



# The Future of Hospital Employee Health Benefits

Accountable Care Organizations for hospital employees offer a unique opportunity to improve the well-being of our healthcare workers and form the model for future healthcare delivery

**BY ERIC M. PARMENTER**



## Introduction

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There has been significant discussion among policymakers and healthcare stakeholders about value-based purchasing and the advent of accountable care organizations (ACOs). Health systems and health plans are moving rapidly to establish ACOs, shifting the focus of care delivery from volume to outcomes. Consequently, population health management—that is, working to improve the health not just of one patient but of a health system’s entire population—has emerged as a critical tool for those moving toward value-based care delivery models.

But the path toward ACOs is somewhat uncertain; while there is broad excitement and support for the model, health systems have few points of reference for how to build a successful ACO. This is uncharted water, and many systems are learning as they go. For that reason, many health systems have opted to pilot smaller scale ACOs so that they can glean insights into what works and what doesn’t, before they radically change their business models.

This paper examines how health systems’ own employee populations might serve as an ideal test case for ACO development, through the creation of the employee accountable care organization—what Evolent Health refers to as eACO.

**Evolent Health is a population health and managed services company that provides the technology, tools and on-the-ground resources to support health systems on their population health and care transformation objectives. Our services enable health system partners to deliver a full set of population health capabilities and services across the care continuum to the physicians and patients in their local communities.**

# The Poor Health of America's Healthcare Worker

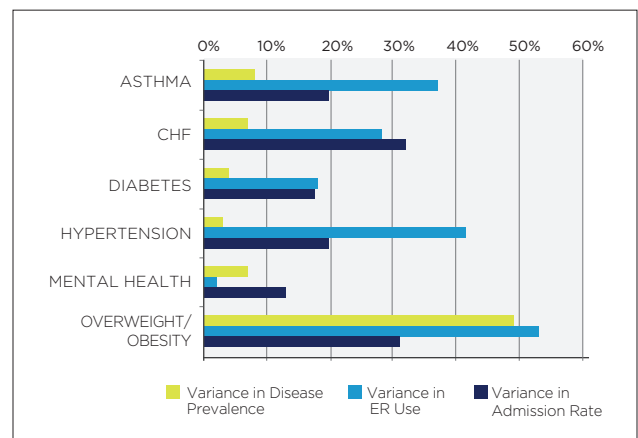
The health of our healthcare workers is worse than in just about any other industry in the United States. Employees in this industry (referring specifically to hospitals, health systems, and other healthcare providers) show higher instances of obesity, smoking, chronic disease, and stress-related illnesses than the average employee in America.<sup>1</sup>

Based on Thomson Reuters' two-year comparison of health data comparing paid claims and utilization of 1.1 million hospital workers to 17.8 million workers in all industries, through the 3rd quarter of 2010, hospitals showed higher levels of claims by double digits than all industries in four out of five categories.<sup>2</sup>

According to the same Thomson Reuters data, not only are the prevalence rates of six common chronic disease states higher for hospital workers, the use of the emergency department (ED) and hospital admission rates are higher as well (Exhibit 1). This suggests a troubling dual pattern of poor health and high utilization of expensive healthcare services.

Additionally, healthcare workers face a wide range of hazards on the job including needle-stick injuries, back injuries, latex allergies, violence, and stress. In fact, rates of occupational injury to healthcare workers have risen over the past decade, while two of the most hazardous industries, agriculture and

**EXHIBIT 1** Hospital Employee Variance from All-Employee Median Disease Prevalence, ER Use, and Admission Rates



Source: Thomson Reuters Healthcare

construction, are safer today than they were a decade ago.<sup>3</sup>

There are a number of factors that contribute to the poor health of healthcare workers, including the obvious factors like exposure to germs and viruses and high levels of stress. There are less obvious factors, like unhealthy food in hospital cafeterias and the fact that these workers often put patient and family needs ahead of their own. Also, the long hours inherent in the healthcare profession foster fatigue.

