RESEARCH REPORT

2019 Employer Market Growth Outlook

How to manage a suite of nonclinical new product features

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RECOMMENDED FOR

Employer line of business leaders, wellness program leaders, member engagement teams

READING TIME

15 min.

Executive summary

Employers and their employees shoulder an outsized share of total health care costs in America. Accordingly, employers demand tighter cost management from health plans but these employers also don't want to restrict networks and risk upsetting employees when the unemployment rate is at a record low level.

Instead, health plans in the employer line of business are looking towards expanding nonclinical and wellness services to manage member health at a reasonable price. The challenge here is in navigating through the world of wellness which has few demonstrated clinical or financial benefits.

Plans must use existing network management capabilities to become the manager of this new product feature network. To achieve this goal, the three network questions plans must answer are:

1 **Which partners do I include in the network?**

The most important first step here is to pre-determine standards. Plans should only enter contracts, and then enable partners, once there are standards for accountability that both parties agree on.

2 **To which members do I offer access?**

It is crucial that plans target appropriate members since not everyone should receive all services. Calculate which members will guarantee an ROI and then proactively propose features to them.

3 **How do I get members to use services?**

Plans must deploy familiar messengers to engage members in these new offerings. Use sources that members already derive value from, such as providers or technologies, to share feature information.

Introduction

Case studies

Employers, employees face increasing health care costs

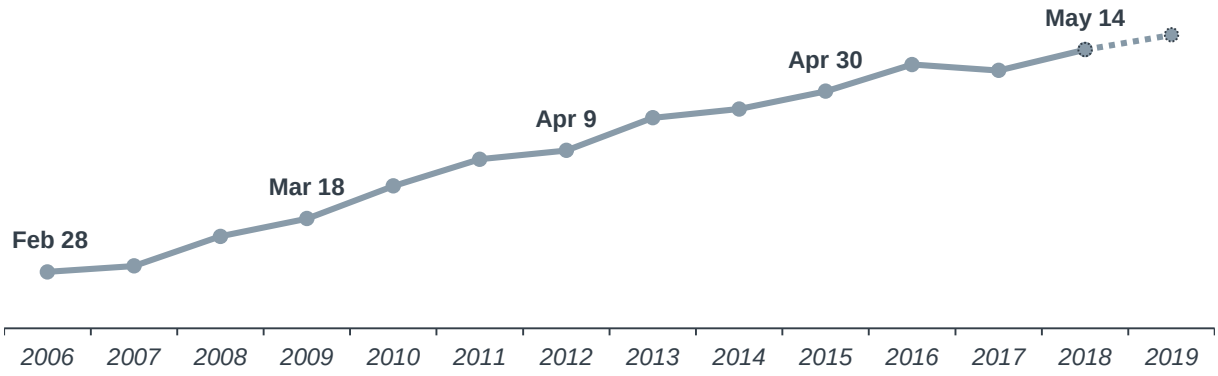
Plans that can give more services at lower costs will win this market

In 2019, annual premiums rose 5%, causing the average total cost of employer-provided health care coverage for a family plan to pass $20K for the first time. In response, employers and health plans have tried to get employees to use efficient care using high deductibles but employees are unable to bear their growing burden.

"Deductible relief day" is coming later and later on in the year, leaving employees unable to see the value of their plan for the majority of the year. The data also shows that employees are seeing their health care spending increase, even more than employers are, while their disposable income decreases.

"Deductible Relief Day," annually

Day of the year when average health spending for large group members exceeds the average deductible in that year

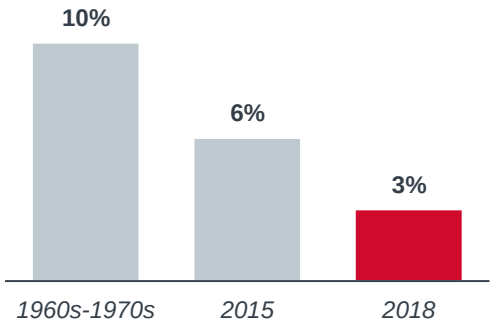


Employees increasingly unable to bear their growing burden

27 percentage point

difference in employee and employer growth of health spending contribution, 2009-2017

Percentage of disposable income saved on average by US families[1]



Employers feel strapped and are demanding that plans drop costs and offer competitive benefits, without using restrictive tools that would upset employees. Though it will be difficult, the plan that succeeds at this will have a great competitive opportunity because this is a market hungry for change. All of these opportunities for diversification and growth in the employer business means plans must do more with less.

