The Health Care Benefit Crisis, Ten Years Later: Part I

by Eric M. Parmenter, CLU, ChFC, LUTCF, REBC, RHU, CEBS, SPHR, MBA

ABSTRACT

More than 10 years have passed since "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions" appeared in the July 2004 issue of the *Journal of Financial Service Professionals* [Parmenter, *Journal of Financial Service Professionals* 58, No. 4 (2004): 63-78]. Part 1 of this two-part analysis reviews the cost patterns over the past decade and demonstrates that the same cost drivers persist but have taken on new dimensions. Part 2 outlines strategic solutions to improve health and lower health care costs in the next decade.

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Introduction

More than 10 years have passed since "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions" appeared in the July 2004 issue of the *Journal of Financial Service Professionals*.[1] What is the current state of the crisis? Did the crisis diminish or worsen? What happened to health care costs and health care benefit costs over the past 10 years? What were the drivers of costs over the past 10 years and were they different from the ones cited in 2004? While this material is lengthy and cites sources that are readily available in the public domain, this article serves as a history of the past 10 years of health benefit costs and the driving forces behind those costs, and pulls together the sources that illustrate this history in one document.

Part 2 explores which elements of this history constitute long-term trends and identifies new trends that are influencing whether or how employers will continue to provide employee health benefits in the future and strategic solutions that hold the most promise for the overall health and efficiency of the American health care system for the next decade.

This material is important for financial advisors to understand as the health care landscape impacts all aspects of financial well-being, whether retirement planning, planning for long-term care needs, planning for special needs of dependent children, or providing direct employee benefit advice.

What Is the Current State of the Crisis?

The crisis has worsened. Employers continue to wrestle with the high and ever-increasing cost of employer-sponsored health benefits covering about 149 million people.[2] As a new era of health care unfolds with the implementation of the Affordable Care Act (ACA)[3] (health care reform legislation passed by Congress and signed into law by President Obama in March of 2010, and largely upheld by the Supreme Court in a decision announced in June of 2012), employers are asking new questions about whether and how they continue to provide competitive health care benefits as a key component to a total rewards compensation package for employees.

The following analysis illustrates that not only is the crisis affecting employers, and by extension the financial services, employee benefit, and health care industries, but the nation as a whole. The overall and worsening poor health of our nation, inadequate performance of the health care system (or sick care nonsystem), including disparities in the practice of health care, the impact of health care reform, and the bite health care costs continue to take out of the slow-growing U.S. economy, constitute a national health care crisis.

The Sluggish Economy

A growing share of the national economy is consumed by the cost of health care, measured by the total money spent in the U.S. on health care, called Health Care Expenditures (HCE), compared to the total money spent in the U.S. on all goods and services, called the Gross Domestic Product (GDP).

According to the U.S. National Bureau of Economic Research (the official arbiter of U.S. recessions) the U.S. recession began in December 2007 and ended in June 2009, and thus extended over 18 months. Since the end of the recession, however, the economic recovery has been "nasty, brutish and long."[4] After almost 5 years, the recovery is proving to be one of the most lackluster in modern times. The nation's 6.7 percent unemployment rate is the highest on record at this stage of recent expansions. GDP has grown 1.8 percent a year on average since the recession, half the pace of the previous three expansions.[5]

The Center for Medicare and Medicaid Services (CMS) Office of the Actuary released in September of 2014 estimates for HCEs and concluded that overall health care spending will stay at 17.2 percent of the national economy for the second straight year.[6] However, the CMS Actuary is expecting health spending to grow 5.6 percent in 2014, partly because of the ACA coverage expansion to previously uninsured individuals, as well as the law's more generous coverage requirements. The Actuary is expecting the growth in health spending in 2015 to slow down to 4.9 percent, mostly due to payment reductions in Medicare Advantage and Medicaid, and then pick up again, growing a projected 6.1 percent per year between 2016 and 2023.[7] Health care costs have taken and are expected to take a growing bite out of the U.S. economy; costs were 15.3 percent in 2004,[8] 17.2 percent in 2014, and are expected to grow to 19.3 percent by 2022, to an annual spend of $5.2 trillion.[9]

Some health care economists foresee a potential parallel pattern in health care costs between the early 1990s and now, with a significant speeding up of health care costs later in this decade. A steep increase in costs occurred in the late 1990s after the slowdown in the early 1990s.[10]

What Has Happened to Health Care Costs over the Past 10 Years?

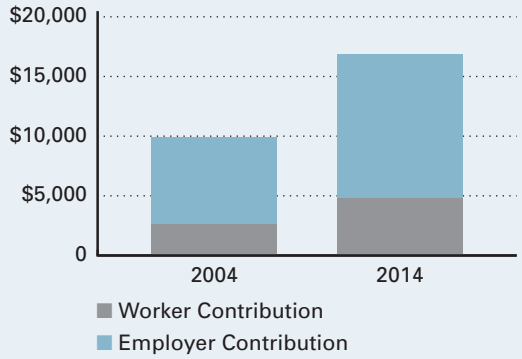
Hand-in-hand with the macrotrend of rising health care costs, health benefit costs have increased by over 60 percent in the past 10 years.[11] The following drill-down into employer-sponsored health benefit cost data shows the progression of increased costs. Various sources of data are used that tell a consistent story on the issue of cost, including data from the National Business Group on Health/Towers Watson, Aon/Hewitt, and the Henry J. Kaiser Family Foun-

dation. While the numbers may differ slightly from one source to the next, primarily due to minor differences in methodology, the story is consistent.

The 60-plus percent increase in costs noted above (between 2004 and 2014) is based on premiums, or premium-equivalent rates for self-funded plans (81 percent of plans with more than 200 employees are self-funded partially or completely),[12] which represents an increase in premiums for single coverage from $3,695 to $6,025 (63 percent increase) and family premiums from $9,950 to $16,834 (69 percent increase), shown in Figures 1 and 2.[13] When single and family premiums are blended together, the 2014 average annual cost per employee, per year hit $11,176.[14]

Between 2004 and 2014, these increases in health benefit costs have occurred incrementally each year ranging from 4.4 percent to 10.6 percent, the net increase after the employer made plan design changes. Figure 3 shows the annual rates of increase for employer-sponsored health benefit plans from 1999 to 2004, without a single year with a lower increase than 7.5 percent; the rate then continues through 2014 with no increase greater than 8.5 percent.

FIGURE 1
Average Annual Health Insurance Premiums and Contributions for Family Coverage, 2004 to 2014

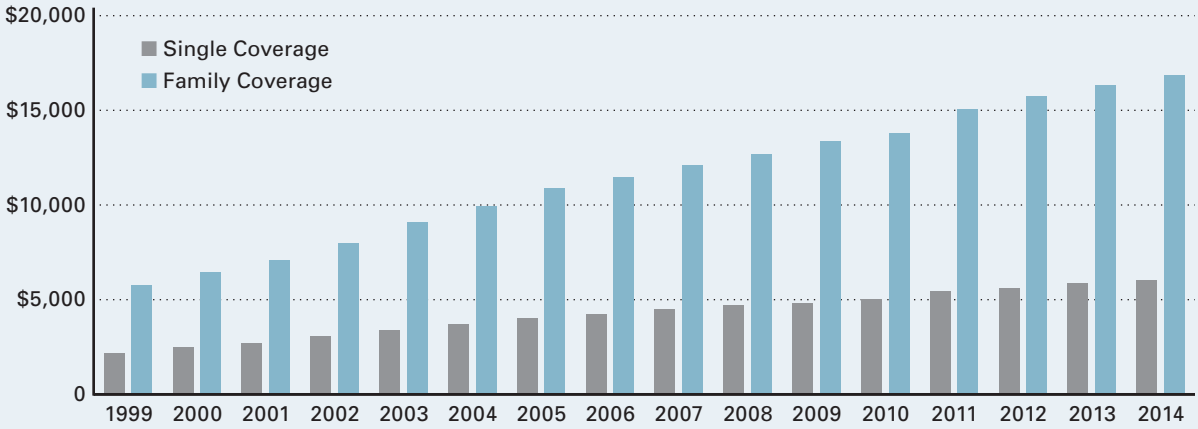


Source: The Henry J. Kaiser Family Foundation, "2014 Employer Health Benefits Survey," September 10, 2014; used with permission.

Figure 3 also shows the rate of increase before plan design changes beginning in 2007.[15]

The 2004 health benefit crisis article being updated here was written at a time following 4 straight

FIGURE 2
Average Health Benefit Cost in Single and Family Premium, 1999 to 2014

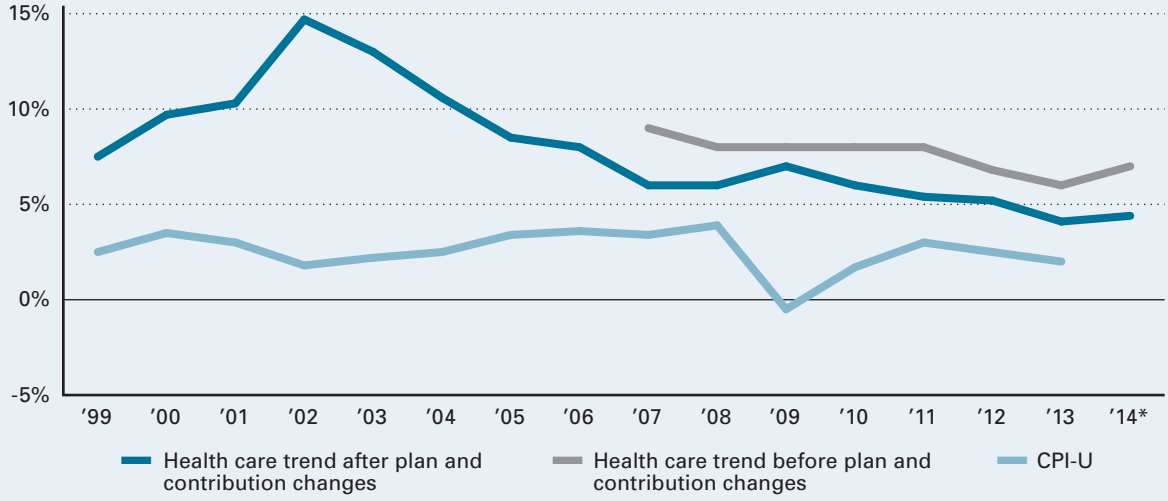


Source: The Henry J. Kaiser Family Foundation, "2014 Employer Health Benefits Survey," September 10, 2014; used with permission.

years of double-digit increases in health benefit cost with no end in sight at that time. Historically, the rate of increase continues to be greater than four times the rate of general inflation, as measured by the Consumer Price Index–Urban (CPI-U).[16] There is broad agreement among financial service and health care professionals alike that the rate of increase has not softened enough to provide real relief. These professionals, including the CMS Actuary, fear the rate of increase will rise again to over 6 percent and continue to rise faster than general inflation.[17] Finally, there is wide agreement these expected increases are unsustainable.[18] Having said that, as noted above, the recent slowdown in health spending occurred during unusual times, which included nearly a decade of slow economic growth with low inflation, a major health care reform law accompanied by much confusion and fear, and a huge increase in national budget deficits.[19]

While the actual rate of increase in costs of health benefits has slowed overall, it has increased in some markets (e.g., Orange County, Los Angeles, San Francisco, Philadelphia) due in part to the disparities of underlying cost and quality by region but also due to the influence of the dominant payers and providers in certain markets, where the jockeying for respective market share is intense.[20] Because these rates of increase are on a baseline of over $10,000, the cost increase in many markets is over $1,000 per employee, per year, on average.[21]

FIGURE 3
Annual Rates of Increase in Health Plan Benefit Costs



Notes: Median trends for medical and drug claims for active employees. CPI-U extracted from the Department of Labor, Bureau of Labor Statistics.

