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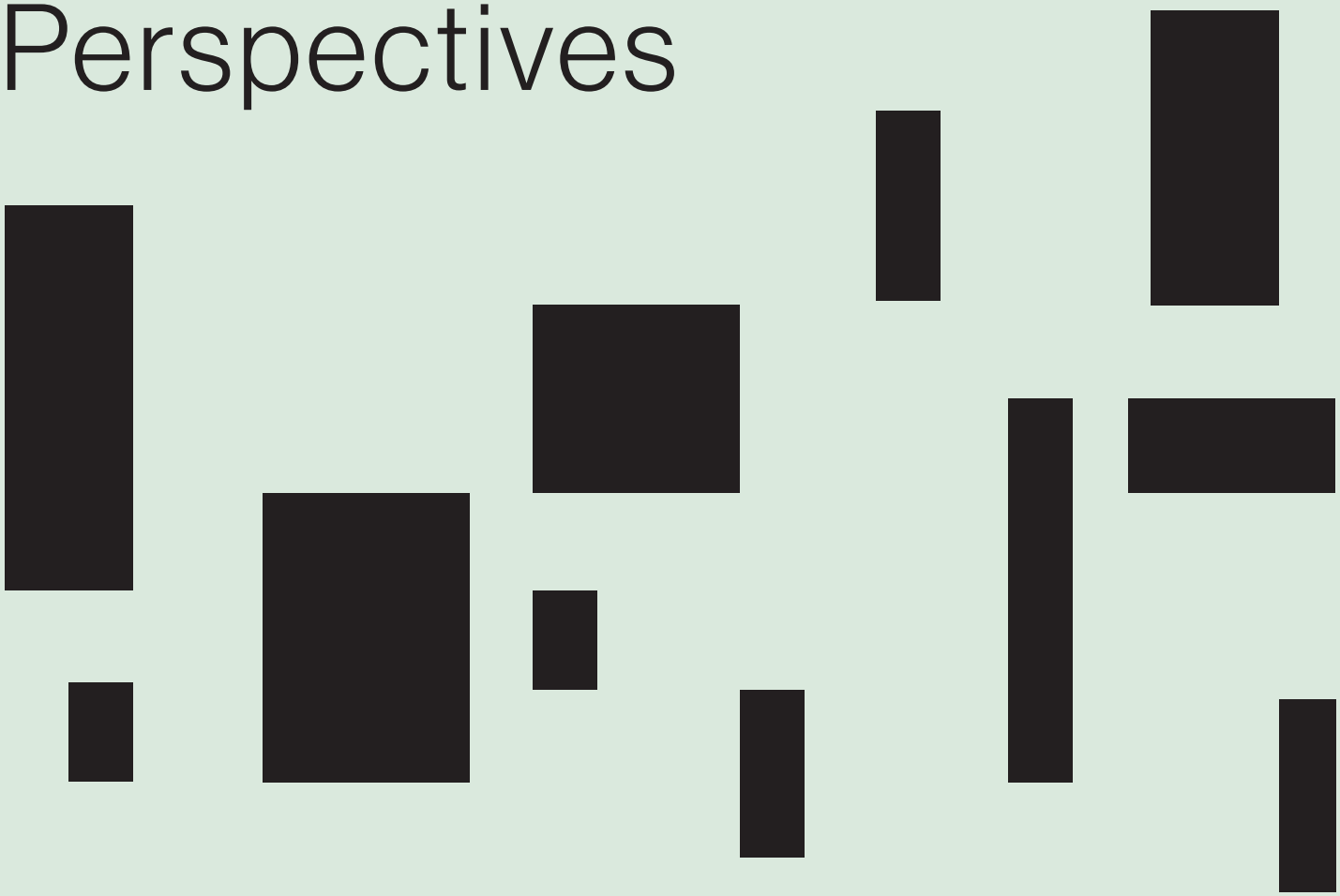
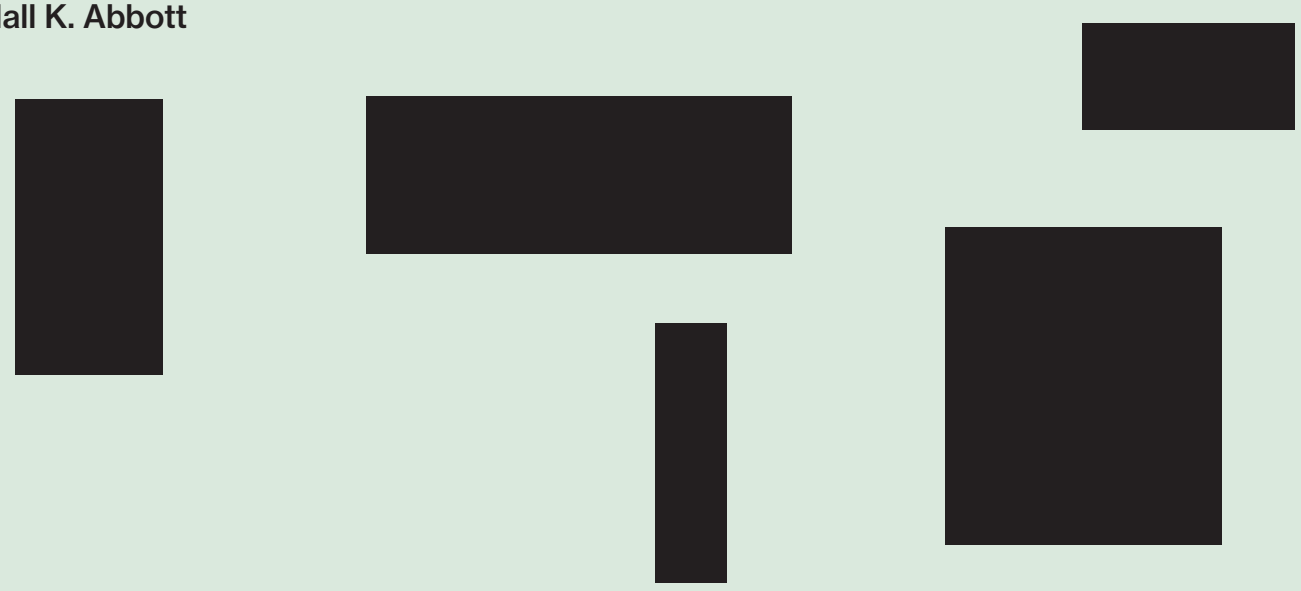
Perspectives