1. Based on US Federal Reserve data.

Source: Rae, Matthew et al., "Deductible Relief Day", *Kaiser Family Foundation*, May 2019, https://www.healthsystemtracker.org/brief/deductible-relief-day-how-rising-deductibles-are-affecting-people-with-employer-coverage/#item-start; White C and Whaley C, "Prices paid to hospitals by private health plans are high relative to Medicare and vary widely," RAND, 2019; "Health sector economic indicators: price brief," Altarum, March 15, 2019; Schulman K, "The implications of 'Medicare for All' for US hospitals," JAMA, April 4, 2019; Goldsmith J et al., "Medicare expansion: A preliminary analysis of hospital financial impacts," Navigant, 2019; Kamal R and Sawyer B, "How much is health spending expected to grow?," Kaiser Family Foundation, March 12, 2019; Sullivan, Bob. "Once Again, Americans Are Not Saving Enough," *MarketWatch*, 28 Aug 2018; Mathews, Anna, "Cost of employer-provided health coverage passes $20,000 a year" WSJ, 25 September 2019..
Health Care Advisory Board interviews and analysis.

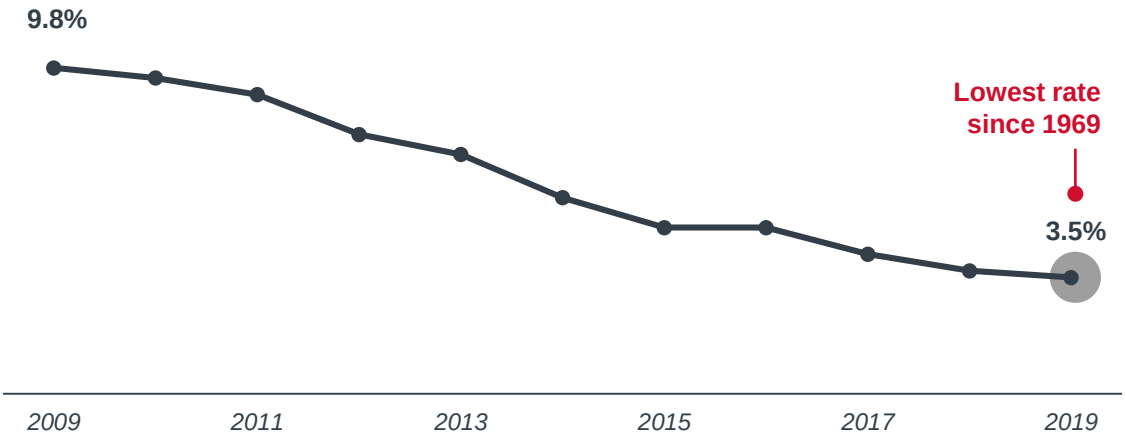
Low unemployment rate means employee satisfaction is key

Employers are starting to add low-cost features rather than cut high-cost ones

Starting in 2020, employers will be able to offer their employees, and even sub-groups of their employees, money to buy marketplace coverage with Health Reimbursement Arrangement (HRA) funds. Whether employers will be interested in these new products will depend on the labor market. If the labor market remains tight, uptick will likely remain low.

As of late 2019, the U.S. is at the lowest unemployment level in the past 50 years. Though this is only a measure of those actively seeking employment and there has not been commensurate wage growth, employers still find themselves competing for workers.