A company's medical and pharmacy benefit expenses for insured plans include the medical and pharmacy premiums paid by the company. For self-insured plans, this includes all medical and pharmacy claims paid by the plan, company contributions to medical accounts (FSA/HRA/HSA), and costs of administration. For administration costs, these include claim-processing fees, network access fees, utilization review fees, stop loss premiums, and any health management program costs and program participation incentives paid by the plan. This includes any carve-out plans for prescription drugs and mental health, but excludes costs for dental benefits and employee point-of-care (or out-of-pocket) costs for medical and pharmacy plans.

* Expected

Source: "The 2014 Towers Watson/NBGH Employer Survey on Purchasing Value in Health Care," Towers Watson, 2014. Used with permission.

What Were the Drivers of Cost over the Past Ten Years?

Table 1 lists the cost drivers that were cited in the 2004 health benefit crisis article as significant reasons for the cost increases leading up to 2004, followed by a narrative section with discussion and analysis regarding the current relevancy or modifications to those drivers. Most of the cost drivers described leading up to 2004 continued to have a relevant impact on the cost of health care benefits and many took on new dynamics and dimensions.

Population Aging

In 2011, the first of the baby boom generation reached what used to be known as retirement age, 65. For 18 years to follow, baby boomers have turned and will continue to turn 65 at a rate of about 8,000 a day, with many losing eligibility for employer-sponsored plans and shifting to government and private insurance plans for health care benefits. Many baby boomers will continue to work in various ways, through extended or new careers, or as self-employed individuals or entrepreneurs, and will live longer.

By the middle of this century, American life expectancy at birth will be 88 years. By the end of the century, it will be 100 years.[22] Because of increased life expectancy and the baby boomers aging, centenarians may become the norm.[23] Improving longevity is one of the goals of the health care system as is eliminating disease and improving the quality of life. The cost of retiree health care benefits and long-term care insurance, for in-home care or long-term care facilities, is enormous and compounds the health care cost crisis discussed herein, but is outside the scope of this article. If people live longer without more progress at preventing and reducing disease, the detrimental impacts of disease and health care costs, which grow as people age, will continue to escalate. Securing adequate health care protection remains a primary goal for many Americans but coverage is more costly than in years past.

TABLE 1
2004 Cost Drivers and Current Relevancy

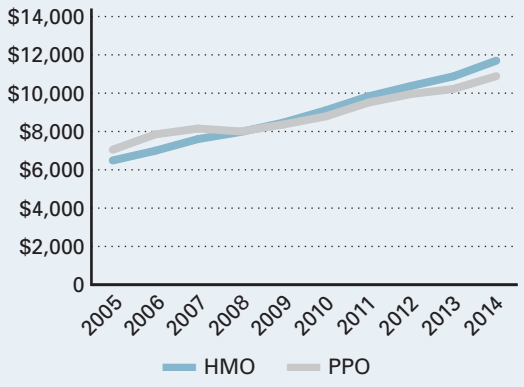
Original Health Cost Drivers	Current Relevancy and Modifications
Population Aging	• Continues • Greater impact today and accelerating
Technology	• Continued significance – perhaps greater
Managed Care Saturation	• HMO managed care receded • Re-emergence under "narrow network" options
Direct-to-consumer Rx Marketing	• Still prevalent, though impact moderated due to emergence of generics • Emerging threats in specialty drugs and biologics
Insurance Consolidation and Profit Taking	• Receding due to fewer consolidation options • Profit-taking being offset by health care reform regulations • New threats to carriers from exchanges – private and public
Legislation	• Significant due to the ACA
Litigation	• Malpractice claims are down and defensive medicine continues
Uninsured	• Increased during recession but reducing due to ACA but remains an issue
Poor Health	• Continues and has worsened • Higher priority and new focus • Expansion of focus to include well-being in addition to chronic and acute disease but results of wellness and medical management programs have been mixed

Technology

Medical technology continues to advance in many beneficial ways even though overuse of common and less effective technology persists. Examples include:

- Development of new treatments for previously untreatable terminal conditions, including long-term maintenance therapy for treatment of such diseases as diabetes, end-stage renal disease, AIDS, and Hepatitis C, for which the medication Sovaldi has a cure rate of over 90 percent but costs over $84,000 for a complete treatment;[24] major advances in clinical ability to treat previously untreatable acute conditions, such as advances in treating cancer;
- Development of new procedures for discovering and treating secondary diseases within a disease, such as new molecular-based technologies to make early diagnoses and develop new targeted and "personalized" treatments;
- Expansion of the indications for a treatment over time, increasing the patient population to which the treatment is applied;
- Ongoing, incremental improvements in existing capabilities, which may improve quality, like proton beam accelerators, a very expensive technology that targets tumors;
- Clinical progress, through major advances or by the cumulative effect of incremental improvements, that extends the scope of medicine to conditions once regarded as beyond its boundaries, such as mental illness and substance abuse.[25]

FIGURE 4
HMO vs. PPO Annual Cost per Person, per Year



Sources: "Kaiser/HRET Survey of Employer-Sponsored Health Benefits," The Henry J. Kaiser Family Foundation (September 10, 2014), used with permission; Hewitt Health Value Initiative 2005-2014.

While technology holds promise to improve health and lower the overall cost of health care, the cost of technology continues to make up a significant portion of health care costs. While it is not possible to directly measure the impact of new medical technology on total health care spending, innovation in the health care sector occurs continuously, contributing to the size of the sector (17.2 percent of GDP in 2014) and its diversity (thousands of procedures, products, and interventions). Economists have used indirect approaches to try to estimate the impact of new technology on the cost of health care. In an often-cited article,[26] Newhouse evaluates the impact of medical technology on health care spending by first estimating the impact of factors that can reasonably be accounted for, such as the spread of insurance, increasing per capita income, aging of the population, supplier-induced demand, and low medical sector productivity gains. Then, he concludes that the factors account for well under half of the growth in real medical spending, and the bulk of the unexplained residual increase should be attributed to technological change—what he calls "the enhanced capabilities of medicine."[27]

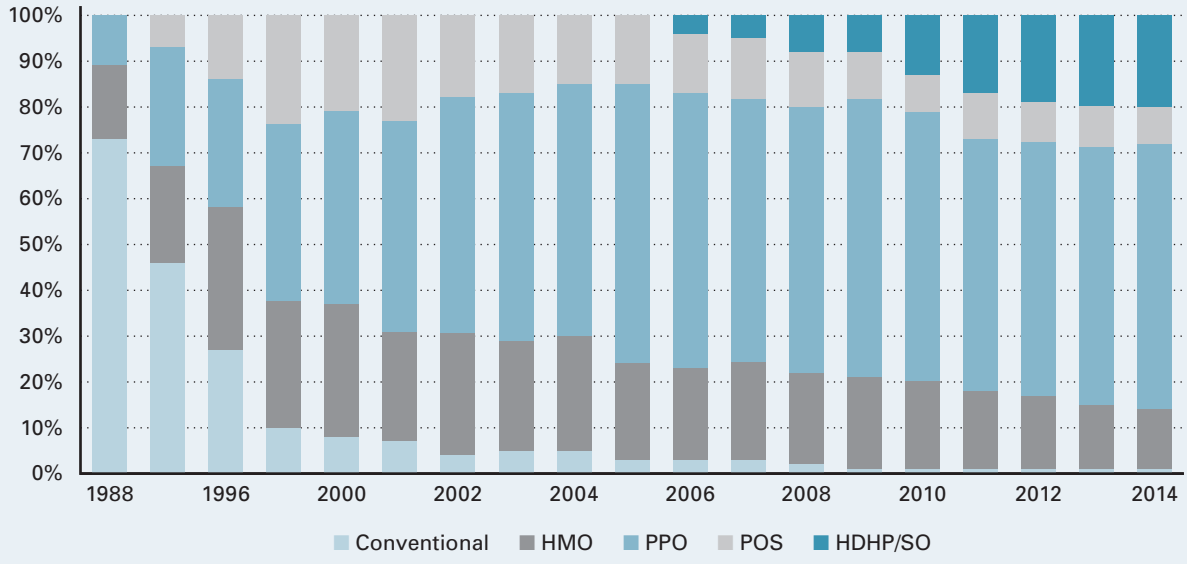
In addition to medical technology, information technology (IT) in the form of electronic medical records (EMRs), health care information exchanges, data warehouses, and many other electronic portals, storage, and analytics platforms have grown in adoption. This is largely due to legislation that provides incentives to providers to achieve meaningful use of medical data. While these investments expect to generate savings in the long term, the cost and interoperability concerns in the short term are high.