Eight macro-trends influencing employer-sponsored health care strategies

By Randall K. Abbott



Employer-provided health care is being transformed by a convergence of macro-trends that are creating significant strategic planning challenges. This convergence is also creating new opportunities and new decisions for employers, and ultimately for their employees. Health care reform has contributed to — and accelerated — change, but it is only one of many factors that will reshape health care benefits and health care delivery over the next five to 10 years.

The first step for employers examining the changing health care landscape and its evolving strategic considerations is understanding these overarching trends and their inherent dimensions. While other forces are certainly at work, we view the following eight as the dominant trends influencing employer-provided plans:

- Legislative and regulatory uncertainty
- Provider system redefinition
- The changing practice of medicine
- New entrants and disintermediators
- Health technology
- A realignment of patient care and health management
- The role of exchanges
- Change and the employee value proposition (EVP)

We'll look at each trend, highlighting its dimensions and specific employer health plan implications to help employers understand, examine and implement strategies that leverage these trends, improve performance, create efficiencies and anticipate the changes ahead. In addition, we will delve into the broader business, workforce, total rewards, EVP and talent management issues these dynamics will inevitably influence.

Key implications for employers

- The advent of public (and private) exchanges creates new benefit delivery channels.
- Most employers will evolve to cohort segmentation. They will likely segment their population and position each cohort with the delivery channel that affords the greatest value to the employer and the individual. The result will be a hybrid delivery model utilizing public exchanges, private exchanges and a self-managed plan to achieve the greatest value (cohort value optimization).
- Beyond managing annual cost increases, the excise tax and other tax-related risks create an even greater need to optimize health plan performance. Six major dimensions must be examined and incorporated into strategic planning to help ensure maximum performance of employer plans.
- The ultimate form of the excise tax may change, but health benefit tax treatment must be considered a business risk and scenarios must be developed to mitigate its impact in order to achieve both business needs and the desired EVP.
- The excise tax has caused managing cost trend to the Consumer Price Index (CPI) to become the gold standard of health plan cost performance, since the tax, as currently written, is indexed at the CPI (currently less than 2%), not health care trend rates. (This is indeed possible, as top performers have averaged less than 2% a year in recent years.)*

*2015 20th Annual Willis Towers Watson/National Business Group on Health Best Practices in Health Care Survey

Ultimately, all employers need to achieve and sustain an organizational health care strategy that is affordable, cost effective, efficient, aligned with its business needs and delivering value. In addition, they must create a program that is both consistent with their EVP and providing a meaningful health care experience for employees. Given the need to transcend average performance, this challenge calls on leaders to issue a high-performance imperative both operationally and financially, as well as to optimize engagement.