Unemployment rate as of September 2019

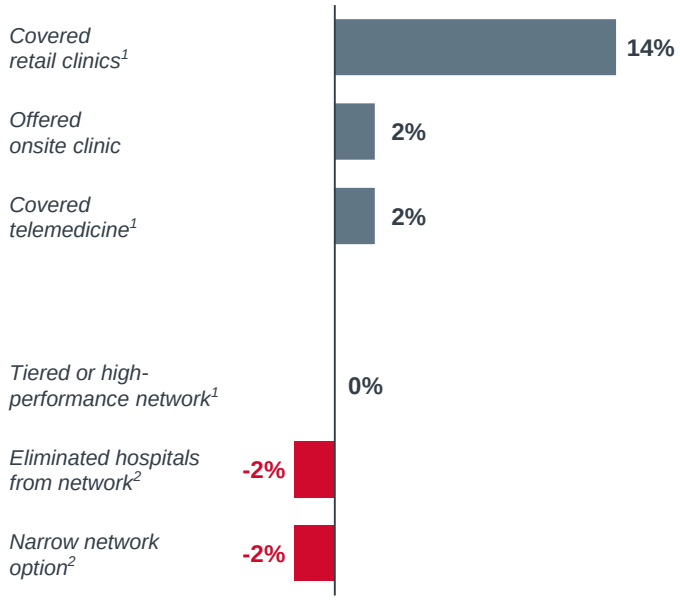


Because of this tight and demanding labor market, employers are backing off from further restrictions on broad networks. The chart on the right shows the changes in 2019 employer offerings from 2018. All the changes are aimed at adding low-cost features, rather than cutting high-cost ones.

Narrow network products, or even heavily tiered products, have quickly grown out of favor in the employer market because they have upset employees with complicated benefit structures and surprise bills. Employers now want more for their employees, but at the same price or lower.

Changes in 2019 employer offerings (from 2018)

Percentage point change in proportion of firms with health benefit feature



1. For firm's product with largest enrollment.
2. For any product offered by firm.

Source: "Unemployment Rate," Bureau of Labor Statistics; Employer Health Benefits 2018 Annual Survey, Kaiser Family Foundation; Employer Health Benefits 2019 Annual Survey, Kaiser Family Foundation; Health Plan Advisory Council research and analysis.

Employers offer more high-value, low-cost benefits

The world of “wellness” has expanded to include many non-traditional benefits

In an attempt to satisfy employees while also managing their health, employers have typically invested in wellness programs. The average large employer spends 3.6 million dollars annually on wellness programs. Unfortunately, much of that is wasted on programs without any demonstrated clinical or financial outcomes. Instead of passively allowing employers to invest in the newest wellness fad, plans can actively deliver programs that actually make a financial and/or health impact on their employees.

DATA SPOTLIGHT

Employers spending more on wellness programs

$3.6M Average amount spent by a large employer on wellness programs[1]

81% Of employers expect their health and wellness program spending to increase

The good and bad news is that the world of wellness continues to grow. On the good side, wellness is becoming more than just paying members to take a health risk assessment or other activities with little to no health impact. On the bad side, because the world has grown so large, it is challenging to know which initiatives are worth the investment. Below are some of the many services purchasers are asking for from plans on top of traditional clinical benefits.

Example additional product features in the new world of “wellness”

Substance use programs
Internet access UniteUs DigitalHealth WildflowerHealth
Literacy classes Free housing Digital glucose monitoring Livongo CBO data base
Aledade Smart Shopper Call center Disease management
Phreesia Mindfulness classes Stress management Education financing
Acupuncture Step tracker Weight management Transportation services
Fertility treatment Avalon Fitness trackers Smoking cessation
Social classes Meditation apps Health risk assessments Solera Peloton
Omada Biometric screenings Gym membership
Food delivery Amino Collective Consumerism tools WebMD Aunt Bertha
Centers of excellence Transparency tools Behavioral telehealth
early childhood education Meal assistance Navigation services Translation services
FastMed Preconception programs Virtual reality Onsite clinics
Fall prevention device Medical tourism HealthCatalyst Change Health

Source: Kent, Jessica. “Large Employers to Average $3.6M on Wellness Programs in 2019”, *Health Payer Intelligence*, April, 2019, https://healthpayerintelligence.com/news/large-employers-to-average-3.6m-on-wellness-programs-in-2019; Keckley, Paul, “The Wellness Economy: Its Time Has Finally Come”, The Keckley Report, Dec 31, 2018; “Ten Years of Health and Well-Being at Work: Learning from our past and reimagining the future, Health Plan Advisory Council interviews and analysis.

1. >5K employees.

Third party vendors have advantage in feature creation

Plans left to choose from hundreds of product features, many with no ROI

Employers are pushing plans to offer many new programs and services but it's difficult to figure out which ones are worth the investment. Some plans wish that they could create the programs themselves because then they could tailor them to the employers' exact specifications but the harsh reality is that most plans are not currently prepared to create these programs.