# The Costs of Poor Health

While there are a number of reasons why a hospital or health system should consider forming an eACO, it is the disproportionately poor health of healthcare workers—and the high cost of that care—that deserves special notice.

An unhealthy workforce in the healthcare sector has numerous and ominous implications. The most obvious is higher direct benefit costs. According to the 2012 SullivanCotter/HighRoads Survey of Employee Benefit Practices in Hospitals and Health Systems, the median cost of annual health benefits to healthcare employees and their families is \$11,651 per employee, per year (Exhibit 2), for Preferred Provider Organization/Point of Service (PPO/POS) plans, the most prevalent

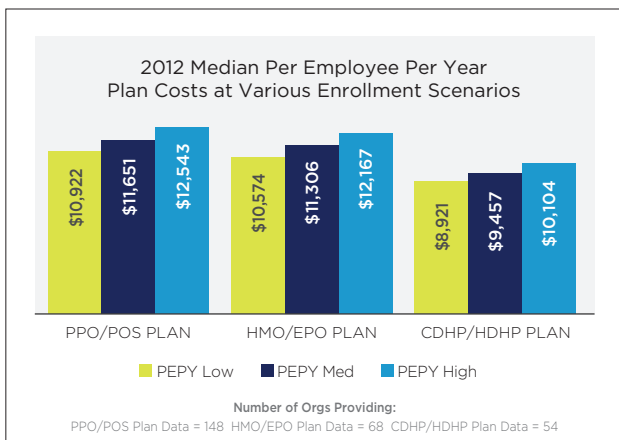
plan offered by hospitals. The cost for this group can range up to \$12,543.<sup>4</sup> This compares to an average annual benefit cost of \$10,475 for large companies from all industries.<sup>5</sup> In addition to the high cost, the average annual cost increase is 6.7 percent for PPO/POS plans (Exhibit 3).<sup>6</sup>

**EXHIBIT 3** Anticipated Cost Increases

2011 to 2012 Trend Rate	PPO/POS	HMO/EPO	CDHP/HDHP
25th Percentile	3.0%	2.0%	1.2%
Median	5.2%	5.0%	6.0%
Average	6.7%	5.1%	6.7%
75th Percentile	9.0%	7.2%	9.5%
Responses	130	62	48

Source: 2012 SullivanCotter/HighRoads Survey of Employee Benefit Practices in Hospitals and Health Systems

**EXHIBIT 2** Annual Health Benefit Cost for Health System Employees



Source: 2012 SullivanCotter/HighRoads Survey of Employee Benefit Practices in Hospitals and Health Systems

The looming excise tax, called the “Cadillac Tax,” which slated to take effect in 2018, is another concern for hospitals. This concern is based on the high cost of their self-funded insurance plans. In 2018, a 40 percent excise tax will be imposed on any health plan (for employers with 50 or more employees) whose costs are above the established thresholds of \$10,200 for self-only coverage and \$27,500 for family coverage. According to the Sullivan Cotter/HighRoads survey, one-third of hospital employers expect that the costs of their health plan would trigger the

## The Costs of Poor Health

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Cadillac tax. Additionally, one actuarial study predicted that over 50 percent of hospitals and health systems would exceed the Cadillac tax threshold if their plans continued to trend upwards at the same rate as they have in the past few years, based on their current costs.<sup>7</sup>

As stifling as health benefit costs are, they are only the tip of the iceberg when it comes to measuring the costs of poor health. According to an Institute for Integrated Benefits (IBI) study, productivity loss, measured as potential lost revenue, can be as much as **three times** the direct benefits cost of group health and all disability program expenditures combined.<sup>8</sup> In fact, medical expenses represented only 18 percent of total costs. Productivity costs factor in absenteeism, presenteeism, disability benefits, workers' compensation costs, and overtime and turnover costs.

While lost productivity costs of three times the direct benefits cost seems enormous, this does not even account for the indirect costs of inadequate staffing, such as reduced patient satisfaction and, even worse, suboptimal clinical outcomes.

With healthcare costs at an all-time high and hospital budgets being continually squeezed, a sick workforce doesn't just impact hospitals and health systems. It impacts us all.