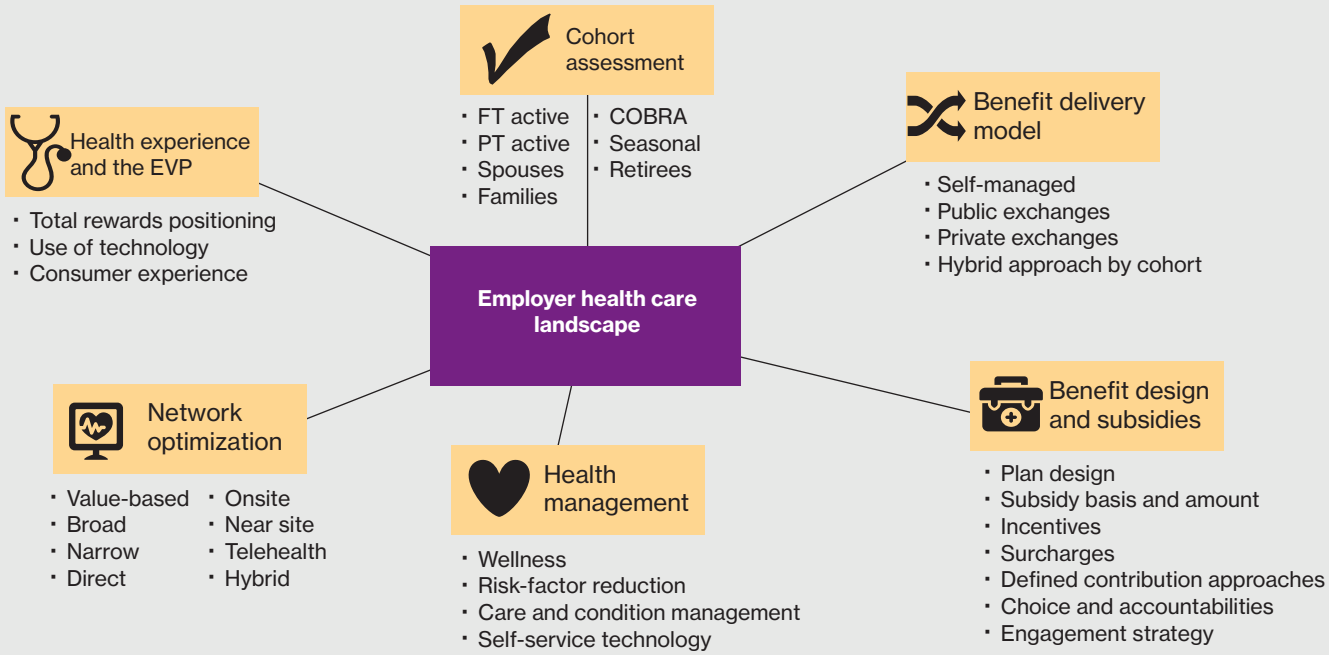
Flexibility and agility in a VUCA world

The eight trends identified are both independent and interdependent. The degree of change — as well as the speed of change — is creating what the U.S. military refers to as a VUCA world — an environment that is volatile, uncertain, complex and ambiguous. As employers face many unknowns, adjacencies and interdependencies trying to assess health care strategy in their VUCA world, organizations must have a clear vision and direction, a consistent framework of intent, and the ability to remain flexible and agile in getting there.

Legislative and regulatory uncertainty

Since the passage of the Patient Protection and Affordable Care Act (PPACA), uncertainty and ambiguity have been an employer's constant companions in health care planning.

Figure 1. **Six key dimensions of the new health care landscape**



The known unknowns and the unknown unknowns are many,* but two elements are most germane to strategic planning: the definition and ultimate form of the excise tax, currently deferred until 2020, and the question of whether the public exchanges will be considered a viable alternative channel for employees, pre-Medicare retirees, part-timers, seasonal workers, COBRA participants and, potentially, even actives as these exchanges mature and as large employers are allowed access as a group by law starting in 2017 (page 9).

To date, many employers have been reluctant to channel these workforce cohorts to the public exchanges, but as exchange connectivity is enhanced and the concept of the public marketplace is better accepted, more will take action to do so — for actives much later than the others, if at all — often with the help of a third party to facilitate navigation and aid in the determination of subsidy eligibility.