When it comes to scalable, technology-based product features or social determinants of health (SDOH) services, third party vendors have the clear advantage over plans for three main reasons.

First, they are more nimble because they are not dealing with legacy technology systems, they don't have the restriction of entrenched business priorities and policies, and they have qualified technology professionals who are eager to work for them.

Second, they are more specialized so they can offer services to broader populations. For example, a program for diabetes patients could serve all of the diabetic patients in a state or even the country rather than the small subset of diabetic members in one plan's membership.

Third, they are often less distrusted because they don't have the plan baggage of being seen only as a company who wants to save money. This is especially true for community based organizations (CBOs) that are often delivering the SDOH services on behalf of health plans.

Partner strengths for product feature creation

Eventually, larger plans may start creating these solutions in-house but for now, most plans must be reliant on these third party vendors. The downside for plans is that they are left with hundreds of potential product features and programs that others have created. In fact, **638** corporate wellness companies exist in 2019.

Plans must sift through hundreds of features that may or may not cut costs or show an ROI. Currently, both employers and plans are passively choosing features that are either new and popular or marketed heavily. In fact, one plan remarked that they offer features based on what the loudest employer is asking for and *then* they will go find the data to support the investment. This kind of unmanaged selection process leads to thousands of dollars being invested in programs with no ROI.

Consequences of choosing poor wellness programs

JAMA, April 16, 2019

"No significant difference in health care spending or utilization for people enrolled in programs... focused on nutrition, physical activity, and stress reduction"

DATA SPOTLIGHT

61% Of employees are dissatisfied with existing wellness offerings

Source: "Corporate Wellness Services Industry in the US - Market Research Report", IBIS World, May, 2019, https://www.ibisworld.com/industry-trends/specialized-market-research-reports/life-sciences/wellness-services/corporate-wellness-services.html; Gray, Erine, "How does Aunt Bertha get its data?", Aunt Bertha, Jan., 2018,https://company.auntbertha.com/blog/2019/01/18/letter-from-founder/; Song Z, Baicker K; "Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes", *JAMA*, 2019; Beaton T, "61% of employees dissatisfied with employer wellness programs," *Health payer intelligence*, Dec 2017, https://healthpayerintelligence.com/news/61-of-employees-dissatisfied-with-employer-wellness-programs; Health Plan Advisory Council interviews and analysis.

Aggregators emerge to manage new product features

Plans can and should be the first network aggregators for new product features

Because of the large number of new product features, the industry is now seeing the next level of opportunistic innovation here in the form of aggregators that are emerging to manage all of these new product features.

In the vendor space, there are companies such as the TPA[1] Collective Health. Its value proposition lies in curating and managing a network of wellness vendors for employers. Not only do they curate the network but they also provide employers with data on vendor performance.

In the CBO space, there are players such as Unite U.S. or Aunt Bertha. Unite U.S. is a tech company that connects CBOs and providers to address SDOH. They popped up six years ago to serve military veterans but have since expanded to Medicaid and Medicare beneficiaries because they saw the need for a network manager in this market as well.

The clear need in the market for someone to sift through and manage the proliferation of product features has contributed to the growth of these new players. These new aggregators are starting to look like network managers, which is the *plan's* value proposition. If this role is taken away from plans, plans should be concerned about what *their* role is in this space. **Plans can and should be the network aggregators for nonclinical product features.**

Plans have the competencies to manage networks as they have been doing this for decades in the provider space. They have access to site of care analytics, know optimal referral pathways, and have the financial resources to invest in preferred partners. Perhaps most importantly, plans have the third party objectivity to set outcomes-based standards—one of the unique benefits of being in a system where plans are neither the purchaser nor the utilizer.

Plan competencies in managing networks

- Access to member utilization data and site of care analytics
- Understanding of optimal referral pathways
- Third party objectivity to set outcomes-based standards
- Financial resources to invest in preferred partners

Plans also have a lot to gain here if they take the lead. If plans become the network manager and develop preferred partnerships, they can get preferential access for members. Also, they receive the ability to justify offering new and unique features because only once plans calculate the potential ROI on providing completely new features can they do so and set themselves apart..

