In the COVID Era, Corporate Health Benefits Demand CEO Leadership

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The expectation that employers provide people's health insurance has been around since World War II.[1] And for virtually all of the eight decades since, most CEOs have delegated to staff members the design and overview of the plans that so deeply impact the health and loyalty of their employees. These corporate staff, in turn often count on insurers, brokers, and other outside experts to advise them.[2]

Unfortunately, the way most corporate health plans are currently managed can hardly be termed a success. Though employees consider it their most important benefit, an Employment Benefit Research Institute (EBRI) study found that only 21% of those surveyed are extremely satisfied with their current health plan.[3] At a time when one survey found 52% of respondents felt the pandemic had "made me question the purpose of my day to day job",[4] another one found that only 29% of surveyed employees strongly agreed that they trusted their employer would take care of their emotional and mental wellbeing, and 27% disagreed.[5] None of this is reassuring news for companies scrambling to hold onto talent these days.

Simultaneously, rising healthcare costs dramatically affected employees' income. The average premiums for family coverage in all firms— $22,221 in 2021[6] had risen faster than inflation, increasing 22% over the last five years (vs. 11% change in inflation) and 47% over the past ten years (vs. 19% rise in inflation).[7] To calibrate this amount, consider that the yearly income for full-time U.S. wage or salary workers in the second quarter of 2022 amounted to $54,380.[8] If you think this doesn't sound like much to live on, you're not alone: with inflation skyrocketing, two/thirds of American workers say their pay is inadequate, while 58% are living paycheck to paycheck.[9]

Although healthcare cost increases moderated in 2022,[10] this long history has negatively affected employee welfare. According to the EBRI 2021Wellness Survey, employees have experienced decreasing contributions to their retirement plan, delayed going to the doctor, increased their credit card debt, or used up all or most of their savings. Forty percent had difficulty in paying bills or other basic needs, up from 29% in 2020.[11] Quest Diagnostics' recent survey of over 400

I am very grateful to Steve Rusckowski, Chairman, CEO and President of Quest Diagnostics, for sharing his company's healthcare benefit innovations journey and research and to Dr. James Wallace, President at AmeriPlus Select Services , for his partnership in researching and shaping this article from its inception.

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executives with decision-making authority and nearly 850 employees at companies with at least 100 workers found that they appear to see no relief on the horizon, as 87% of the executives and 89% of employees worried healthcare costs will increase this year.[12]

Most employees want cost control, of course.[13] But they also want policies with more personalized choices tailored to characteristics such as age, preexisting conditions, and risk tolerance, and they want guidance in selecting their benefits.[14] In the age of COVID and working from home, they also want smoother, more convenient communication with their health plans and providers.[15]

Corporate attention to fulfilling employees needs like these has always mattered, but it is even more important now that the Great Resignation is in full swing, with 4.2 million employees leaving their jobs in June of 2022[16] and 40% thinking of resigning.[17] While many people have reportedly left their jobs "for better work,"[18] other sources mention Baby Boomers retiring, a dearth of Millennials or Gen-Zers to replace them, and even long COVID cases and parents with child-care woes as reasons for the tight job market.[19] Whatever the reasons, the labor market has shrunk, with 10.7 million job openings reported in June of 2022.[20]

Quest's survey found that 78% of key decision makers say their organization has been impacted by the Great Resignation. Most have increased wages and/or added rewards and benefits to counter the trend to attract and retain workers. And yet, their employees may not be getting the message, as 66% say that they are thinking about changing jobs in the next year or have begun or recently completed a job change.

The upshot is that employees have more power than ever. Yes, employers have steeply raised wages and salaries[21] but employees want more --they are adamant about expecting companies to treat them as individuals, personalize their experiences, and make their wellbeing a priority.[22]

Yet as I have already discussed (and will explore further in a moment), organizations are failing to meet these expectations. In the midst of an unprecedented staffing shortage,[23] we can scarce afford to be complacent about this state of affairs.