The well-being of our healthcare workforce and the nation are intrinsically linked. After all, we depend on our healthcare workers to keep us healthy. The eACO, therefore, has the potential to not just improve the health and well-being of the healthcare workforce, but also of an entire population.

# The ACO Opportunity for Hospital Employees

With the emergence of ACOs, an opportunity exists for hospitals and health systems to transform their own employee benefit health plans into an ACO-like structure that leverages the providers and clinical resources of the health system to provide care to employees and their covered dependents.

**For healthcare organizations that are contemplating becoming an ACO, an eACO may provide several key advantages.**

**FIRST**, the eACO serves as a proof-of-concept opportunity in a more controlled environment than an external offering.

**SECOND**, tackling population health for employees through the eACO will help the health system get to scale on health management capabilities quicker.

**THIRD**, hospitals and health systems are both an employer paying for workers' health benefits as well as a provider of care, which means there is a unique financial incentive to optimize population health management.

**FOURTH**, the eACO places new focus on the health and well-being of its workers, resulting in improved health, lower health benefit cost, and greater productivity.

Hospitals and health systems are a target-rich environment for lowering costs and improving health because the costs associated with employee health benefits are higher and overall health status is worse than that of employees in many other industries.

If health systems can bend the cost trend of their own health plans and make meaningful strides in improving health, then those same employees who are part of the eACO will be in a position to deliver ACO services to the Medicare, Medicaid, and commercial markets should their employer decide to become a formal ACO.

These employees will have lived the experience and personally benefited from the model, enabling them to become advocates for the same structure in the communities in which they live and work.

## How the eACO Works

The eACO, which operates as a self-funded employee benefit plan governed by ERISA and other regulations for self-funded plans, mirrors much of the structure of the traditional ACO. However, additional steps need to be taken in order for the eACO to thrive.



Hospitals and health system employers contemplating building an eACO must first **ensure that their culture encourages and supports total health and well-being**. This includes understanding the link between employee health and productivity, and requires a foundation rich in decision-support tools, like health improvement programs and screenings.



The employer health system cannot be the only facility where employees can access care under the eACO. Health systems will need to strike the proper balance between clinical resources that are part of the health system with outside partnerships that add value to the care they offer employees and their families, therefore **hospitals will need to build a network of health system facilities and providers that are aligned around coordinated care delivery**.



To ensure access to all services, hospitals and health systems building eACOs will need to **recruit primary care physicians and other specialists** to join the aligned network to coordinate patient services for employees and their dependents.



Hospitals implementing the eACO will need to **promote the program within the employee population to grow membership and engagement**, and they will need to provide incentives to participants to engage with their PCPs and comply with treatment plans and healthy lifestyle behaviors. Further, plan design will be a key factor when attracting participation in an incentive wellness program.



Because facilities participating in the eACO will be both the employer paying for benefits, as well as the health system reaping the rewards of shared savings, **health systems will need to develop internal cost-accounting protocols to properly measure costs and revenue flow**.

A light gray map of the United States is shown in the background. The state of Pennsylvania is highlighted in a darker gray. A small blue star with the letters "UPMC" next to it is positioned over the state of Pennsylvania.

CASE STUDY

## The University of Pittsburgh Medical Center (UPMC)

UPMC transformed its employee health plan to an ACO-like structure in **2004**, when it launched **MYHEALTH**, a population health management program enhanced with a full suite of wellness offerings **AIMED AT EMPLOYEES AND DEPENDENTS**. At first, some employees were reluctant to participate; however, within two years, approximately **90% OF EMPLOYEES HAD ACTIVELY ENGAGED IN THE PROGRAM**, a level that UPMC has since sustained.