These aren't small advantages that plans can afford to miss out on but it's going to take some adaptation of current plan competencies.

First-mover advantages from preferred partnerships

- Preferential access to new product features for your members
- Reduced admin burden from sending data to fewer partners
- Ability to justify offering new, unique product features
- Prioritized investments in services most valuable for your membership

1. Third party administrator.

Source: Health Plan Advisory Council interviews and analysis.

Innate differences exist between providers and new features

Plans must answer three key questions for new feature network management

The transition from a physician network manager to a new product feature network manager won't be simple due to the fundamental differences between provider and new partner networks.

In the physician network, plans are used to answering the following questions but now they must adapt their responses for the new partner network.

1) Which partners do I include in the network? With physicians, plans include quality, licensed providers who meet clinical standards. There are clear standards for what each type of specialist should do. In the new partner network, it's harder to discern because a wellness digital health vendor is so different from a food bank and a food bank is also very different from another food bank.

2) To which members do I offer access? In the physician network, plans want to open access to all their members. Everyone is equally allowed to go to their care provider given that they are in the same product. Even when there's primary care gatekeeping, members still have consistent coverage among one another. In the new partner network, plans can't give access to everyone or they will go bankrupt.

3) How do I get members to use services? Plans often grapple with *too much* use of providers in their traditional networks. Members know when they need or want clinical care, sometimes inappropriately, which leads to overutilization. In the new partner network, plans struggle with underutilization because members don't even know that they have access to these features and plans aren't used to promoting them properly either.

Three key questions for network management

	Which partners do I include in the network?	To which members do I offer access?	How do I get members to use services?
Physicians	Quality, licensed providers who meet clinical standards	Equal access for membership	Not an issue because overutilization occurs
New partners	Unclear due to diverse partners with varied standards	Targeted subpopulation	Challenging because members don't know of features

Source: Health Plan Advisory Council interviews and analysis.

How plans can manage a new partner network

Three plan action steps with associated case studies

Plans have to adjust their actions to fit the new product feature network. Below are the three ways plans can answer the key network questions for the new partner network.

First, over-invest in pre-determining standards. It's impossible to contract with everyone so plans should only partner once there are standards for accountability. And then, enable these partners to be better.

Second, calculate which members will guarantee an ROI to avoid financial challenges. Then, proactively propose features to these members.

Third, deploy familiar messengers. Members aren't going to scour plan websites for new services. Instead, plans should use sources that members already derive value from to share feature information.

Plans are still at the beginning of this new era so it's the perfect time to get ahead start for a competitive growth advantage. Plans should set their network management foundations to suit what they want to accomplish rather than having to grapple with legacy infrastructure as is the case in the provider network.

View the three case studies on the following pages to see how health plans are already starting to take these three action steps to manage a new partner network.

Three plan action steps to manage a new partner network

Which partners do I include in the network?

Pre-determine standards
Only enter contracts and enable partners once there are standards for accountability

CASE STUDY

Blue Shield of California's
Wellvolution platform

To which members do I offer access?

Target appropriate members
Calculate which members will guarantee an ROI and proactively propose features

CASE STUDY

Blue Cross Blue Shield of Louisiana's
Impactability score

How do I get members to use services?

Deploy familiar messengers
Use sources that members already derive value from to share feature information

CASE STUDY

Oscar Health's
step tracking app

Source: Health Plan Advisory Council interviews and analysis.

Curate a platform of value-based vendors for members

CASE EXAMPLE

Blue Shield of California

Health plan serving 4 million members • Oakland, California

In the crowded vendor ecosystem, it can be a challenge for plans to choose which vendors are the best quality partners to work with. Unlike the highly regulated provider sphere, there are constantly new vendors being created with no standardized metrics to judge them against each other. Blue Shield of California's Wellvolution program is unique for multiple reasons, including both its vendor vetting process and its payment model.

Blue Shield of California's Wellvolution program

Vendor vetting process	Payment model
Strict vendor vetting process to assess clinical efficacy and customer satisfaction	High acuity programs are paid via medical claims
Ability to quickly vet vendors assures expedited speed to market	Vendors paid incrementally as engagement and outcomes-based milestones are achieved

Blue Shield of California strictly vets vendors before allowing them on the Wellvolution platform. In fact, they looked at over 314,000 apps before deciding on less than 40. When vetting vendors, they are looking not only at proven clinical results but also app store reviews to gauge member satisfaction.