Managed Care Saturation

Heavily managed care, most prevalent in Health Maintenance Organization (HMO) plans, has saturated the market and has lost ground to more open-panel plans such as Preferred Provider Organization (PPO) plans.[28] HMOs are slightly more expensive now than PPOs (Figure 4). This dynamic could be due to a variety of reasons, including demographic selection where lower-wage earners or those with more health care needs prefer HMOs because of lower copayments and out-of-pocket costs, misaligned incentives between members and providers to improve health, and local market share dominance. Also, saturation could be due to some consumerism effects of participants in PPOs. Because PPOs typically have higher deductibles, coinsurance, and out-of-pocket cost, participants are more careful about how they use the plan, which lowers the cost of the plan over time, and they often attract a younger, healthier population.

In addition, the enrollment in HMO plans has shrunk from 25 percent in 2004 to 13 percent by 2014 (Figure 5). Enrollment in Point-of-Service (POS) plans, a hybrid form of HMO, has shrunk as well from 15 percent to 8 percent. The enrollment in PPO plans has increased slightly between 2004 and 2014, 55 percent to 58 percent. The popularity of account-based health plans (ABHPs), Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs) savings options, has grown significantly with employers; 73 percent of employers offered them in 2014 with expected growth in popularity to 82 percent by 2015.[29] The term account-based plans is an umbrella term for the type of plan that generally features two types of accompany-

FIGURE 5
Distribution of Health Plan Enrollment by Plan Type, 1988-2014



NOTE: Conventional is a traditional Indemnity plan. HDHP/SO is a High-Deductible Health Plan with a Savings Option. Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

Source: The Henry J. Kaiser Family Foundation, "2014 Employer Health Benefits Survey," September 10, 2014.

ing savings or spending accounts, HSAs and HRAs. ABHPs are also called consumer-driven health plans (CDHPs). These plans, while popular with employers due to lower cost, are much less popular with employees due to higher out-of-pocket risk. Enrollment grew to 20 percent in 2014 from virtually 0 percent in 2004, the year legislation was passed that created High-Deductible Health Plans (HDHPs) and HSAs.

The savings offered by ABHPs or CDHPs has been found to be modest when adjustments are made for typical risk and benefit factors.[30] CDHPs deliver cost savings that are modestly better than non-CDHPs. Specifically, these plans produce 1.5 percent in savings beyond non-CDHPs. This contrasts with the more dramatic savings CDHPs appear to bring if certain adjustments are not taken into account. Adjustments include selection bias. For instance, healthier people are choosing CDHPs while others are less likely to migrate from old plans. A deeper analysis of the plan design is outside of the scope of this discussion.

Managed care saturation continued after 2004 but new network dynamics have emerged in managed care through narrow networks. Narrow networks take on two primary forms. The first form cuts out the most expensive providers, often Academic Medical Centers (AMCs), offering fewer providers but at lower reimbursement rates. This type of narrow network has two primary problems. First, it continues to use payment systems to providers that are based on fee-for-service (FFS) provider reimbursement, which is now widely considered one of the most significant drivers of increased health care cost. FFS essentially rewards providers for volume because it is a piece-rate type of compensation: perform a task, get paid; perform two tasks, get paid twice as much; etc. The more office visits, tests, and procedures a provider delivers, the more compensation is paid, leading to increased overall cost. Second, by eliminating AMCs, some of the most advanced providers are either not covered or covered at a lower benefit rate, which drives some patients out-of-network to seek or continue treatment from well-known specialists, driving up the cost to the participant and society. AMCs that are integrated often have more consistent adherence to evidence-based standards which can lower the total cost of care, even though the fees for hospitals and physicians may be higher.

The second type of narrow network, however, is based on value-based care, which compensates providers through bundled payments, risk or gain-sharing, or other methods based more on coordination of care and quality outcomes than on volume. These networks are often called clinically integrated networks (CINs) or high-performing networks, and are encouraged under the ACA through various provisions, such as the creation of the Medicare Shared Savings Program, which created a formal Medicare Shared Savings Accountable Care Organization (ACO), with features such as readmission penalties, bundled payments, withholds, and bonuses for hitting cost-savings targets. The ACA is also transforming the way hospitals and health systems deliver care, by shifting the way providers get paid from volume to value-based care.[31] Many AMCs sponsor or participate in CINs, which offer cost savings opportunities along with the most advanced care.

Direct-to-Consumer Drug Marketing

While direct-to-consumer drug marketing continues, other factors have pushed drug prices higher, such as a plethora of new brand-name drugs including highly specialized and expensive drugs. Table 2 compares some of the major differences in prescription benefit trends between 2004 and 2014.

Insurance Consolidation and Profit Taking

The megamergers in the Prescription Benefit Manager (PBM) corner of the health insurance industry are good examples of continued consolidation in the health care industry. Moreover, mergers and acquisitions have continued among payers, or health insurance carriers, which includes companies who manage individual and group fully-insured plans, Medicare Advantage plans, and self-funded Admin-

TABLE 2
Pharmacy Changes in the Last Decade

2004	2014
INDUSTRY TRENDS	
Marketing and advertising drive utilization	Consumerism and instant gratification are the norm (marketing was/is successful)
Drug trend driven by multiple brand products and overall increasing utilization (specialty drugs < 5% of drugs spend)	Drug trend largely driven by specialty medications. 1-2% of the population drives 30+% of spend
Brand drugs race to be first in a new class, compete against other Brands	Specialty products are developed for rare and often untreated conditions and now more common conditions such as high cholesterol, cancer, and autoimmune disease
Brand drugs met with some generic alternatives	Brand drugs face multiple generic competitors: Specialty drugs face little to no generic competition (biosimilars have not yet arrived)
Expensive defined as a few hundred dollars per month	Expensive defined as tens of thousands of dollars per month, or more
Pharmaceutical gifts abound	Sunshine Act requires disclosure of gifts, physician practices locking out drug samples
Multiple blockbuster drugs near patent expiration – "generic cliff" looming	Near the bottom of the generic cliff; Generic Dispensing Rate (GDR) likely to decrease just slightly, then stabilize. Years of low trend nearing an end.
Over-the-Counter (OTC) drugs cough/cold focused, smaller market, Big Pharma experiments with prescription antihistamine launch into OTC space	Big Pharma has huge launches into OTC space before patent expiration, multiple anti-ulcer medications known as proton pump inhibitors
Niche Pharmacy Benefit Managers (PBMs) can thrive in a growing market	PBM consolidation, with megamergers
Pharmacy chain store growth and consolidation	Big Pharmacy chains diversifying business; pharmacists now vaccinate. Pharmacies provide urgent care services in store. Some pharmacies offer infusion services as well.
BENEFIT DESIGNS	
Two-tier open formularies common, some 3-tier designs	3-, 4-, 5- tiered formularies, open and closed exist, along with new specialty tiers, and even preferred specialty tiers
Reward for treating the condition	Rewards for compliance and adherence such as value-based designs that waive or lower copays for maintenance medications as well as the mandate to cover preventative care which can include certain drugs
Reward for using less expensive medications	Rewards for clinical outcomes
Broad pharmacy networks common	Narrower becoming in favor, consolidation of chains, and fewer independent pharmacies. Tiering of retail pharmacy chains occurs from a benefit perspective.
Relatively open access to providers	Site of service steering to less costly providers including pharmacists, urgent care centers, and infusion clinics
Pharmacy seen as an "add on" benefit	Pharmacy understood to be an integral part of, and major influencer of total medical expense
Pharmacy benefit = drugs acquired at retail pharmacies	Pharmacy benefit = expands into injectibles and infusables. Lines blur between pharmacy and medical benefits, especially as they pertain to specialty

istrative Services Only (ASO) plans. Enrollment in plans managed by the four largest payers, combining all Blue Cross Blue Shield plans, has grown by 114 percent from 2003 to 2013. Figure 6 illustrates how the largest payers have grown while the smaller payers have lost market share or have disappeared altogether.

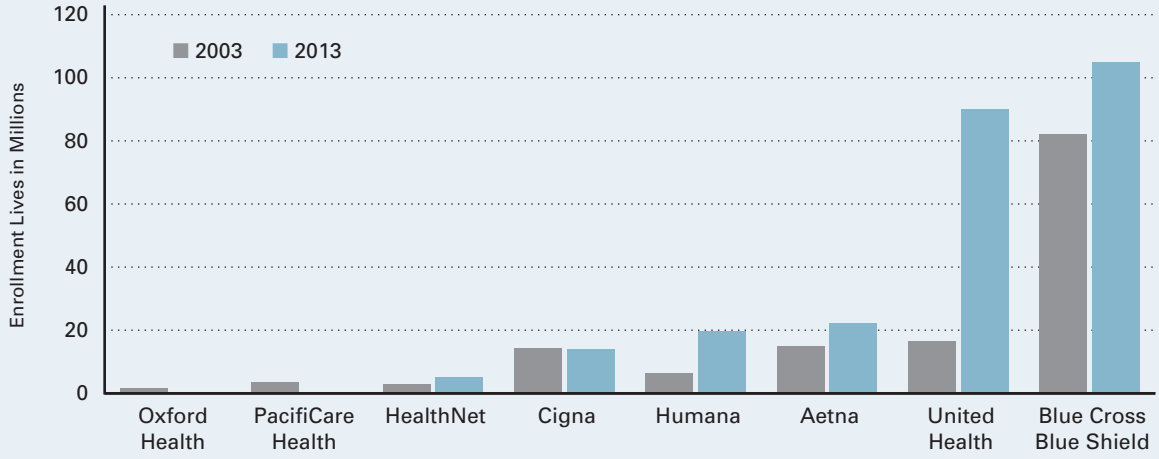
Many smaller plans have been acquired by larger plans, including Oxford and parts of PacifiCare by United and Coventry by Aetna. Among the leading health plans in the United States, net income (also referred to as profit) of the top five health insurer stocks was up 30-55 percent over 2013, much better than the broad stock market during 2013. Net income (profits) for United was $7 billion, $2.4 billion for WellPoint, $2.1 billion for Aetna, $1.7 billion for Humana, and $1.9 billion for Cigna for the year ending December 31, 2013.[32] A review of the stock prices from the beginning of 2005 to October 24, 2014 for United, WellPoint, Aetna, Humana, and Cigna shows a steadily increasing stock price for each publically traded payer over the past 10 years, with a dip around the time of the passage of the ACA.[33]

Health Care Provider Consolidation

Finally, not only has the health insurance industry consolidated, but the health care provider industry has as well. Mergers and acquisitions in 2013 among some of the largest for-profit and not-for-profit health systems created hospital systems that rival some Fortune 500 companies. Regional systems acquired nearby hospitals to strengthen their position as local players. Over 67,000 physicians were added as employees of health systems in 2013.[34]

