Designing Incentive Programs That Work for Your Organization

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Incentives have long been a part of wellness initiatives. Recently, however, several developments in health care benefits management are leading to the need to place greater emphasis on incentives to motivate employees.

With the continued rise in health care costs and yearly rate increases, employers are eager to try out new health management programs that require employees to take on more responsibility and accountability for their health care utilization and health behaviors.

Unlike programs that relied on past health care use and selected participants based on past claims, new programs are focused on not only finding employees that have been sick, but also those that will most likely get sick in the near future. In order to help and intervene with employees on the road to poor health, employers need employees as engaged and participative as possible.

Employers realize that they have a choice: either keep pushing costs off to the employees, or make the true costs known to employees and help them see clearly that there is a direct correlation between positive changes in health behavior and their ability to keep premiums from increasing.

The good news is that this has put an increased focus on implementing incentive programs along with health management initiatives. The bad news is that some companies decide to create an incentive program without thorough planning. Many choose an incentive program that has been "in the news" and seems to work at another company. Unfortunately, incentive programs are not a one-size-fits-all proposition; companies need to decide what program will work best in their specific situation.

Why Incentives Anyway?

Our nation's health care system, and in particular employer-sponsored health benefit plans, place little accountability and responsibility on an employee for their present or potential future use. Employees have become conditioned, in part by the system, to choose and use with little or no concern. Today, many experts cite this lack of accountability and responsibility, particularly related to health behaviors, as a primary driver of the increases in health care utilization and costs. As a result, encouragement alone isn't enough of a motivator for real health behavior improvements.

Health behaviors, whether bad or good, are voluntary and, on a daily basis, employees decide whether to subscribe to good or bad habits. While this decision-making process is complex, it can be influenced, especially when the person is open to improving his or her health.

In this way, incentives can become a catalyst for change and can influence performance. They tap into the "what's in it for me" factor, and motivate individuals to make better choices, develop a better sense of accountability and create a willingness to comply with healthy suggestions and recommendations.

Employers certainly are realizing the importance of incentives. Currently about 41 percent of companies have incentives aimed at encouraging healthy behavior, up from 34 percent in 1996 (source: Hewitt and Associates). A 2006 survey of 435 employers by the Hay Group revealed some of the most common incentives:

- Cash (18 percent)
- Merchandise/trinkets (10 percent)
- Paid time off (7 percent)
- Lower medical premiums (6 percent)
- FSA/HSA credits (5 percent)
- Recognition and rewards*
  *Not included in study

However, increased use of incentives doesn't necessarily correlate to success.

Deciding on the Incentive

When deciding on the right incentive, many companies rely on what they've heard in the news or a success story that circulates in their industry. High-profile incentive – or disincentive – stories abound: "Scotts Miracle-Gro plans to fire smokers" (BillingsGazette.com, 12/10/05) and "Northwest Airlines plans to impose a health care premium surcharge on workers who use tobacco products" (Star Tribune, 10/10/05).

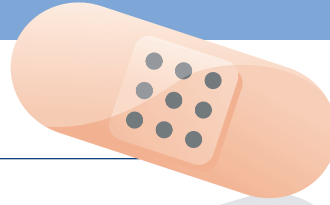
Not only should employers be concerned about adopting these types of incentives due to the legal implications, but they also really should be more focused on what incentive or disincentive would work in their organization.

Although premium discount incentives quickly are becoming one of the most popular incentive methods, they are not a panacea and they have failed in some organizations. Moreover, the debate continues about which works better – the "carrot vs. stick" approach, with some experts believing that only carrots should be offered.

However, many experts favor a more balanced approach, possibly a combination of carrots and sticks. When considering which is best, companies need to think about their unique organization and its unique employee mix before determining which is the right combination.

Before deciding on any program, employers should ask several questions as they are preparing and planning for their incentive program:

- What type of incentive will be needed to achieve 60 percent, 75 percent or 100 percent participation?
- What behavior do we want to motivate? I.e. for employees to quit smoking, or for employees to seek preventive exams?



- What are my options? Is it even possible for me to use benefits-linked incentives such as a premium credit, or is my only option merchandise and trinkets?
- Does senior leadership support my incentive program? How will I respond to objections by leadership if they tell me that they don't believe incentives are necessary?
- What is my budget for my incentive program? If cash, what is the long-term value of cash for the program, and will that value erode over time?
- What's unique about my company and target population and that might impact the design of an incentive program? I.e. average age of population, union vs. non-union environment, etc.
- Could this incentive program produce any undesired effects such as encouraging people to cheat or manipulate the system, or reward the wrong behavior?
  – For example, if a company offered to pay employees for each pound they lost by the end of the year, this might encourage someone to wait until the last month to try and drop as much weight as possible, thus risking his or her health.