The other unique feature of the Wellvolution program is their payment model for vendors. Certain vendors are paid incrementally, as members reach 6 to 9 engagement and outcomes-based milestones. For example, a weight management vendor might be paid $500 once a member enrolls in the program, and then another $500 once the member loses 2% of their body weight, and then another $500 once the member keeps that weight off for three months. This means if the vendor's program doesn't work, the vendor would not get paid.

Blue Shield of California's network is also flexible, which means they can quickly bring in any new providers that they deem effective and appropriate, as well as remove providers that are not performing as required. They are constantly monitoring the performance of vendors. They talk to the high performers to see what they are doing that's leading to proven results and then share this "best practice" advice with low performers. They also proactively warn low performers that they could be removed from the network unless they improve their results.

DATA SPOTLIGHT

17K
Members enrolled

85%
Of enrolled members are actively engaged[1]

51%
Of enrolled members are engaged in intensive reversal programs[2]

5-point
Jump in NPS for Blue Shield of California's diabetes prevention program

1. Regular interactions with Wellvolution program.
2. Such as disease management.

Source: Blue Shield of California, San Francisco, CA; Health Plan Advisory Council interviews and analysis

Target interventions to members willing to change

CASE EXAMPLE

Blue Cross and Blue Shield of Louisiana

Health plan serving 1.1 million members • Baton Rouge, Louisiana

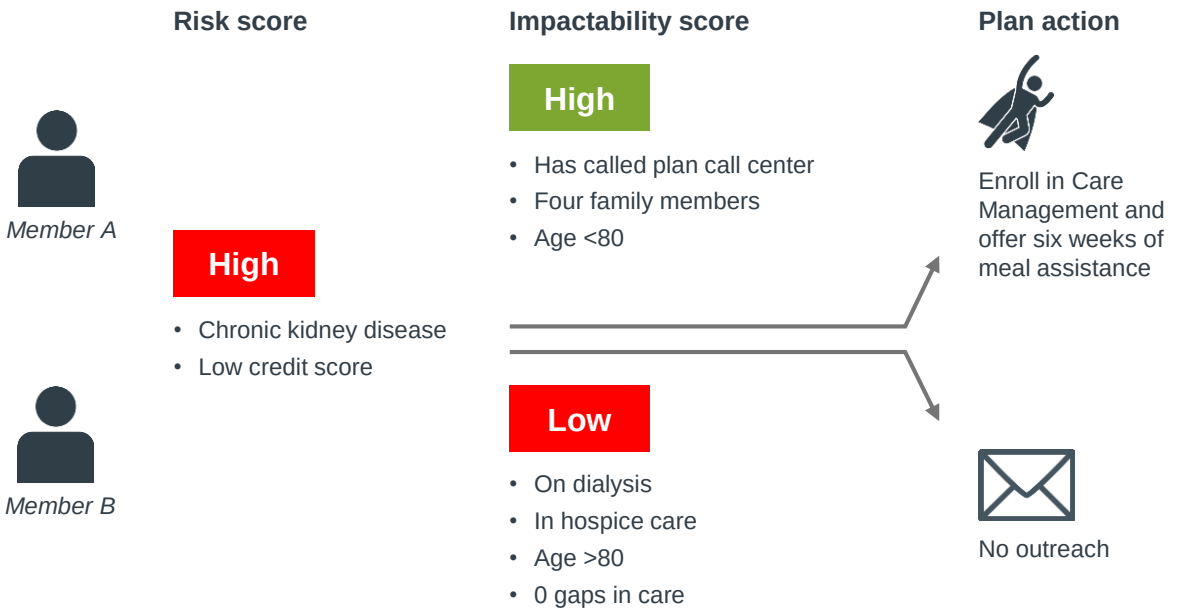
Locating high-cost members is challenging and failing to do so is costly. But even once plans have identified the members who need additional services, it is difficult to try and make members change their behavior.

Blue Cross and Blue Shield of Louisiana (Blue Cross) identifies members for new product features using not only a risk score, which is common practice among plans, but also an Impactability score.