HCA is the largest U.S. health system by revenue and is based in Nashville. The for-profit system owns 165 hospitals and ended 2013 with net patient revenue of $38 billion. Ascension Health is based in St. Louis and is the second largest system. The not-for-profit system acquired regional health systems in Kansas, Oklahoma, and Wisconsin, adding nearly $4 billion in revenue for a total of $15.3 billion and 32 hospitals, bringing its total hospitals owned up to 102. The third largest health system, for-profit, Nashville-based Community Health Systems ended 2013 with 135

FIGURE 6
Payer Consolidation/Plan Enrollment, 2003 to 2013*



*The author assembled the data on payer consolidation from independent research, relying primarily on 2013 Annual Financial Reports from each carrier's Web site. The author does not attest to the accuracy of the data. Blue Cross Blue Shield data combine all plans including, for 2010, WellPoint, Inc. HCSC, Highmark, and Blue Shield of CA. United Health 2010 data include acquisition of Oxford Health, PacifiCare, and part of Health Net among others. Aetna 2010 data include acquisition of Coventry. (October 2014).

hospitals and revenue of close to $13 billion. Trinity Health and Novi Catholic Health East merged to create not-for-profit CHE Trinity Health with more than $12 billion in operating revenue in 2013, making it the fourth-largest system with 63 hospitals.[35]

It is unclear in the short run whether provider consolidation leads to lower or higher cost. Certain economies of scale can be achieved through consolidation for shared services such as EMRs, executive leadership, legal, finance, billing, etc. On the other hand, consolidated providers may have more leverage in the market to negotiate higher rates from payers, leading to increased cost. Over time, as payment reform continues, the efficiencies of consolidated health care systems should create leaner and more efficient cost structures and ultimately lower health care cost.

Legislation

Because health care costs have continued to rise, with cost and quality varying widely by region and provider, the appetite for health care reform continued to grow, leading up to the passage of the ACA, which significantly changes the rules of engagement for employers, providers, governments, and individuals.

The ACA itself is perhaps the single most influential force of change for employers and health care providers. The ACA is influencing the way employers with more than 50 employees are thinking about delivering health benefits to their employees over the next several years, as well as influencing the way health care providers practice medicine and conduct business. While the details of the 2,000-page ACA legislation are beyond the scope of this article, the high-level impacts are outlined below.

The ACA affects employers and health systems in significant ways, as illustrated in the Health Reform House graphic (Figure 7). Six core building blocks of the ACA impact employers, including: 1) The individual mandate that requires individuals to obtain some form of health care coverage, 2) Individual and small group market reform changing several rules regarding affordability and minimum coverage, 3) Subsidies to low- and middle-income individuals who purchase coverage on a public exchange, 4) The creation of federal and state public exchanges, 5) The employer pay-or-play mandate and, 6) A new excise tax, referred to as the Cadillac Tax, for high-cost plans beginning in 2018. Employers are ramping up their focus on employee health and well-being, looking for ways to reduce costs and improve employee health in order to comply with the new law and increase employee productivity, in order to remain competitive.

For health care providers, the four building blocks shown in the Health Reform House illustration are: 1) Expanded coverage for individuals who seek care; 2) Reduced reimbursement rates; 3) New pay-for-performance measures; and 4) Significant emphasis on primary care and the underserved, including Patient-Centered Medical Homes (PCMHs) and ACOs.[36]

FIGURE 7
The Core Building Blocks of the ACA for Employers and Health Care Providers

Employer Building Blocks	Provider Building Blocks
Individual mandate	Expanded coverage
Individual and small market reform	
Subsidies to low- and middle-income individuals	Reduced reimbursement
Health insurance exchanges	Pay for performance
Employer pay-or-play mandate	
Excise on high-cost employer health coverage	Shift to primary care and underserved

Source: "Employee Benefit Practices in Hospitals and Health Systems Survey," Sullivan, Cotter and Associates, Inc. (2014). Figure created by author.

In the short run, nearly 60 percent of hospitals and health systems expect that health care reform will potentially decrease their revenues. With reductions in reimbursement rates and lower operating margins occurring, it will be important for health systems to find new ways to reduce their costs.[37]

As hospitals and health systems strive to do more with less and rethink their roles in an evolving health care marketplace, many are looking to new models, such as ACOs, to more effectively manage care, improve clinical outcomes, and soften the impact of decreasing fee-for-service reimbursement. They look to these models to change the way large payers cooperate with integrated health systems, and to deliver and finance care where doctors and hospitals take on more risk and agree to be accountable for the outcomes of patient care.

One bold view, espoused by Ezekiel Emanuel and Jeffery Liebman, suggests that "By 2020, the American health insurance industry will be extinct. Insurance companies will be replaced by accountable care organizations—groups of doctors, hospitals and other health care providers who come together to provide the full range of medical care for patients."[38] By contrast, however, ACOs have emerged as a viable new form of health care delivery that is fostering payer-provider partnerships that better align incentives to providers to manage the health and outcomes of a population.

Litigation

Medical malpractice payments made on behalf of doctors fell to a historic low in 2012 with the following trends:

- The number of malpractice payments on behalf of doctors (9,379) was the lowest on record in 2012, falling for the ninth consecutive year through 2012;
- The value of payments made on behalf of doctors ($3.1 billion) was the lowest on record if adjusted for inflation. In unadjusted dollars, payments were at their lowest level since 1998;
- More than four-fifths of medical malpractice awards compensated for death, catastrophic harm, or serious permanent injuries;
- Medical malpractice payments' share of the nation's health care bill was the lowest on record, falling to about one-tenth of 1 percent of national health care costs;
- Medical liability insurance premiums, a broad measure that takes into account defense litigation costs and other factors as well as actual payments, fell to 0.36 of 1 percent of health care costs, the lowest level in the prior decade.[39]

While the cost of medical malpractice litigation has decreased, physicians' fear of being sued remains and promotes the practice of defensive medicine. According to a Gallup poll, physicians attributed 34 percent of overall health care costs to defensive medicine and 21 percent of their practices to being defensive in nature. Specifically, they estimated that 35 percent of diagnostic tests, 29 percent of lab tests, 19 percent of hospitalizations, 14 percent of prescriptions, and 8 percent of surgeries were performed to avoid lawsuits.[40]

The Uninsured

The recession was marked by an increase of almost 6 million uninsured individuals between 2007 and 2010. The losses in coverage were mostly driven by large numbers of individuals losing employer-sponsored insurance, although gains in Medicaid coverage partly offset these losses. The recession caused an increase in the low-income population, a group that tends to have lower employer coverage rates, higher Medicaid coverage rates, and higher uninsured rates than other groups. However, increased economic opportunities after the recession between 2010 and 2012 saw this population decrease, and correspondingly saw a decrease in national uninsured rates.[41] The number of uninsured Americans fell by about 3.8 million people in the first quarter of 2014, a drop that roughly matched what experts were expecting based on polling by private groups, like Gallup. The survey also measured physical health but found little evidence of change.[42] While having fewer un-

insured people increases revenue to physicians and hospitals (hospitals must treat patients in need of care regardless of their insurance coverage status), the cost of new mandates, subsidies, and other regulatory requirements imposed by the ACA, generally increases the cost of health care benefits for employers even as revenue goes down for providers.[43] It may not be clear for several years whether the decline in the number of uninsured Americans will continue and, if so, by how much. The net economic effect on HCE may not be clear for several years as well.

Poor Health

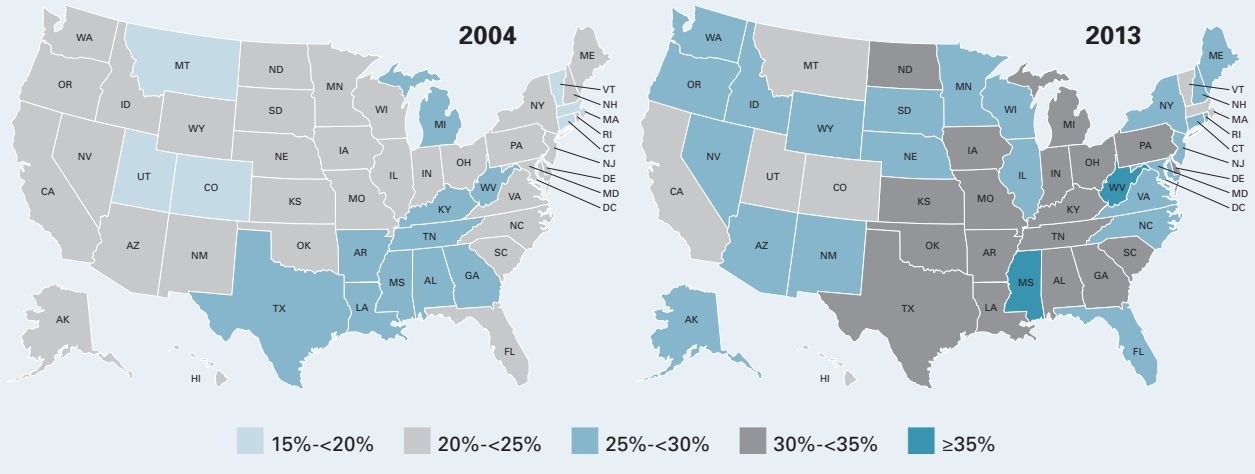
The overall health of the U.S. population is poor and worsening every year. Diseases and conditions that are often preventable—such as heart disease, stroke, cancer, diabetes, and obesity—are among the most common and costly of all health problems.