It's Time to Change Our Corporate Management of Healthcare Benefits

The many large self-insured corporations typically pay outside firms--brokers, health insurers, third-party administrators, and consultants-- to shape and manage their plans. Although these outsourcers have deep industry expertise, their incentives may not line up well with fulfilling employee wishes.

Brokers, when paid a percentage of the corporation's premiums as fees, are not well aligned with a cost-control strategy.[24] At times, brokers may even be swayed to choose insurers that promise lavish gifts and bonuses as incentives.[25] For their part, the insurers are additionally not incented to rock the boat in the design of the plans or to alter their relationships with health care

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providers. They typically prefer as uniform a plan structure as possible across their customers and are leery of offering new forms of payment to their contracted providers.[26] And because these self-insured plans are a sideline to the insurers' full-risk business, they generally do not fully focus on them.[27] Consultants who earn a flat fee are better aligned; but they too should not be the primary source for a function that is best managed organically within the firm, reflecting the firm's culture and accounting for specific employee needs.

Nevertheless, HR may find these "maintenance of the status quo" incentives appealing. In terms of psychological risk-related traits, HR professionals were more likely to be rated as "prudent" than the general population and less likely to be rated as "adventurous."[28] While they are lauded for knowing their job, coaching others, and building relationships, HR professionals in general are not applauded for their strategic vision and enthusiasm for stretch goals. One study found when HR leaders were compared to those who lead other functions, on average, their overall leadership effectiveness is 6 percentile points below the others.[29]

Their risk-aversion makes sense when you consider that many HR professionals see their role in terms of protecting the firm from legal entanglements with difficult employees. This important goal may, however, act against the firm's interests. To illustrate, by keeping an underperforming salesperson on staff to avoid an age-discrimination lawsuit, one company missed out on years of dramatically increased revenue.[30] The lesson we can glean here is that, in many cases, letting naturally risk-averse people make critical decisions runs counter to an organization's long-term interests.

It's clear that the status quo corporate management of healthcare no longer works. It's time to re-think this system by creating a healthcare strategy that can dramatically improve the employee experience—and ultimately, your business performance.

In this article, I focus not only on how to change corporate health care benefits, but also on how to change their corporate management. HR professionals do a great job in HR functions; but their risk avoidance mindset is not conducive to the innovative solutions that fulfilling employee needs demand.[31]

Making the best decisions about health benefits requires deep internal skills, day-to-day on-the-job experience, understanding of corporate culture, and solid vendor relationships. These are difficult attributes to outsource. CEOs, abetted by their CFOs, need to lead the charge by reorganizing the work done around providing health insurance so that it explores and incorporates the innovations their employees want.

Why should CEOs, who already have so much on their plate, take on this additional challenge? Simply put, they are well-suited for the job; "innovative" leads the list of effective characteristics of leaders like CEOs.[32] As for CFOs, in contrast to risk-averse HR personnel, they are unusually risk-tolerant—dominant, skeptical, fast-paced[33]—and tend to work in jobs requiring more analysis than coaching.[34] One key to their effectiveness is their analytical nature.

And, frankly, CEOs and CFOs are a dynamic duo that not only have a big picture understanding of how important it is to keep employees engaged, retained, and high-performing but also understand the long-term consequences of not doing so.

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How Quest Diagnostics' CEO Improved the Cost and Quality of Health Benefits

Even before the Great Resignation, as an employer of more than 50,000 people Quest felt the impact of rising health care costs on its employees and its bottom line. The company was faced with rising healthcare costs to the tune of approximately $20 million in annual incremental spend.

The company's leadership team, led by Steve Rusckowski, Chairman, CEO and President, decided to do something about it.[35]

Here's what Rusckowski and his team did:

- Moved responsibility of the company's group health plan from Human Resources to the Chief Medical Officer. Rusckowski believed that the medical team understood the system better and could provide effective care pathways and reduce unnecessary medical expenses.
- Hired a physician executive with previous experience of working at a health plan to manage the strategy.

"The toll of rising health care costs was having an unmistakable impact on our employees and our bottom line," Rusckowski said. "We started to see real change when we shifted the responsibility of the group health plan to our medical team. They spent their whole careers dedicated to improving healthcare."