The excise tax, while deferred two years until 2020, remains a key aspect of strategic planning. From a strategic perspective, the excise tax should be considered a real business risk for which careful scenario planning must be done to consider risk factors driving volatility, various approaches to mitigating it, and an organized and well-planned glide path to bring plans below the excise taxes limits. Solving the rate of cost trend alone is not enough. The base cost must be controlled by improving health; delivering better care; and using high-value techniques that lower unit cost, engage patients and leverage new technologies as well as new health benefit delivery channels. In addition, the focus must align both cost and value, with value defined as the health outcome or result per dollar spent.

Developing the glide path requires paying attention to both an employer's cost base and rate of cost trend. It also requires recognizing the changes plan sponsors can make to influence:

- Unit cost of services
- Utilization of higher-value health care goods and services
- Employee health status and risk-factor reduction
- Optimal management of care and chronic conditions
- Maximization of opportunities as provider recontracting and reimbursement methods shift from discounts to value
- The potential use of nontraditional benefit delivery channels, like public or private exchanges, for various populations

Figure 1 illustrates six dimensions Willis Towers Watson has identified as key factors to consider in examining how to optimize health plan performance in the years ahead. These dimensions reflect the practical elements that the macro-trends will influence.

*Modified from Donald Rumsfeld, former Secretary of Defense

The excise tax issue is complicated by the absence of detailed regulatory guidance, which has given rise to discussion about some definitions and calculations changing, such as the definition of included benefits and services, the indexing factor and potential demographic adjustments. All of these are unknowns. While the outcome is unclear, what is clear is that managing cost and the rate of cost escalation is imperative in any business-planning scenario.

Clearly, the excise tax risk is a consideration for which employers can plan. Staying below the excise tax levels (or any alternative) will inevitably require optimal health plan performance, improvements in workforce health and, for many employers, a shift to significantly greater point-of-care cost sharing (often via high-deductible plans accompanied by an account, e.g., a health savings account), or adoption of more restrictive high-performance networks with more stringent care management criteria. But again, regardless of how the excise tax rules unfold, it is imperative for employers to manage cost challenges, change employee health behaviors and optimize program performance.

Understanding the six dimensions

- **Cohort assessment** is the segmentation of an employer's active and/or retired workforce to align each group with the optimal benefit delivery channel.
- **Benefit delivery models** include the traditional self-managed employer plan; public exchanges that could cover COBRA continuees, seasonal workers, early retirees and possibly part-time workers; Medicare retiree private exchanges; and private exchanges for active employees.
- **Benefit design and subsidies** determine who is covered, how the employer subsidizes coverage for individuals and families, how benefits are determined and how employees might be steered to preferred care delivery channels. Subsidy transparency means the explicitness of the employer subsidy and the specific behaviors expected to optimize employer subsidies to the employee and family. Increasingly, these are aligning with broader EVP objectives.
- **Health management** includes broad-based wellness efforts; targeted risk-factor reduction efforts; the spectrum of care and condition management activities; and the burgeoning use of technology to improve self-care, self-triage and monitoring.
- **Network optimization** addresses the use of all available care delivery channels as well as the leveraging of value-based contracting to improve the quality, efficiency and outcomes of care; telehealth, alternative networks and direct contracting; as well as onsite and near-site health.
- **Health experience and the EVP** focus on positioning health care within the total rewards strategy and EVP as well as acknowledging the generational shift emerging in the workforce, often including a focus on enhancing the health care experience, with greater decision support, transparency tools and more choice.

Provider system redefinition

Health care reform, technology and the pure economics of providing care in the 21st century are causing a massive consolidation among health care providers, including hospitals, physician groups and pharmacies, reducing the number of options available in many locales. From a pragmatic perspective, provider consolidation allows for the leveraging of capital expenses over a larger community, and creates the potential for better integrated care and meeting the expectations of the new generation of physicians who often prefer to work as salaried employees rather than independent practitioners. In brief, consolidation has the potential of upside economic advantage to all parties, despite a narrowing of choice and decrease in competition.

Concurrent with this trend is the growing shortage of physicians – especially in primary care. Presently, the shortage in primary care is estimated at 16,000 doctors, but it is projected to grow to a shortfall of 50,000 to 55,000 by 2025. Partly the result of Baby Boomer physicians retiring, the shortage is mostly due to population growth and aging, with a modest portion attributable to health care reform's expanding access.

To a degree, the shortage can be mitigated in many ways by more self-care using health applications, the expansion of telemedicine and remote monitoring, as well as a growing recognition that many physician activities can be assumed by other health professionals. And with technology, self-service will become more of a reality in health care. Nonetheless, wait times for physician office visits have increased in many markets, and poor access can lead to lower quality of care, higher costs, productivity erosion and slower returns to work.