1. As of 2012, about half of all adults in the U.S.—117 million people—have one or more chronic health conditions. One of four adults has two or more chronic health conditions.[44]
2. Seven of the top 10 causes of death in 2010 were from diseases that in many instances could be prevented. Two of these diseases—heart disease and cancer—together accounted for nearly 48 percent of all deaths.[45]
3. Diabetes is the leading cause of kidney failure, lower limb amputations other than those caused by injury, and blindness among adults.[46]
4. Obesity is a serious health concern. During 2009–2010, more than one-third of adults, or about 78 million people, were obese (defined as body mass index [BMI] ≥30 lb./in.) and nearly one of five youths aged 2–19 years was obese (BMI ≥ 95th percentile).[47]

A major source of this macrotrend of worsening health, which is driving high chronic disease, is the prevalence of obesity across the U.S. (Figure 8).[48] Obesity rates have risen each year for the past several years, leading to the following metrics in 2013:

- No state had a prevalence of obesity less than 20 percent
- 7 states and the District of Columbia had a preva-

FIGURE 8
Prevalence of Obesity among U.S. Adults by State, 2004 vs. 2013



Source: "NCHS Data on Obesity: NCHS Fact Sheet," Centers for Disease Control and Prevention); used with permission.

lence of obesity between 20 percent and <25 percent;
- 23 states had a prevalence of obesity between 25 percent and <30 percent;
- 18 states had a prevalence of obesity between 30 percent and <35 percent;
- 2 states (Mississippi and West Virginia) had a prevalence of obesity of 35 percent or greater;
- The South had the highest prevalence of obesity (30.2 percent), followed by the Midwest (30.1 percent), the Northeast (26.5 percent), and the West (24.9 percent).

Many employers have implemented health promotion or workplace wellness programs for employees and family members of employees, which when designed and implemented properly, can serve an important function in managing population health risk by helping employees and family members identify and better manage health risks and chronic and/or preventable diseases. An increasing number of employers are focused on strategies to improve the health of their organizations, including improving condition and care management, reducing risk factors, improving closure of care gaps, enhancing population stratification and predictive modeling, and tailoring communications and change management to targeted segments of employees and family members. By 2015, 77 percent of employers expect to integrate their health benefit plans with their health management programs (up 20 percent over 2014).[49]

While the results of wellness programs have been mixed, and in many cases overstated,[50] many programs have succeeded in lowering overall group risk factors, as measured by methodology developed by Dee Edington of the University of Michigan, from high risk (defined as 5 or more risk factors) to moderate risk (3 to 4 risk factors) to low risk (0 to 2 risk factors).[51] One such program, an incentive-based health and wellness program for the University of Pittsburgh Medical Center (UPMC) employees, experienced improvements in health-risk status as well as increases in the use of preventive and chronic disease management services among UPMC employees who participated in the program.[52] In addition, a Harvard metastudy of 56 peer-reviewed journal articles found that the more recent studies documented a return on investment (ROI) in the range of 6:1 compared to 3:1 in the older studies.[53]

It is often difficult to measure the specific ROI of lifestyle management programs but employee engagement is linked to a culture that promotes health and productivity. A survey by Virgin HealthMiles Inc. and *Workforce Management* magazine suggests as much: 77 percent of employees responded that "health and wellness programs positively impact the culture at work."[54] While wellness may not always produce an ROI, it may just be the right thing to do. As William Bruce Cameron says, "not everything that can be counted counts, and not everything that counts can be counted."[55]

Inadequate Performance of the U.S. Health Care System

Related to poor health is the fragmented U.S. health care system, which is the most expensive in the world, but consistently underperforms relative to other countries on most dimensions of performance. Among the 11 nations studied by the Commonwealth Fund—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—the U.S. ranks last, as it did in the 2010, 2007, 2006, and 2004 studies (Figure 9). Most troubling, the U.S. fails to achieve better health outcomes than the other countries. The U.S. is last or near last on dimensions of access, efficiency, and equity.[56]

One of the reasons behind this macrotrend of deteriorating health is the way health and illness are treated, in an uncoordinated and unsystematic manner. This lack of focus leads to huge disparities in cost, quality, and outcomes.[57] However, the clues to change the behavior patterns of health care providers are often hidden in layers of complexity with huge variation by region and provider. The Dartmouth Institute for Health Policy and Clinical Practice, led by Dr. Elliott Fisher, has developed the Dartmouth Atlas of Health Care that graphically illustrates variances in health

care spending across geographic regions, service categories, and other measures.[58] Using Dartmouth and other data, a special commission of the Institutes of Medicine (IOM) concluded that variation not only exists across geographies, but also among hospital service areas within them, across health service sectors and clinical condition categories, and for individual providers. There is no clear pattern suggesting that certain regions or providers uniformly deliver higher-value care than others.[59] This lack of patterns that influence disparities makes the development of strategies to reduce them particularly challenging. As a result, disparities have become a major focus of the CMS. In fact, the ACA mandates CMS to identify and implement programs to reduce disparities in care.

Because the ACA impacts multiple populations such as individuals, employers, and Medicare and Medicaid plans, references are made throughout this discussion to nonemployee populations, such as those governed by CMS, the oversight and management authority for government-run health care programs such as Medicare. While the focus of this article is on employer-sponsored health benefits, many of the trends, strategies, and practices that are observed in government-sponsored plans apply to employer-sponsored plans as well.

Part of the reason for disparities in care is the overprescription of low-value care.[60] A recent study of the Medicare population identified 26 measures of low-value services in six categories: low-value cancer screening, low-value diagnostic and preventive test-

FIGURE 9
The U.S. Health Care System Compared to Other Developed Countries, 2013

Country Rankings: Top 2* Middle Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
Overall Ranking (2013)	**4**	**10**	**9**	**5**	**5**	**7**	**7**	**3**	**2**	**1**	**11**
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/ Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: *Includes Ties. **Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

Source: "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally," The Commonwealth Fund (2014); used with permission.

ing, low-value preoperative testing, low-value imaging, low-value cardiovascular testing and procedures, and other low-value surgical procedures. The results detected spending for low-value services of $10.4 billion for the entire Medicare population, or $381 per beneficiary. These amounts comprised 3.3 percent of total annual spending in 2009 on services covered by Medicare Parts A and B. Michael Porter, Harvard Business School Professor and leading authority on competitive strategy, says the following about health care:

> In health care, the days of business as usual are over. Around the world, every health care system is struggling with rising costs and uneven quality despite the hard work of well-intentioned, well-trained clinicians. Health care leaders and policy makers have tried countless incremental fixes—attacking fraud, reducing errors, enforcing practice guidelines, making patients better 'consumers,' implementing electronic medical records—but none have had much impact.[61]

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Eric M. Parmenter, CLU, ChFC, LUTCF, REBC, RHU, CEBS, SPHR, MBA, is Vice President of Employer Solutions for Evolent Health. He leads a team of consultants who design and implement value-based care strategies for large health systems. He holds a master's degree in business from the University of Chicago Booth School of Business and authored, "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions," (*Journal of Financial Service Professionals* 58, No.4), which was selected as the second place winner in the Kenneth Black, Junior, Journal Author Awards 2004. Mr. Parmenter can be reached at eparmenter@evolenthealth.com.

(1) Eric M. Parmenter, "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions," *Journal of Financial Service Professionals* 58, No.4 (2004): 63-78.
(2) The Henry J. Kaiser Family Foundation, "2014 Employer Health Benefits Survey," September 10, 2014; accessed at: http://kff.org/report-section/ehbs-2014-section-one-cost-of-health-insurance.
(3) The Affordable Care Act (ACA) is the commonly accepted shortened name of the Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010.
(4) Jason Millman, "The End of Health Care's Historic Spending Slowdown Is Near," *Washington Post Wonkblog* (September 3, 2014).
(5) *Ibid.*
(6) Keehan Sisko et al., "National Health Expenditure Projections, 2013–23: Faster Growth Expected with Expanded Coverage and Improving Economy," *Health Affairs* 34, No. 1, January 2015; accessed at: http://content.healthaffairs.org.33/10/1841.
(7) Millman 2014, endnote 4.
(8) The Henry J. Kaiser Family Foundation 2014, endnote 2.
(9) Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.
(10) Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, "Is This Time Different? The Slowdown in Healthcare Spending," *National Bureau of Economic Research* (December 2013) Working Paper 19700; accessed at: http://www.nber.org/papers/w19700.
(11) The Henry J. Kaiser Family Foundation 2014, endnote 2.
(12) *Ibid.*
(13) *Ibid.*
(14) "Aon Hewitt Analysis Shows Lowest U.S. Health Care Cost Increases in More Than a Decade Despite Modest Increases, Employees' Share of Costs Hits Nearly $5,000," *AonHewitt*, (October 17, 2013).
(15) "The New Health Care Imperative Driving Performance, Connecting to Value 2014," 19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care," used with permission (2014).
(16) The Consumer Price Index for All Urban Consumers (CPI-U) introduced in 1978 is representative of the buying habits of approximately 80 percent of the noninstitutional population of the United States.
(17) Jason Millman, 2014, endnote 4.
(18) "A Roadmap to High Quality Affordable Health Care for All Americans," *America's Health Insurance Plans* (November 2013).
(19) Louise Sheiner, "Perspectives on Health Care Spending Growth," *Hutchins Center on Fiscal and Monetary Policy, Brookings Institution,* Working Paper #4 (August 2014).
(20) Hewitt Health Value Initiative, 2010.
(21) *Ibid.*
(22) Gregg Easterbrook, "What Happens When We All Live to 100?," *The Atlantic* (October 2014).
(23) *Ibid.*
(24) Jonathan Rockoff, "Gilead Gets U.S. Approval to Sell New