Here's what happened:

- Cumulatively, Quest saved an estimated $40M over 4 years in healthcare costs; saw more than 80 percent of employees participate in employer-sponsored health programs;; achieved measurable improvements in health (reduced diabetes and cardiovascular risk); improved preventative screening compliance; and maintained a positive member experience, according to a published study.
- As a result, Quest was able to keep employee contributions to medical care flat between 2016-18.
- In 2020 the company received the prestigious C. Everett Koop National Health Award, given to organizations that demonstrate their health programs deliver significant health improvements and business results. In a quarter of a century, fewer than 60 organizations have won the honor.

"Employers need to recognize our employees are paying too much for healthcare and we have a responsibility to lower their out-of-pocket healthcare costs," Rusckowski said. "By offering quality, innovative healthcare solutions at the right price, employers can help improve the healthcare experience for their employees, minimize out-of-pocket costs and support better outcomes."

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END OF CALLOUT

The Biggest "Problem Areas" Employers Need to Address….

We've talked about health insurance costs, and they are indeed an issue that needs aggressive attention, but the problem companies face with health benefits is much bigger. In the search for better work/life balance, employees are also unhappy with many other aspects of their health insurance benefits. For example:

* *Undifferentiated patient care*. Currently, employees are offered "one-size-fits-all" policies that fail to account for individual differences, such as gender preferences, ethnic/minority status, and chronic disease status.[36] For example, in the typical "everything for everybody" health plan, all too many people with chronic diseases/conditions receive fragmented care from many different uncoordinated providers.[37]

When you realize that 42% of U.S. adults had more than one chronic disease[38] and the average Medicare patient saw a median of two primary care physicians and five specialists over a two-year time period,[39] it is clear what a huge issue this is. Coordinated treatment for those suffering from chronic diseases/conditions could profoundly improve their health status and help control the 90% of U.S. healthcare costs for which they account.[40]

Employers agree that undifferentiated care is a problem: one survey found that only half (51%) believe their benefit programs address the individual needs of their workforce, and even fewer (39%) offer significant flexibility and choice in benefits.[41]

* *Difficult access to care delivery.* Status quo corporate healthcare management is disconnected from the new reality that's been emerging for a while—one that has taken a drastic turn since the early 2020 COVID lockdown normalized working from home. The resultant hybrid work model that combines work in the office with work at home appears to be sticking. For example, some economists predict that millions of people will continue to work at home due to lingering concerns about COVID, buoyed by investments in equipment technologies and work habits that support remote work. A 2021 National Bureau of Economic Research study's analysis of survey responses found that employers plan for workers to supply 21.3 percent of full workdays from home after the pandemic ends. They claim that this change in the post-pandemic economy will boost productivity by 4.6 percent relative to the pre-pandemic situation.[42]

* *Lack of reinforcement for self-care*. Ensuring self-care, or patient adherence with the treatment prescribed, offers great promise for improved quality of care and cost control. Non-adherence is estimated to have caused approximately 275,000 U.S. deaths and at least 10% of all hospitalizations at a cost of up to $673 billion.[43]

Patients could use self-management to ameliorate a chronic illness.[44] But a large array of clinical resources is needed to support patients' self-management, including nurses and social workers, psychologists, psychiatrists, chaplains, nutritionists, naturopaths, and physical therapists who can

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assist individuals to manage various aspects of their illness, including medical, psychosocial, spiritual, and financial facets.[45]

Lower levels of adherence were generally associated with significantly higher total costs. The annual adjusted costs attributed to "all causes" of non-adherence ranged from $5,271 to $52,341.[46] Non-adherence to self-care is a special problem for medication. As many as 30% of all prescriptions written are not filled, and as many as 50% of those filled are not completed.[47]

**Plan administration.* At times over the years, health and accident insurance received more consumer complaints than any other category of insurance.[48] The categories of health insurance complaints tracked by New York State's Department of Financial Services include prompt payment, the process for internal and external appeals, and getting quick or needed access to care.[49]

In addition, patients are all-too-often hit with surprise bills when they receive care from out-of-network providers they did not choose[50] and other studies find this happens in about 1 in 5 emergency room visits[51]. In addition, between 9% and 16% of in-network hospitalizations for non-emergency care include surprise bills from out-of-network providers (such as anesthesiologists) whom the patient did not choose.