While incentives are becoming key to any successful health management program, a company must ensure the following: There is complete executive buy-in and the will to enforce any rules; the cost does not outweigh the benefit of the program; there is a clear communications strategy; and the morale and culture of the company will support this program.

And it does not hurt – given the current legal climate – to get direct advice from your own attorney and even run the incentive by your certified public accountant.

Incentive Success Stories

When Scott Insurance – my organization – decided to try a new health management program, we knew that incentives were going to be an important part of the program's success. We decided on a predictive modeling and health coaching system, One Care Street from The Haelan Group. The plan was to use a self-perception survey to find employees that were considered high-risk or those that would most likely seek health care within the coming year.

Unlike past wellness surveys, this type of survey asks a series of questions that not only finds high-risk employees based on more than disease symptoms, but also includes feelings, attitudes and perceptions of how they think or perceive they should feel. Employees that are found to be high-risk through predictive modeling are then offered one-on-one health coaching.

The goal is to proactively find and intervene with employees who will end up needing health care – before it becomes serious and costly. With this type of program, participation is key. If the survey is not completed, then the program loses its effectiveness – potentially missing high-risk individuals. The goal of our incentive was to get as close to 100 percent participation among our employees as possible.

Our history with wellness told us that we would need a strong incentive – one that would be valued by our employees and also start tying health accountability and responsibility to benefits. Also, with our highly distributed work force, we needed administrative simplicity in our incentive program. We also had to consider our unique, entrepreneurial culture during the incentive-planning phase.

After considering the practical issues and asking ourselves the practical questions, we decided to set up a premium-based incentive. If employees completed the One Care Street survey and either accepted the initial health coaching call – if high-risk – or set and committed to achieving a health goal during the following year – if low risk – they would receive a $50 reduction in their monthly premium contribution.

Before we introduced this incentive, the completion rate had been 80 percent. This would seem to be a "high enough" participation rate, but we felt strongly that the 20 percent that were not participating were most likely our riskiest group and had to be brought into the fold. After the incentive program, we achieved 97 percent survey completion, and among our health plan participants, we achieved 100 percent participation.

Due to the high participation in the One Care Street survey, 32 percent of the group was identified as high risk, with 60 percent of that group engaging in health coaching. What is the value of this high participation?

With this incredibly high participation rate, our company feels it has a greater impact on identifying health risks within our organization. After two years, health outcomes within our employee group have improved, including measurable change in health behaviors. Although the size of our employee population surveyed precludes us from performing a meaningful financial outcomes analysis, we have realized two years of negative health plan renewal rates, which we view as extremely favorable and attribute this, at least in part, to our aggressive program – a tool that prospectively finds people, a solid communications plan and an aggressive incentive.

Several of our own clients also have found success with well-planned incentives. One client that only projected a 35 percent participant rate – due to employees being geographically dispersed – obtained 50 percent participation in the One Care Street survey through the use of a lottery drawing for merchandise.

Another one of our clients had started out with a premium credit amount, but the impact – around 80 percent participation – was not significant enough. In this approach, employees pledged to participate and then would receive a credit when they fulfilled the pledge.

In the next year, the employer changed tactics – it switched to a premium contribution incentive for both employees and spouses as the way to drive participation and use of the One Care Street program. This means that participants had to complete all the requirements, or, if they did not, they would have to pay the full amount of their employee or spouse portion of the premium.

With this change, the organization's participation increased to more than 90 percent through the modification of the incentive. With this company, a premium contribution carried more weight, or motivation, among the population.

Incentives That Fit Your Organization

Intuitively, incenting employees toward better health makes sense. From the employer's perspective, it is critical that careful thought and planning go into planning for an incentive.

Before you start a program, determine the following: What is the goal of your incentive program, what practical considerations should you take into account that apply only to your unique situation and culture, and do you have the executive support and communications strategy to push the incentive program through?

With proper planning and design, incentives can positively impact your health care budget and make employees much healthier, productive and engaged in their own care. B&C

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Opportunities Abound to Improve and Save on Pharmacy Programs

BY JEFF HAWES, PHARM.D., RPH.,
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The new year is shaping up to favor employers and health plans that want to improve and save on their pharmacy benefit programs. Several factors indicate that 2007 brings tremendous opportunities for a slowing drug trend, which is the yearly percentage of incremental increases in pharmacy expenses. By taking advantage of slower growth in newly introduced brand-name drugs and working with their pharmacy benefit manager, employers and health plans can take advantage of unprecedented generic drug opportunities while considering more consumer-directed benefits.