Instead of using the usual 25 to 35 metrics to create a risk score for their members, Blue Cross is using an algorithm that analyzes up to 8,000 metrics to calculate a risk score, and then adjusts that score for how impactable an individual's risk score is to create an impactability score. Some of the metrics used to calculate these scores include: ZIP code, job title, number of family members, credit score, claims data, and more.

For example, two members may both have a very high risk score but very different Impactability scores. It is more worthwhile for the plan to reach out to the member under age 80, with multiple care gaps, and a history with the plan, than the member who is already in hospice care and on dialysis.

Blue Cross and Blue Shield of Louisiana's member outreach process



DATA SPOTLIGHT

Impactability score results

1.5x
More likely for model to predict unplanned hospitalization in high-risk group than control group

4x
Increase in engagement rate from Care Management nurses

$620K
Saved from avoided admissions and ED visits in first year

$150
PMPM difference between members in disease management (DM) versus members not engaged in DM

Source: Blue Cross Blue Shield of Louisiana, Baton Rouge, LA; Health Plan Advisory Council interviews and analysis.

Design apps to provide value based on what *members* want

CASE EXAMPLE

Oscar Health

Health plan founded in 2012 with 230K members • New York City, NY

Health plans (often correctly) presume that members don't want to be bothered by their plans unless necessary. But to offer effective support, plans need members to see them as partners who are always available to assist.

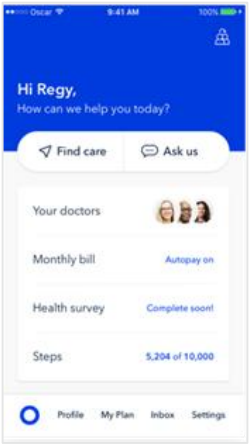
Oscar Health, a health plan with a focus on digital platforms, strives to make its digital platforms mirror how members want to think about their health. One of the ways Oscar drives use of their digital member platform is by putting their members' top personal interests first in their interface design—not necessarily their health care interests.

Oscar conducted tests of multiple versions of their app and learned that the top point of interest was the step tracker feature. Oscar has a steps incentive program already in place—one dollar a day for hitting 10,000 steps. The design of the front page substantially drives utilization: Oscar found that members preferred a version of the platform that prominently featured the steps tracker at the top when they opened the app, rather than a navigation support tool like a doctor finder.

Oscar's A|B test for member priorities

OPTION A

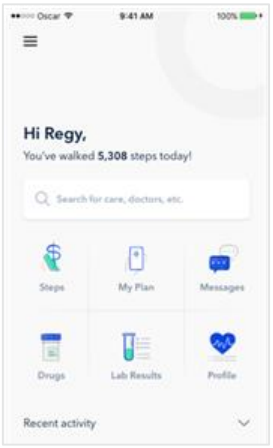
App features tools that relate directly to care or impact costs



OPTION B

App features step tracker prominently

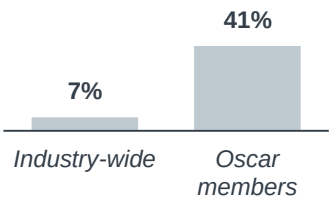
Preferred by member testers



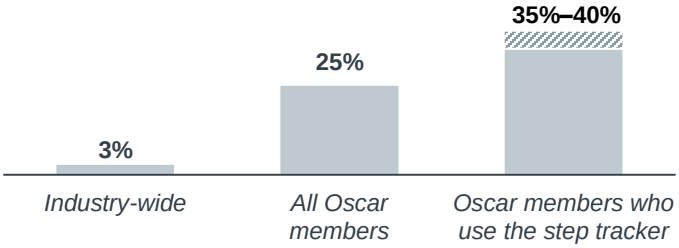
After Oscar released the preferred app design, they saw increased engagement with the tool. Oscar members who use the step tracking feature are more likely to use the app for other services such as telehealth.

Oscar's app utilization results

Monthly active app users, 2017



Oscar's telehealth utilization rates



Source: Perlera Regy, "How We Designed Oscar 2.0," *Medium*, August 29, 2017, https://medium.com/@perlerar/how-we-designed-oscar-2-0-fbba97087bae; Deep Dive, Oscar, 2018, https://www.hioscar.com/deepdive/virtual-care-platform; Oscar Health, New York, NY; Health Plan Advisory Council interviews and analysis.

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