Yet, even with these inadequacies, the healthcare sector spends approximately $42 billion each year conducting administrative transactions.[52]

In general, the healthcare benefits offered by companies are out of alignment with the massive number of innovations that have occurred since COVID that can help to respond to these needs. Let's explore a few of them below.

…And Four Innovation Categories That Can Help

Besides the obvious work/life balance solutions (like flexibility around work hours and locations), CEOs can also make employees' healthcare lives much easier to navigate using health care innovations. Below, we have listed some innovations under four categories that correspond with the four problem areas detailed above.

Undifferentiated Patient Care

More and more, companies are recognizing the value of treating employees as the individuals they are.[53] And as we discussed earlier, employees want healthcare tailored to their unique needs.[54] For instance:

- *Customer segmentation.* Prevent Senior, a Brazilian health care company, focuses on the needs of those ages 49 and older. When it found that loneliness bought many to the hospital Emergency Room, it organized social functions for them, including recreational trips to a hotel owned by the company, thus lowering cost and improving satisfaction.[55]

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- *Pricing and outcome sharing.* Change Healthcare, a digital health company, leverages the ten billion health care transactions it processes annually by collating them into price and outcome data. The company's patient engagement platform combines data for medications and medical procedures with a Provider Directory tool to deliver integrated cost, quality, and access data to patients.[56]

- *Acuity matching*. One hospital chain has teamed with New York-based Hospital for Special Surgery (HSS) to share its expertise in low acuity procedures in outpatient facilities with HSS's surgical expertise. This acuity matching reduces the cost of care and the recovery period for patients.[57]

- *Demand management.* Indian cancer firm Health Care Global has organized care into hub-and-spoke models and paired round-the-clock procedures with yield pricing. Employees can receive the treatment in the most suitable cost and location environments.[58]

- *Consumer preference payments.* Johnson & Johnson offers a "one-procedure" pricing model for cataracts with presbyopia (loss of focus at intermediate and near range), allowing the patient to "buy up" to a single procedure addressing both conditions.[59]

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Plan Administration

Simplifying health plan administration equates to less time spent in getting needed care.

- *Technology*. Employers can leverage an array of digital technology to simplify administration, like smart sensors that measure heart rate, blood oxygen saturation, glucose levels, etc.[60]

- *Pre-registration.* Harborview Medical Center, a primary-care clinic in Seattle, Washington, enables patients to identify their agenda for medical appointments before meeting with their clinician. Both patients and physicians agreed strongly that this improved their care (79% and 74%, respectively).[61] Corporations that incorporate a pre-registration feature in their benefit plan can mitigate downtime incurred from health concerns.

- *Appointment intake.* Digital health company, Phreesia, claims that physicians can influence outcomes by linking check-in activity with other data (e.g., clinical gaps in care, patient adherence/compliance, etc.), opening up significant opportunities for cost and quality of care improvement.[62]

- *No surprise law.* A 2022 law prohibits surprise billing from doctors and other healthcare workers in emergency rooms, as well as out-of-network hospital providers like anesthesiologists and radiologists who work at an in-network hospital or facility without the patient's prior authorization.[63]

Lack of Self-Care Reinforcement

More and more companies are concerned about employee wellbeing. It's a trend that has been growing for a while but has really gained momentum since COVID.[64] That's why these innovations are so timely: what better way to ensure that people are "okay" than to verify that they're adhering to their self-care regimen?