Hepatitis C Drug," *Wall Street Journal* (October 10, 2014).
(25) "Snapshots: How Changes in Medical Technology Affect Health Care Costs," Henry J. Kaiser Family Foundation (March 2007).
(26) Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives* 6, No. 3 (1992): 3-21. For a thorough discussion of the components of health care spending growth and medical technology's significant role, see the report of the Technical Review Panel on the Medicare Trustees Reports, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (December 2000), accessed at: http://www.cms.hhs.gov/ReportsTrustFunds/02_TechnicalPanelReports.asp#TopOfPage.
(27) *Ibid*.
(28) *Ibid*.
(29) "The New Health Care Imperative Driving Performance, Connecting to Value 2014," 19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care.
(30) Jack Burke and Rob Pipich, "Consumer-Driven Impact Study," *Milliman* (April 2008).
(31) Eric M. Parmenter, "eACOs—The Next Generation of Health Plans," *Benefit Magazine* (December 2012).
(32) Based on 2013 Financial Reports for each payer.
(33) New York Stock Exchange data, publically available.
(34) Melanie Evans, "Consolidation Creating Giant Hospital Systems," *Modern Healthcare* (June 21, 2014).
(35) *Ibid*.
(36) Michael Rosenbaum, Bruce Stickler, and Eric Parmenter, "Health Care Reform: Strategic Implications for Hospitals and Health Systems," *American Society for Health Care Human Resources sponsored Web cast* (April 29, 2010). Health Reform House model created by Eric Parmenter, Towers Watson; all rights reserved by Towers Watson (2010).
(37) "Employee Benefit Practices in Hospitals and Health Systems Survey," Sullivan, Cotter and Associates, Inc. (2014).
(38) E.J. Emanuel and J.B. Liebman, "The End of Health Insurance Companies," *New York Times* (January 30, 2012).
(39) Frank Irving, "Report Says Litigation Not to Blame for High Healthcare Costs," *Medical Malpractice Insider* (August 8, 2013).
(40) Carolyn M. Hettrich et al., "The Cost of Defensive Medicine," *American Academy of Orthopaedic Surgeons AAOS Now* (December 2012); accessed at: http://www.aaos.org/news/aaosnow/dec10/advocacy2.asp.
(41) John Holohan and Megan McGrath, "As the Economy Improves, the Number of Uninsured Is Falling but Not Because of a Rebound in Employer Sponsored Insurance," Kaiser Family Foundation (March 11, 2014); accessed at: http://kff.org/uninsured/issue-brief/as-the-economy-improves-the-number-of-uninsured-is-falling-but-not-because-of-a-rebound-in-employer-sponsored-insurance.
(42) Sabrina Tavernise, "Number of Americans without Health Insurance Falls Survey Shows," *New York Times* (September 16, 2014).
(43) "ACA's Cost Impact: Employer Sponsored Health Plans – 2013 Survey Results," International Foundation of Employee Benefit Plans (2013).
(44) B.W. Ward, J.S. Schiller, R.A. Goodman, "Multiple Chronic Conditions among U.S. Adults: A 2012 Update," *Prevention of Chronic Disease* 11:130389 (2014); accessed at: http://dx.doi.org/10.5888/pcd11.130389.
(45) Centers for Disease Control and Prevention: Death and Mortality, "NCHS FastStats;" accessed at: http://www.cdc.gov/nchs/fastats/deaths.htm.
(46) Centers for Disease Control and Prevention and U. S. Dept. of Health and Human Services, "National Diabetes Fact Sheet" (2011); accessed at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.
(47) Centers for Disease Control and Prevention, "NCHS Data on Obesity: NCHS Fact Sheet;" accessed at: http://www.cdc.gov/nchs/data/factsheets/factsheet_obesity.htm.
(48) *Ibid*.
(49) Towers Watson 2014, endnote 29.
(50) Al Lewis, "Is It Time to Re-Examine Workplace Wellness Get Well Quick Schemes?," *Health Affairs Blog* (January 16, 2013); accessed at: http://healthaffairs.org/blog/2013/01/16/is-it-time-to-re-examine-workplace-wellness-get-well-quick-schemes/.
(51) Dee W. Edington, "Zero Trends: Health as a Serious Economic Strategy," *Health Management Research Center* (March 2013).
(52) Michael D. Parkinson et al., "UPMC MyHealth: Managing the Health and Costs of U.S. Healthcare Workers," *American Journal of Preventative Medicine* (June 17, 2014).
(53) K. Baicker, D. Cutler, and Z. Song, "Workplace Wellness Programs Can Generate Savings," *Health Affairs* (2010).
(54) Judy Martin, "Challenge 2013: Linking Employee Wellness, Morale And the Bottom-Line," *Forbes Magazine* (June 11, 2013).
(55) William Bruce Cameron, *Informal Sociology: A Casual Introduction to Sociological Thinking,* New York: Random House, 1963.
(56) "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally," *The Commonwealth Fund* (2014); accessed at: http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror.
(57) Elliott S. Fisher, David C. Goodman, and Amitabh Chandra, "Aligning Forces for Quality: Improving Health and Health Care in Communities Across America," *Robert Wood Johnson Foundation* (2008); accessed at: http://www.dartmouthatlas.org/downloads/reports/AF4Q_Disparities_Report.pdf.
(58) *Ibid*.
(59) Michael E. Porter and Thomas H. Lee, "The Strategy That Will Fix Health Care," *Harvard Business Review* (October 2013).
(60) Aaron L. Schwartz et al., "Measuring Low-Value Care in Medicine," *JAMA Intern Med.* 174, No.7 (2014):1067-1076.
(61) Michael E. Porter and Thomas H. Lee 2013, endnote 59.

The Health Care Benefit Crisis, Ten Years Later: Part 2

by Eric M. Parmenter, CLU, ChFC, LUTCF, REBC, RHU, CEBS, SPHR, MBA

ABSTRACT

More than 10 years have passed since "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions" appeared in the July 2004 issue of the *Journal of Financial Service Professionals* [Parmenter, *Journal of Financial Service Professionals* 58, No. 4 (2004): 63-78]. Part 1 of this two-part analysis reviewed the cost patterns over the past decade and demonstrated that the same cost drivers persist but have taken on new dimensions. Part 2 outlines strategic solutions to improve health and lower health care cost in the next decade.

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Introduction

More than 10 years have passed since "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions" appeared in the July 2004 issue of the *Journal of Financial Service Professionals*.[1] Part 1 of the update concluded that the crisis has worsened, that costs have continued to rise to unsustainable levels, and the drivers of cost over the past 10 years were mostly variations of the same drivers in 2004.

Part 2 looks at new trends emerging that influence whether and how employers provide employee health benefits in the future. Regardless of decisions by employers about whether to directly sponsor health benefits, a healthy, productive workforce is essential to the success of firms in the global economy. Therefore, what strategic solutions hold the most promise for the overall health and efficiency of the American health care system for the next decade? This material is important for financial advisors to understand as the health care landscape impacts all aspects of financial well-being, whether retirement planning, planning for long-term care needs or special needs of dependent children, or direct employee benefit advice.

What Strategic Solutions Hold the Most Promise for the Next Decade?

The Most Common Strategic Levers

Table 1 lists the strategic levers proposed in the

2004 "Health Benefit Crisis" article with high-level comments on the current relevancy of each lever. In retrospect, many employers, particularly those with self-funded plans, deployed many or all of these levers with varying degrees of success. The past decade did in fact experience a lower rate of increase in their benefit plans, due perhaps in part to a more focused effort by employers to deploy the types of strategies outlined herein.

In order to provide context for the discussion of strategic levers, a further discussion of some of the key components of the Affordable Care Act (ACA) in addition to those in Part 1 is useful because the ACA sets new boundary lines for many health plan strategies. While the technical details of the new rules affecting employers under the ACA are outside of the scope of this discussion, the core building blocks impact the strategic direction for employers. The Employer Pay or Play Mandate generally allows employers, those with 50 or more employees who work at least 30 hours per week on average, a choice to "pay" or "play" with respect to sponsoring employee health benefits. Employers who fail to offer qualified health benefits to employees must pay a penalty of $2,000 per employee, per year. The employees who are cut loose by employers who pay the penalty must obtain coverage elsewhere because of the Individual Mandate, or pay an individual penalty. These individuals may purchase a plan on a state or the federal public exchange, with tax subsidies available for many low- to middle-income individuals. If an employer chooses to play, it must follow all of the rules under the ACA, including the provision of subsidized affordable health benefits with minimum coverage features, whereby the employer covers at least 60 percent of covered expenses, expressed as an actuarial value of 60 percent. These minimum requirements of affordability, coverage, and actuarial value can be considered a "floor" because they represent the bottom or minimum level of benefit that can be offered to employees without triggering potential penalties.

Looking forward, despite concerns about cost, few employers plan to exit the role of plan sponsor of health benefits. In fact, 98 percent plan to play, at least for the short term. Their commitment is not as strong for part-time and seasonal employees, spouses, or retirees. When it comes to the longer term, employers' confidence about their role in health care coverage

TABLE 1
2004 Original Strategic Levers and Current Relevancy[2]

Original Strategic Levers	Current Relevancy and Modifications
Defined-contribution approach	• Has evolved with private exchange model • Growing popularity
Health promotion plan	• Remains relevant • Has grown in popularity with mixed results • Evolving due to challenged value and emergence of new technologies
Account-based plans	• Exceptional growth in employer adoption but slower growth in employee enrollment
Accountable plans	• Value-based care with re-aligned provider incentives offer hope • Emergence of Accountable Care Organizations
Intensive health coaching	• Still relevant, evolving to more personalized approach with providers • Better risk segmentation and targeting • Better engagement platforms

continues on a decline that began with the passage of the ACA. Only 25 percent are confident they will offer coverage to their employees 10 years from now.[3]

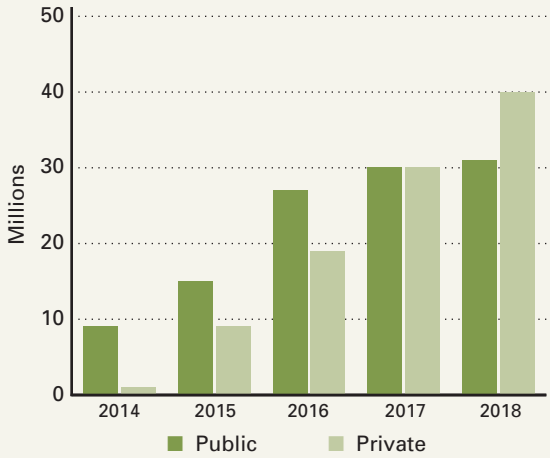
One of the most significant reasons for this lack of confidence is the excise, or "Cadillac" tax, created as part of the ACA. This 40 percent tax will be levied on the value of all affected health care programs a participant elects that exceed certain dollar thresholds in 2018 and beyond. This nondeductible excise tax must be paid by the employer. While the minimum requirements constitute the floor, the Cadillac tax is thought of as a ceiling, or the top value, for health benefits. Employers will need to manage their benefits within the health reform house between the floor and ceiling. Despite continuing efforts to rein in rising health care costs, roughly half of large U.S. employers will begin to hit the excise tax threshold in 2018, and the percentage is expected to rise significantly in subsequent years, with 48 percent likely to trigger the tax in 2018 and 82 percent by 2023.[4]

A growing strategy that sits between pay and play, to help manage benefits between the floor and ceiling, is to outsource the management of health benefits to a private exchange. Private exchanges are built and administered by benefit consulting and administration firms like Towers Watson, Aon/Hewitt, Mercer, and Buck Consultants, as well as carriers and firms that specialize primarily in only private exchange administration, such as Bloom Health.