Lower Brand Drug Growth

Last year marked one of the lowest approval rates for newly branded drugs. Only 17 drugs were approved compared to prior years in which the average was closer to 28. In addition, many pharmaceutical manufacturers face a shortage of future pipeline drugs, which is impacting their financial well-being. Drug maker Pfizer, for example, laid off 10,000 workers due, in part, to future financial shortfalls. Other manufacturers are talking of similar actions. Still others are discussing the possibility of mergers, with the most recent rumblings involving Sanofi-Aventis and Bristol Myers Squibb. Some analysts predict that this shortfall in pipeline drugs will be compensated for in coming years since more than 2,000 drugs are currently in clinical studies, some of which will hit the marketplace by 2010.

What this means for pharmacy benefit payors is that 2007 is an opportunity to "catch up" after years of major brand drug growth, while preparing for another wave of new drugs in the years to come. This year should give high-volume pharmacy payors a well-deserved breather and time to plan for the future.

Higher Generic Drug Utilization

While brand drug growth is slowing, generic drug growth is at an all-time high. Here is where drug payors have a clear opportunity to save big money on their pharmacy costs, while ensuring the health interests of the people they serve. New generics for blockbuster brand drugs continue to hit the marketplace. Popular drugs like Allegra, Pravachol, Zocor, Zofran and Zoloft all became available in generic form in 2006, while other heavyweights such as Ambien, Coreg, Lotrel, Norvasc and Wellbutrin XL may become available in 2007.

Some pharmacy consulting experts are predicting that well-managed pharmacy benefit programs could realize generic utilization rates (the rate at which generic drugs are dispensed to program beneficiaries versus brand-name drugs) of 60 percent by the end of the year. Experts universally recognize that such a benchmark is a highly desirable goal for pharmacy benefit programs. Research supports the general formula that for every 1 percent increase in generic dispensing, plan sponsors save between 0.5 percent and 1.0 percent of their total drug spend.

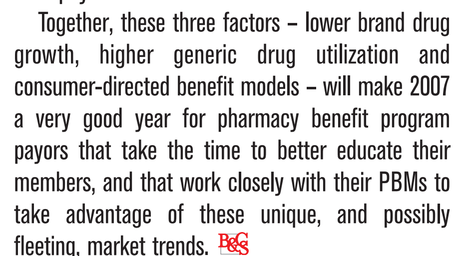
The FDA currently reports that roughly 76 percent of all prescription drugs have generic counterparts. Because generic drugs are FDA-approved, clinically equivalent drugs with substantially equivalent benefits, there is no good reason for patients or program sponsors to pay more for brands if a generic for the medication is available.

Plan sponsors should work with their PBMs to counter the effects of direct-to-consumer advertising that leads their beneficiaries to adopt the false notion that brand-name drugs are the best option for treatment. It simply isn't true and does not work in the best interests of patients or plan sponsors. Plan sponsors must be aware, however, that not all brand-name drugs have a generic equivalent.

Consumer-Directed Benefit Models

A national survey conducted by Pharmaceutical Strategies Group in 2006 indicates that only 22 percent of national employers are offering a consumer-directed pharmacy plan. Of these, about half offer the CDHP on a strictly optional basis. Yet, when offered in this way, only a small portion of employees – 6 percent – elect the CDHP option. This is a missed opportunity. Research shows that CDHPs can have a significant impact on both medical and pharmacy expenses. PSG's survey indicates that employers that implemented CDHPs came within an average of 2 percent of their initial targeted cost-containment goals.

Given these statistics, it is no surprise that another survey conducted by the Society for Human Resources Management discovered that one of the top strategies for health care cost containment selected for review by 54 percent of surveyed employers was to increase member cost sharing for pharmaceuticals with premiums, copays and coinsurance. Many of these plans couple the CDHC strategy with promoting higher generic drug usage by increasing member out-of-pocket expenses for brand drugs while making no changes to generic drug cost liability, or even eliminating it entirely by covering the entire cost of generic medications. These are realizable strategies for pharmacy benefits, even without adopting a total CDHP that includes medical coverage, requires better member communication and adds more member responsibility for the choices they make in conjunction with their physicians.



Together, these three factors – lower brand drug growth, higher generic drug utilization and consumer-directed benefit models – will make 2007 a very good year for pharmacy benefit program payors that take the time to better educate their members, and that work closely with their PBMs to take advantage of these unique, and possibly fleeting, market trends. B&S

A trained and seasoned clinician, Jeff Hawes consults with employers, health plans and other organizations to help maximize the value of their pharmacy benefit management program. Prior to joining PSG, he had P&L responsibility for the pharmacy benefit as a hospital pharmacy manager and as a pharmacy director for a large managed care plan. Prior to this, he focused on delivering solutions to the managed care marketplace as a clinical account manager for a top-tier PBM.