- A number of innovators provide coordinated care for chronic diseases, such as diabetes (Omada) and heart health (Hello Heart). Others are focused on the needs of distinct groups, such as Marvin, which offers telemedicine-based mental health designed solely for medical clinicians.[65]
- CVS Health, the pharmacy/health insurance company, uses patient reinforcement to improve health outcomes for employees taking prescription medicines. It uncovers the patient-specific

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root causes of non-adherence and addresses them with solutions that include personalized packets of pills, synchronization of prescriptions, clinical and motivational counseling, and refill reminders. [66] CVS estimates that plan sponsors could save as much as $63 million per 100,000 members by focusing adherence efforts on patients with three or more co-morbidities.[67]

Difficult Access to Care Delivery

Companies need to do everything possible to simplify healthcare delivery and insurance. Today's workforce, particularly the younger sector, is very comfortable accessing healthcare in a retail environment, and of course technology already permeates every area of their lives…which is why these innovations are a natural fit.

- *Alternate sites of care*. Many alternate sites for care sprang up to compensate for the lack of availability caused by hospitals filled with COVID patents. Employees should have access to these more convenient alternative sites of care: retail medical centers such as those run by CVS, Walmart and Amazon[68] ;hospital to home programs[69] [70]; neighborhood centers for urgent care and ambulatory surgery; and even laptops and smart phones that offer telemedicine.[71]

With all of the innovations available, there's much employers could be doing to better meet employee wants and needs. Instead, many of them passively accept yearly cost increases and pass them on to employees. They are reluctant to be first to market in testing new strategies.[72] This hesitancy is unsurprising given the risk-averse nature of HR professionals. However, if health insurance decisions were driven by the leadership mindset of CEOs (in conjunction with CFOs), we would likely see a far greater willingness to test the various innovations that have risen up in the past several years.

How to Make It Happen

For all the reasons listed above, we've reached a critical juncture. The healthcare that's so central to employee wellbeing has gotten so depersonalized, so difficult to navigate, and so expensive that choosing a plan calls for the visionary insight, strategic thinking, and decision-making implementation that only the CEO can provide.

The whole system cries out for a massive overhaul. Having the best healthcare plan has become a competitive advantage and a market differentiator for your company. That means you need an innovative healthcare strategy, one that is driven by the highest echelons of the organization.

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The analytic and strategic perspective of CEOs (and CFOs) make them best equipped to navigate the complex health insurance landscape and devise innovative strategies that meet their organization's goals. Yet, for the most part they've been hesitant to venture into these murky depths, and for good reason, considering some highly visible failures. For example, Haven—the highly-publicized intended disruptor formed by the powerful business triumvirate of Amazon, Berkshire Hathaway, and JP Morgan—shut down in 2021 after only three years in operation, due in part to lack of expertise in the complexity of innovating in health care.[73] Haven failed because these brilliant CEOs, nevertheless, lacked a clear goal and did not know enough about healthcare. It is crucial to have a solid strategy and to know the territory you're venturing into.

Even so, the changes we've enumerated here make it a risk worth taking—indeed, one that CEOs can't afford to ignore. A robust and workable healthcare strategy is no longer a "nice to have" but a "must have." It's telling that on the heels of its Haven failure, an undaunted Amazon bought One Medical, with nearly 200 health care centers that can help alleviate the access to care problems.[74]

With the problems of our healthcare system still fresh in our collective minds, and with America more open to innovative thinking, we need to strike while the iron is hot. And CEOs need to lead the way with a focused healthcare strategy.

CEO To-Dos

It is my hope that after reading about the wealth of innovations out there, including those that have emerged over the last several years, you are feeling energized and inspired. You have the opportunity to get those spiraling healthcare costs under control, make life significantly better for your employees, breathe new life into your culture, all the while setting a bold example for other likeminded industry leaders.

Here are a few suggestions for how to implement this innovative health care strategy by changing the composition and incentives of your health care personnel and/or outside advisor. We will describe how a corporation can implement this strategy internally first.

• **Set up innovation areas designed to address the four strategic imperatives**. These units, which comprise the think tank for your company's new health strategy, should be overseen by an analytic leader, like the CFO.

• **Incentivize those in charge of these four areas to control costs and maximize benefits.** Currently few companies do this. While CEOs tend to incent executives like CFOs and CEOs to create profitability and efficiency, they do not do the same for people in charge of health benefits.[75] Instead, as explained earlier, brokers are at times actually incentivized by the insurance companies.