Private exchanges are marketplaces of health insurance and other related products, where employees may pick from a preselected variety of plans offered by one or more insurance companies. Employers who utilize private exchanges will remain the plan sponsor. The private exchange will typically manage communications, enrollment, plan pricing, compliance, and other responsibilities. Insurance carriers and pharmacy benefit managers (PBMs) pay claims, issue insurance cards, and perform traditional carrier and PBM functions. One big attraction of private exchanges for employers is the opportunity to change from a traditional premium contribution model where the employer typically pays 75-80 percent of the premium, or premium equivalent rate, to a defined-contribution model. The traditional contribution model escalates the cost to the employer each year as costs increase. Because private exchanges provide a wider array of choices to employees, the employer can more easily change from the traditional contribution model to a defined-contribution model where a flat amount, like a voucher, is provided to employees who then apply that flat amount to the plan they select. In subsequent years, the employer may increase the defined contribution but at a level that is not directly tied to cost trend. Private exchanges, however, can operate with or without defined contributions.[5]

Private and public exchange enrollment is projected to reach 71 million by 2018, with 40 million on private and 31 million on public exchanges (Figure 1). This represents a monumental shift in how health

FIGURE 1
Public versus Private Exchange Enrollment (millions)[7]



Source: Private exchange analysis by Accenture based on data from the "U.S. Census Bureau of Labor and Statistics," "Kaiser Employer Health Benefits Annual Survey" (2012). Calculations exclude post-65 retirees and individuals. Public exchange analysis by Accenture based on data from "Congressional Budget Office 2013 Estimate of Effects of the ACA on Health Insurance Coverage" (February 2013). Baseline depicts average monthly enrollment, including spouses and dependents for individual and small business health options programs (SHOP); used with permission.

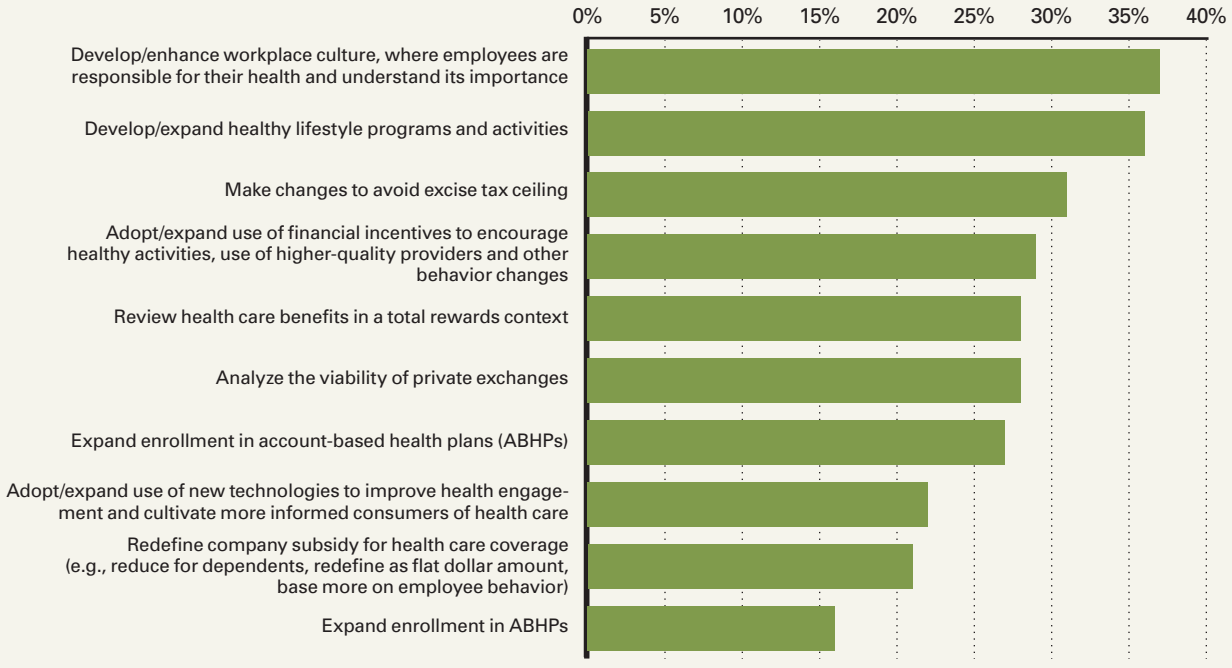
coverage will be procured. The winners of private exchange enrollment will be the plans that demonstrate the ability to manage population health, a function that has been noticeably missing from most private exchange platforms.[6]

Employers know they must lower the cost of health benefits between the floor and ceiling or pay new penalties or taxes. Because most large employers plan to play rather than pay, they are considering the strategies listed in Figure 2. These strategies are designed to improve health and lower health benefit cost; many are extensions of the levers described in 2004. These strategies may be deployed directly by employers working with vendor partners or through private exchanges.

Further, a growing trend of low-cost retail clinics and telemedicine options offers the promise of lowering the cost of on-demand care. For instance, Walmart, the nation's largest retailer and biggest private employer, plans to offer primary and prompt care in stores with $40 office visits. Walgreens, CVS, Kroger, and other retail chains provide low-acuity clinical visits on demand including flu shots, school physicals, and treatment of common ailments.[9] This growing part of the health care market, offering a range of medical services from basic triage and prevention to management of chronic conditions like diabetes and heart disease, often delivered by nurse practitioners and supported by connected kiosks and Web and mobile technology, may provide some cost relief but could also exacerbate the problem of fragmentation in health care where coordination of care is needed.

In addition, many large employers with a concentration of employees in a few locations, such as

FIGURE 2
Top Focus Areas for Employer Health Benefit Strategy in 2014[8]



Source: "The 2014 Towers Watson/NBGH Employer Survey on Purchasing Value in Health Care." ©Towers Watson 2014; used with permission.

manufacturing plants, have built on-site clinics that provide a range of services including occupational health, prompt and primary care, wellness screenings, and education.[10] These clinics provide convenient access for employees, and in some cases family members, and often result in less time missed from work and lower medical cost because fee-for-service (FFS) office visits are replaced with services that cost the employer a fixed cost. Near-site clinics are becoming more popular for employers who are not large enough to have their own clinics but in combination with other employers can experience the benefits of an employee health center.

While these strategic levers have merit and will serve an important role in titrating precious resources carefully to manage health benefit cost in the future, and helping employers avoid the Cadillac tax or push it out a few years, they will not fundamentally remove the single strongest driver of health care cost—misaligned incentives for providers created by FFS reimbursement. Therefore, the single most significant opportunity to lower cost and improve health and health care outcomes can be found in full implementation of value-based care.

Transformational Value-Based Care

The most important lesson learned from the past decade of attempting to manage health care cost is that all of the efforts and strategies listed above, while smartly conceived and well intentioned, will not transform the health care industry and materially lower cost, or improve health or the health care experience. Fundamentally, a new model is needed with aligned incentives for all stakeholders, based on value not volume. Value-based care is a transformational change designed to shift from a predominantly FFS reimbursement environment, wrought with problems of waste and access where providers work independently from one another to care for individuals, to compensation models that align incentives for teams of care providers to take ownership for managing the health, cost, and outcomes of specific populations. Value-based care and compensation represent a move from volume to value and hold the greatest promise to manage cost and quality for the next decade and beyond.

Part of the shift away from FFS to value-based care focuses on eliminating waste. By most accounts, the amount of waste in health care is enormous. Waste can include spending on services that lack evidence of producing better health outcomes compared to less expensive alternatives, inefficiencies in the provision of health care goods and services, and costs incurred while treating avoidable medical injuries, such as preventable infections in hospitals.[11] It can also include fraud and abuse. One study estimated that five categories of waste (not counting fraud and abuse) consumed $476 billion to $992 billion, or 18 percent to 37 percent of the approximately $2.6 trillion annual total of all health spending in 2011.[12]

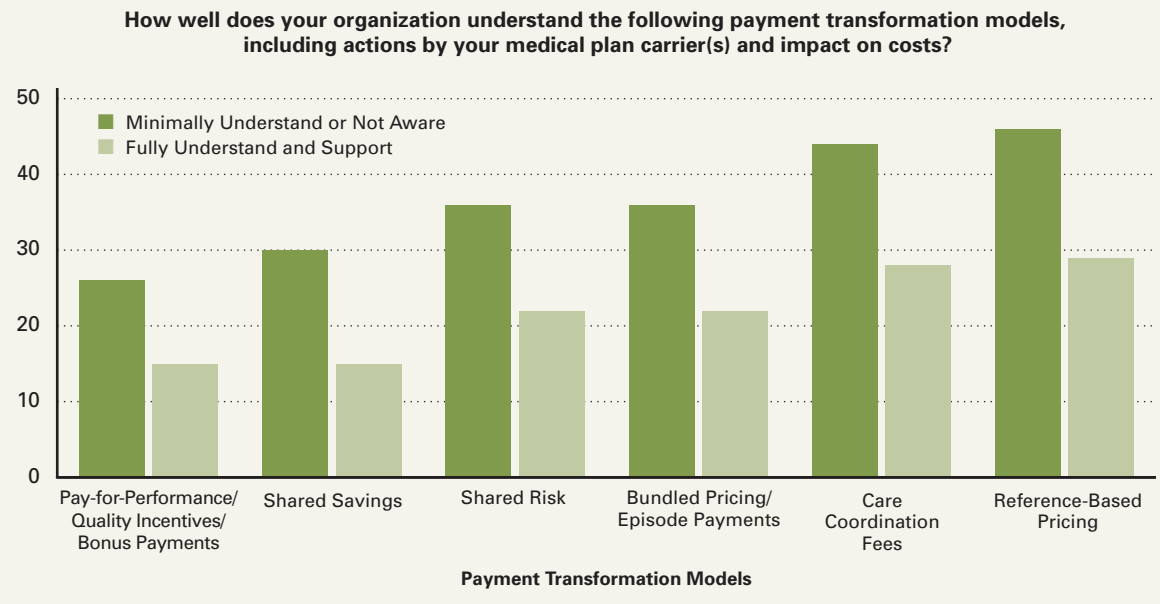
Another key component of value-based care includes improving access to appropriate medical care at the right time, right place, right cost, and with the right result. This includes the availability of facilities and technologies during evenings, weekends, and other off-peak times, as well as the growing use of connected technology where patients can speak directly with clinicians in a live video chat on their smartphones, tablets, or personal computers.