Turning a Vicious Circle Into a Virtuous Circle

BY WILL ROBINS, PRESIDENT, ADVANCE FUNDING LLC

Self-administered health care plans face a vicious circle of ever-escalating costs to employers, dissatisfied patients/employees and economic deprivation on the part of health care providers:

- Doctors do not know when or how much they will get paid by health care plans, particularly if they are out of network. Consequently, they raise their prices inordinately. When they get paid less than they charge, they are forced to sue the patient to recover the shortfall.
- The health care plan finds its costs rising inexorably, so it rations the dollars it has budgeted for health care by simply delaying payment. Thus, if the budget for May was 100 but the claims were 120, all claims are put into a queue and paid on a first-come basis, resulting in 20 claims deferred to June.
- The third-party administrator finds itself blamed for the rise in costs and suffers client churn, which, in turn, compels it to bring in new clients by making unrealistic projections about controlling and pricing health care claims.
- The patient, who thinks of the health care plan as a right or a perk, finds himself having to co-pay part of a health care bill – the part that the TPA maintains is "too high" and not justified.
- The employer who sponsors the health care plan finds that, far from earning appreciation from employees, having to pay the "too high" portion of a bill produces resentment.

So there is a perfect vicious circle spiraling out of control: Doctors don't know when or how much they will get paid so they raise their prices; TPAs cut the portion they will pay; health care plans respond by off-loading part of the payment onto their employees and by delaying payment of their share, so the doctor raises his prices again to cover the lower remuneration, longer waiting period and the cost of collecting the un-remunerated portion of the bill. Now a new round begins where the TPA makes even further cuts in what it will authorize, the health care plans delay payment even further, and the patients face even more collection efforts by health care providers.

Enter advance funding

Advance funding introduces an economic incentive to break this vicious circle. The process is extremely simple and inexpensive.

- The TPA immediately notifies the advance funding provider of any claim it receives that fall into a particularly difficult category (such as out-of-network claims) and what the TPA agrees to pay for that claim.
- The advance funding provider immediately contacts the health care provider and offers to pay the bill less a discount, typically 10 percent to 30 percent, and send the payment overnight.
- If the health care provider accepts, it agrees to relinquish all future claims against the patient.
- The health care plan agrees to reimburse the advance funding provider in 30 days.
- Upon getting paid by the health care plan, the advance funding provider will share a portion of the discount. For instance, the TPA might be paid 10 percent of the discount as compensation for the fast turnaround of the claim, and the health care plan might get 50 percent of the discount as an incentive to enter into the advance funding arrangement.

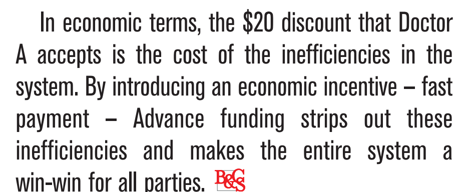
The vicious circle is now broken. The health care provider gets paid an acceptable amount immediately, the patient no longer has to pay any portion of the bill, the TPA earns revenue from creating the entirely new business of fast turnaround and the health care plan brings down its cost.

Put another way, rather than ration the amount it is willing to pay by putting bills in a queue, the health care plan can ration payment by the amount of discount it earns, such that the greater the discount the health care provider is willing to give, the faster it will get paid.

This is not a function that a health care plan easily can provide – the public relations aspects as well as the operational requirements are daunting. In effect, self-administered health care plans can outsource this function to an advance funding provider just as they outsource the administration of the plan to a third-party administrator.

Some numbers may help to illustrate advance funding:

- On May 1, Jones goes to see Doctor A, who is not in the health provider network set up by Jones' employer, the Smith Corporation.
- On May 5, Doctor A files a claim for $125 with Efficient TPA, the third-party administrator of the Smith Corporation's self-administered health care plan.
- Efficient TPA immediately decides that it will pay $100 on the claim and on May 6 notifies Fast Pay Inc., the advance funding provider.
- On May 6, immediately upon notification from Efficient TPA, Fast Pay Inc. calls Doctor A and offers to pay $80 on the claim; the check to be overnighted and received the next day, May 7, by Doctor A.
- Doctor A accepts, and agrees not to pursue Jones for the difference between the $80 payment and the $125 bill.
- On May 7, the Smith Corporation's health care plan pays $100 to Fast Pay Inc.
- On May 8, pursuant to a prior agreement, Fast Pay Inc. pays 10 percent of the $20 discount, or $2, to the TPA, and 50 percent of the discount, or $10, is remitted back to the Smith Corporation's health care plan.



In economic terms, the $20 discount that Doctor A accepts is the cost of the inefficiencies in the system. By introducing an economic incentive – fast payment – Advance funding strips out these inefficiencies and makes the entire system a win-win for all parties. B&CS

To learn more about Fast Pay or to contact Will Robins, see their ad on page 14 of this issue.