• **Form an internal healthcare oversight function to evaluate innovations and fold the right ones into the firm's healthcare strategy.** This individual or team carefully sifts through

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innovative vendors to control costs and quality driven by internal experts or independent firms that specialize in self-insured corporations.

For example, here's what might happen inside each innovation area:

Lack of Differentiation: To personalize health care in the corporate environment, the Benefits Specialist team will engage employees with individualized expert advice regarding provider selection, pricing, payment, and integration. Central to this endeavor is the implementation of one or several analytic platforms to present, educate, clarify, and guide the care options for the employee, and assist them with the next step, accessing care.

One example of a Benefit Specialist analytic platform is ZeOmega's Jiva Digital Consumer Engagement solution. Using a multi-channel approach that interacts with consumers on the basis of their individual behavior, health, and preferences, Jiva claims to integrate patient and clinical data to target users with useful information to achieve better engagement and compliance, access clinical resources more effectively, and deliver better outcomes.[76]

Difficult Access to Care Delivery. The Delivery Management Specialists may contract directly with market providers such as specialized, expert providers (e.g., the Mayo Clinic) or accountable care, preferred provider, or health maintenance organizations. This team may also incorporate ongoing and chronic care assistance with services such as Livongo's Applied Health Signals system, which combines data science, behavior enablement, and clinical impact to reinvent the healthcare experience for people with chronic conditions.

Self-Care Reinforcement. This function, traditionally associated with the Human Resources department, typically engages with corporate health plan members to ensure navigation, adherence, and compliance with medical regimens. It consists of a specialist or team that follows up with members after every care incident or the manages vendors that do so.

Patient reinforcement under the new health strategy expands these limited functions. For example, retail medical centers such as CVS Pharmacy are engaged to ensure member adherence to drug regimens. They uncover the patient-specific root causes of non-adherence and address them with solutions that include personalized packets of pills, synchronization of prescriptions, clinical and motivational counseling, and refill reminders.[77] CVS estimates that plan sponsors could save as much as $63 million per 100,000 members by focusing adherence efforts on patients with three or more co-morbidities.[78]

These aids to self-care serve to close the loop on health care incidents, to assure health outcomes and their attendant effects on employee productivity.

Plan Administration. The Plan Administration specialist coordinates closely with vendor partners, defining and tailoring solutions specifically for the employee needs (e.g., knowledge of prices, easy scheduling, etc.), and implementing regular monitoring and reporting methods to capture value from the efforts in the form of increased productivity, decreased workdays lost, etc. The Plan Administration specialist incorporates and oversees applications such as Change Healthcare's Smart Connect™ tool to assist members in choosing their health plan.

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How *Quest Diagnostics Made It Happen*

The *Fortune 500* clinical lab firm Quest Diagnostics achieved 11% lower cost of care relative to peers in year-over-year growth in employee uptake of the company's plan and a 4.2% improvement in population health leading to fewer clinical interventions. [79]

How did Quest do it? To help *plan administration*, they engaged their plan provider, Aetna, to identify the most significant health-related problems and cost drivers. In the process, Quest moved from an annual analysis of their health care expenses and causative and outcome-oriented measures to monthly and even weekly reviews. Their goal was to *personalize health care* by identifying the highest cost services, causes, and affected populations promptly.

Quest then worked to *encourage self-care* by encouraging employees in the effort, soliciting expectations for cost, access, and quality of care, defining benchmarks and methods to achieve them, and once implemented, communicating the results.

Finally, Quest helped the *difficult access to care* by engaging innovative third-party providers to execute specific elements of their new strategy—for example, helping employees acquire second opinions and physician referrals; assisting them with drug regimens and compliance; and enabling diabetes prevention and tobacco cessation programs.

END OF CALLOUT

Making these changes is no simple task. They will require a huge investment in time, bandwidth, and human capital, but the payoff is potentially enormous. It may help you not only control health insurance costs but also create the kind of culture that attracts and retain high-performing employees, maximizes engagement, and increases productivity long term. It is hard to think of better incentives for shifting to a CEO-led healthcare strategy.

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