UPMC has redefined its delivery of healthcare, including its employee health plan, using innovative science, technology, and medicine to invent new models of accountable, cost-efficient, and patient-centered care. UPMC moved its employee health plan to an ACO-like structure in 2004 by launching MyHealth, a suite of wellness programs. Not surprisingly, some employees were reluctant at first to take on new behaviors. However, after just two years, more than 90 percent of the employee population was participating in the program.<sup>9</sup>

Eight years out from its inception, the UPMC model has produced significant results, namely a health plan cost trend of 1.1 percent in 2011 compared to industry benchmarks of 8.5 percent. The five-year compounded savings for UPMC over industry benchmarks exceeds \$65 million. Given the reduced trend and significant cost savings, it is not surprising that overall health of the UPMC workforce improved, too. From 2007 to 2009, UPMC reports that the program reduced unscheduled time away from work by 5.3 percent, resulting in \$3.1 M savings.

UPMC also reports the program resulted in fewer smokers, improved health risk assessment scores and biometric data, and a lower prevalence of chronic disease. Between 2008 and 2010, results across UPMC's employee population included an increase in the percentage of employees meeting recommended guidelines for physical activity and a decrease in the number who were at nutritional risk.<sup>10</sup> Furthermore, UPMC increased preventive screenings among employees by 167 percent, and increased annual physicians physicals among employees by 188 percent from 2008 to 2010.

Just as the impact of a sick healthcare workforce is felt by patients, the improvement in UPMC employee health continues to flow through to patient satisfaction. UPMC enjoys superior patient engagement, winning the J.D. Power and Associates highest ranking for overall satisfaction in the Pennsylvania Region in 2011. The UPMC's "MyHealth" wellness program also has earned it the National Business Group on Health "Best Employers for Healthy Lifestyles" award.<sup>11</sup>



# Conclusion

Employees of hospitals and health systems are often motivated by the mission of the organization and the satisfaction that comes with helping people in times of poor health. Thus, it is ironic that while healthcare organizations strive to treat illness and to improve the health of the communities they serve, hospital leadership too often overlooks the well-being of the very people responsible for carrying out that mission.

A significant opportunity exists for health systems through eACOs to not only live up to their mission by leading the health improvement charge in their communities starting with their own employees and their families, but also to create a financially successful future. In the process, these systems will be the pioneers that create a sustainable healthcare delivery model for America, led by an engaged, productive, and healthy workforce.



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<sup>1</sup> The various studies referenced below support the hypothesis that workers in hospitals and health systems are less healthy overall than those in other industries.

<sup>2</sup> Thomson Reuters/HighRoads partnership data as provided to the author.

<sup>3</sup> Centers for Disease Control. The National Institute for Occupational Safety and Health (NIOSH)

<sup>4</sup> 2012 SullivanCotter/HighRoads Survey of Employee Benefit Practices in Hospitals and Health Systems.

<sup>5</sup> Average Cost of U.S. Health Coverage per Employee is Expected to Cross the \$10,000 Threshold for the First Time in 2012, According to Aon Hewitt. Aon Hewitt Health Benefit Cost Press Release. October 3, 2011. Available from:

[www.prnewswire.com/news-releases/average-cost-of-us-health-coverage-per-employee-is-expected-to-cross-the-10000-threshold-for-the-first-time-in-2012-according-to-aon-hewitt-130847468.html](http://www.prnewswire.com/news-releases/average-cost-of-us-health-coverage-per-employee-is-expected-to-cross-the-10000-threshold-for-the-first-time-in-2012-according-to-aon-hewitt-130847468.html).

<sup>6</sup> Ibid.

<sup>7</sup> Performance in an Era of Uncertainty. 17th Annual Towers Watson/National Business Group on Health

Employer Survey on Purchasing Value in Healthcare. 2012. Available from: [www.towerswatson.com/assets/pdf/6556/Towers-Watson-NGBH-2012.pdf](http://www.towerswatson.com/assets/pdf/6556/Towers-Watson-NGBH-2012.pdf).

<sup>8</sup> As cited in Benchmarking Study Finds Productivity Loss Dwarfs Direct Benefit Costs. Integrated Benefits Institute. June 2000.

<sup>9</sup> Gantner, RK. Workplace Wellness: Performance with a Purpose. Moon Township, PA: Well Works Publishing, LLC; 2012.

<sup>10</sup> Ibid.

<sup>11</sup> UPMC Work Partners data supplied to the author