; 47:103–104, 105–109). Employers wanting to drive change can provide incentives for having a PCP. In fact, Gebhardt notes that some integrated health management plans require employees to have a PCP in order to be eligible for an enhanced benefit level.
- **Wellness and disease management.** Likewise, wellness and disease management must be fully integrated to reinforce this structure. "Most wellness programs are ineffective because they are stand-alone, piecemeal efforts," he says. Wellness must be part of an overall strategy of integrated health and care. And that overall strategy requires something more than a consumer-driven revolution. The strategy demands a fundamental transformation in employer-based healthcare. (For more information about care coordination, see the November 2007 **CDH.**)
- **Coverage.** Sometimes, the plan design provides obstacles to change. For example, Gebhardt has worked with employers whose plans made it cheaper for the employee to go to the ER than to visit a PCP. That's an extreme example, but it illustrates how employers and employer-based plans may erect barriers to healthy behaviors.
- **Corporate culture.** Do vending machines, cafeteria options, and snacks at meetings promote or undermine wellness efforts? If your workplace has a smoking area, "you are structurally and culturally saying that it's okay to smoke," says Gebhardt.

### Cementing with education

Education and support have their roles: They are the grout that holds the bricks together. The first goal is to incite behavior change. Once that's accomplished, education is critical. "Information and education regarding health should be continuous and ongoing features of health plans," says Gebhardt. "They set the scene for behavior change and reinforce new behaviors as they become habitual."

Although information and education cannot drive behavior by themselves, they can cement new patterns. "Psychologists say that people look for ways to rationalize their behavior as being reasonable, and such information can help reinforce their new behaviors," Gebhardt notes. And that's where outreach and education come in.

He offers an example of how this could work: The employer could send out an e-mail (or other communication) that reads, "Congratulations, you have taken an important first step by (name a behavior). You should know that (give new information about the positive health benefits of the new behavior)."

### Pulling it together

Employers who want a coordinated approach to changing behavior must first have a plan. The first step is to get all the vendors together in one place, outline expectations, and then issue a "requirements document," Gebhardt explains. The document would stipulate that in order to keep the business at the next renewal, everyone needs to work together. Currently, there's more talk than action relative to integration, he says.

"Integration is sometimes diluted to mean integrating wellness and disease management activities, rather than truly integrating all elements of the benefits plan into a true healthcare program," Gebhardt adds. The onus rests on employers to drive insurers and vendors to implement this stronger framework. "The bottom-line message for employers is that until you get true integration of health promotion and care management, you are moving around the deck furniture on the Titanic." ■

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