Employers who contract directly with providers, or contract with payers who have payer-provider partnerships, or through private exchanges that provide employees with a choice of plans built upon an accountable care organization (ACO) model, which is a delivery vehicle for value-based care, will become active participants in the movement from volume to value and reap the rewards of lower cost and better clinical results over time. Direct contracting with providers is becoming more timely and important, especially since the number of uninsured has dropped by over 11 million since the enactment of the ACA.[13]

This author refers to employee health benefit plans that are built on this value-based ACO structure as Employee ACOs, or eACOs.[14] Essential elements of an eACO include:

1. A commitment by the employer to build a robust and sustained culture of health that focuses on the well-being and productivity of employees through workplace food options, vending machines, ergonomics, and leadership values;
2. Health and pharmacy benefit plan design that encourages the use of high-value care and discourages low-value care, provides incentives to participants to use providers in high-performance integrated networks, encourages smart decisions at the point of care, and encourages conservation of dollars through account-based plans;
3. Powerful data management and measurement warehouse, with stratification, analytical, and work-rules technology that connects high-risk, chronically ill, and complex-case patients with a physician-led care team who will develop evidence-based care plans for patients. This data engine must also provide experts, those with legal privacy clearance, with the ability to mine and analyze the data in order to determine drivers of cost, program effectiveness, and ROI, and to inform changes in strategy;
4. A high performance network of health system facilities and providers paid through value-based care models to deliver coordinated care, including primary care providers (PCPs) and specialists and facilities;
5. An integrated clinical prescription drug management model with effective clinical programs, low-net-cost purchasing power, and aligned formularies with appropriate clinical protocols;
6. Well designed and managed health promotion, or workplace wellness strategy that aligns incentives for participants to engage in decision-support structures such as health assessments, biometric screenings, and a broad spectrum of tailored and targeted health improvement and management

FIGURE 3
Employer Understanding of Payment Transformation Models[16]



Source: Aon/Hewitt Web cast on delivery system changes and provider payment strategies, "Aon/Hewitt Employer Pulse Survey," Aon/Hewitt Pay-for-Performance/Quality Incentives/Bonus Payments (October 2014); used with permission.

programs, including evidence-based clinical programs such as complex care advising, transitions care, and gaps in care driven by stratification data. These programs coordinate with PCPs to help people comply with treatment plans and healthy lifestyle behaviors, and use engagement technology to connect individuals to the right resources based on their health profiles. Also, when care is needed, to drive the right care, at the right time, at the right place, at the right price, with the right outcome.

The majority of large employers, 65 percent, said that payment reform and delivery-system change are among their top three priorities, but very few know how to go about implementing such plans that connect their benefits to value-based care, as illustrated by the survey results shown in Figure 3.[15]

Most industries compete on value. Health care historically has not competed on value but volume. The application of value-based care differs by population type. For instance, end-of-life issues and palliative care services are more prevalent in a Medicare population, while behavioral health and obstetrics are more common in an employee population. Having said this, the core principles are similar across populations. One model, developed by the Oliver Wyman organization, is called the Road Map to 2025.[17] Table 2 is an adaptation of some of the key aspects of the model and illustrates the transition from volume to value over the next several years.

The Road Map to 2025 promises reductions in net cost of 10 percent to 20 percent and increases in consumer value from 7.5 percent to 25 percent from Wave 1 to Wave 3. This revolution, if fulfilled, will not only improve health, but also enable the U.S. to thrive in the global economy.

Transactional Next Steps to Value-Based Care

In order for the transformation to value-based care to work, the following transactional components must take place:

1. Health systems with multispecialty practices and

TABLE 2
The Road Map to 2025[18]

WAVE 1		WAVE 2		WAVE 3	
Patient-Centric Care 2010 to 2016		**Consumer Engagement 2014 to 2020**		**Science of Prevention 2018 to 2025**	
FROM	**TO**	**FROM**	**TO**	**FROM**	**TO**
Physician-centered	Patient-focused	Uninformed	Informed, shared decisions	Basic health management	Genome-linked life plan
Transactional, isolating	Care-team managed	Limited engagement	Highly engaged/ empowered	Symptom treatment	Monitoring and prevention
Sick care	Health and well being	Isolated individual	Socially connected	One-size-fits-all	Personalized therapies
Inaccessible	Convenient and 24/7	Limited consequence	Financial rewards/incentives	Limited biomarkers	100% accurate diagnosis
Patient turnover-volume	Patient health-value	Bricks, office hours	Virtual, mobile, anytime	Big pharmaceuticals	Tailored gene/ microbiome therapies
Unwarranted variation	Evidence-based standard	Physician opinion	Informed shared decisions	Medical competencies	Life, social, and ethics competencies

sufficient primary care resources build high performance networks with population health management infrastructure. These health systems need to manage the balance between traditional FFS reimbursement and compensation structures aligned with managing the cost and quality of populations;

2. Payers enter into partnerships with the high performance networks that execute a service contract to manage the health, cost, and outcomes of a contracted population, often called attributed lives or downloaded risk, on a fixed-fee, shared-savings, shared-risk, or financial model other than FFS reimbursement;
3. Employers implement the six components of eACOs described above and enter into contracts either directly with the health systems or with payers who have provider partnerships to deliver value-based care.

Conclusion

Anatomy and physiology describe the respective structure and function of the human body. These words can also be used to describe the U.S. health care system which has all the necessary working parts, a well-developed anatomy, but a physiology that is not functioning well. The solution lies in the psychology of reprogramming the cognitive and behavioral patterns of the collective system to repair, realign, or create the connective tissue. In health care there is a multiplicity of systems. It is not any single system that makes things work but the relationship among them that has the power to transform and invent new transformative architectures.[19]

The transition from volume to value is under way and requires this new physiology and psychology for employers, health care providers, individuals, and governments to fulfill the Triple Aim, a commonly accepted goal of all who strive to change health care by changing the way it is delivered.[20] The Triple Aim is:

a. Improved health care coordination
b. Improved patient experience
c. Lowered health care expenditures

Perhaps Atul Gawande sums it up best in his groundbreaking *New Yorker* article, "The Cost Conundrum:"

> Dramatic improvements and savings will take at least a decade. But a choice must be made. Whom do we want in charge of managing the full complexity of medical care? We can turn to insurers (whether public or private), which have proved repeatedly that they can't do it. Or we can turn to the local medical communities, which have proved that they can. But we have to choose someone—because, in much of the country, no one is in charge. And the result is the most wasteful and the least sustainable health-care system in the world.[21] ■

Eric M. Parmenter, CLU, ChFC, LUTCF, REBC, RHU, CEBS, SPHR, MBA, is Vice President of Employer Solutions for Evolent Health. He leads a team of consultants who design and implement value-based care strategies for large health systems. He holds a master's degree in business from the University of Chicago Booth School of Business and authored, "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions," (*Journal of Financial Service Professionals* 58, No.4), which was selected as the second place winner in the Kenneth Black, Junior, Journal Author Awards 2004. Mr. Parmenter can be reached at eparmenter@evolenthealth.com.

(1) Eric M. Parmenter, "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions," *Journal of Financial Service Professionals* 58, No. 4 (2004): 63-78.
(2) *Ibid.*
(3) "The New Health Care Imperative Driving Performance, Connecting to Value 2014." 19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care, (2014).
(4) "Nearly Half of U.S. Employers Expected to Hit the Health Care 'Cadillac' Tax in 2018 with 82% Triggering the Tax by 2023," Towers Watson, (September 23, 2014); accessed at: http://www.towerswatson.com/en/Press/2014/09/nearly-half-us-employers-to-hit-health-care-cadillac-tax-in-2018-with-82-percent-by-2023.
(5) "The Emergence of Private Health Insurance Exchanges Fueling the 'Consumerization' of Employer-Sponsored Health Insurance," Booz & Company, Inc. (2012).
(6) Private exchange analysis by Accenture based on data from the "U.S. Census Bureau of Labor and Statistics," "Kaiser Employer

Health Benefits Annual Survey" (2012). Calculations exclude post-65 retirees and individuals. Public exchange analysis by Accenture based on data from "Congressional Budget Office 2013 Estimate of Effects of the ACA on Health Insurance Coverage" (February 2013). Baseline depicts average monthly enrollment, including spouses and dependents for individual and small business health options program.

(7) *Ibid.*

(8) *Ibid.*

(9) Sarah Varney and Julie Appleby, "Walmart Wants to be the Nation's Biggest Primary Care Provider," *Kaiser Health News* (November 9, 2014).

(10) Eric Parmenter and Tony Brice, "On-Site Employee Health Centers—A Competitive Advantage in the New World of Employee Health," *HR Pulse* (Spring 2014).

(11) "Reducing Waste in Health Care," Health Affairs Health Policy Briefs (December 13, 2012).

(12) Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *Journal of the American Medical Association* 307, No. 14 (2012): 1513-1516.

(13) *Omaha World Herald,* "CDC: Uninsured Drop by 11 Million Since Passage of Obama's Law," March 24, 2015; accessed at: http://www.omaha.com/news/nation/cdc-uninsured-drop-by-million-since-passage-of-obama-s/article_825bdf54-d208-11e4-92d4-473b38f02d10.html.

(14) Eric M. Parmenter, "eACOs—The Next Generation of Health Plans," *Benefit Magazine* (December 2012), 40-47.

(15) Aon/Hewitt Web cast on delivery system changes and provider payment strategies, "Aon/Hewitt Employer Pulse Survey," Aon/Hewitt (October 2014).

(16) *Ibid.*

(17) Tom Main and Adrian Slywotzky, "The Volume-To-Value Revolution: Rebuilding the DNA of Health from the Patient In," *Oliver Wyman Health Innovation Center* (2012, update 2013) accessed at: http://www.oliverwyman.com/insights/publications/2012/nov/the-volume-to-value-revolution.html#.VO9BfE05Dt4.

(18) *Ibid.*

(19) Thom Mayne, paraphrase from "How architecture can connect us," *Ted Talks* (February 2005). While this quote was about the power of physical architecture to connect us, the same idea can be applied to health care.

(20) Donald M. Berwick, Thomas W. Nolan, and John Whittington, "The Triple Aim: Care, Health, and Cost," *Health Affairs* 27, No. 3 (May 2008): 759-769.

(21) Atul Gawande, "The Cost Conundrum," *The New Yorker* (June 1, 2009).