Also at play is the new nationwide market dynamic caused by the tide of system mergers and consolidation resulting from health reform legislation. Its focus on value-based reimbursement methodologies is causing hospitals and physicians alike not only to restructure but also to assume more risk and accept responsibility for more than just the unit price of care. The PPACA legislates numerous value-based contracting arrangements and reimbursement approaches, challenging providers to manage not only price but also quality of care, efficiency of care and the longitudinal outcomes of the population they are managing.

These elements are converging to create a redefinition of provider systems and how they are compensated. Entities like accountable care organizations (ACOs) create an environment where the unit cost discount alone is no longer the sole criterion for contracting. Already, major health plans are moving to migrate beyond discounted fee for service and are introducing new contracts with their network providers tied not only to unit cost but also to quality metrics and efficiency measures with a gradual directional movement to more provider accountability for population outcomes.

At the same time, access is being enhanced through the focus on primary care expansion by retail clinics, "medical homes" emphasizing primary care and coordinated care management. CVS alone is expected to double its Minute Clinic retail sites by 2017. Similarly, more employers are adopting or expanding onsite or near-site employer-sponsored health services, ranging from biometrics to coaching to urgent care and primary care.

Key implications for employers

- The shift in provider delivery systems will result in fewer options for some markets, with other areas seeing differentiated models, including ACOs and medical home approaches, with the potential for more integrated, less costly care.
- Discounted fee-for-service reimbursements are being supplemented by value-based approaches. Willis Towers Watson estimates that up to 50% of reimbursements for most employers could be value-based beyond 2018 to 2020.
- Employers will increasingly adopt curated networks to maximize the value of multiple care delivery models.
- Access and cost concerns will continue to drive more comprehensive onsite employer health services and spur the use of alternative providers, telehealth solutions and other health-related self-service applications.

Employers will increasingly face a redefinition of the provider system, new contracting arrangements and the evolution to value-based contracting, which will largely supplant discounted fee for service as the dominant reimbursement model over the next five to seven years. The range of delivery options will create the ability for employers to develop "curated" networks, integrating numerous models to achieve optimal value.

In a parallel phenomenon that hasn't been seen since health maintenance organizations (HMOs) evolved over three decades ago, the lines are blurring between providers of care and health plans. We are seeing providers become health plans and health plans purchase providers. For providers, the public health exchanges create a new market for plans with narrow geographic appeal, making the transition more attractive for regional provider systems.

Concurrent with this is a series of health plan mergers and acquisitions, which will ultimately impact the market for group plans and individuals alike.

The changing practice of medicine

Profound changes in the practice of medicine are only now beginning to affect employer-sponsored plans in niche areas, such as specialty drugs, where some genetic testing is being done for specialized treatment regimens, and in the introduction of knowledge management for medical management. However, the implications of how care will be delivered in the future are much greater in the years ahead. These include the transition to precision medicine and the digitization of medicine.

For centuries, physicians have diagnosed by looking at "signs and symptoms." This foundation for diagnosis has been based on the observation of large populations over many years to arrive at a set of conclusions: If this, then it must be that.

Today's precision medicine calls for the tailored treatment of an individual, including medications, based on his or her unique genetic makeup rather than that of a broad population. Three high-tech developments are rapidly accelerating the shift to precision medicine: knowledge networks like IBM's Watson that capture, synthesize and provide access to the latest medical research and analyses very quickly; health care digitization, such as the technology that will lower the cost of genome sequencing; and nanotechnology that is enabling minimally invasive diagnoses and procedures. The shift is further fueled by health technology applications. (See page 7 for more discussion.)

Employers will see the effects of this shift slowly, with genetic sequencing required for a variety of drug regimens and increasingly for targeted cancer treatments. Ultimately, as precision medicine evolves, health benefits will be tuned to optimal patient value using genetic profiles. This could ultimately result in benefit levels defined not by group plan only but also by individual outcome value. In addition, genetic testing creates the opportunity to de-skill aspects of care (for example, once one's genetic profile helps define the right treatment, care can be delivered by nonphysician health professionals).

New entrants and disintermediators

Historically, employer-sponsored plans delivered health care through the major national health plans, including the Blues, Aetna, Cigna, UnitedHealthcare, Anthem Blue Cross and Blue Shield, and niche players, such as Harvard Pilgrim Health Care or Kaiser Permanente. All these entities deliver member services, turnkey provider networks, administration, claim adjudication and related services, such as web-based resources, wellness, condition and care management, incentive arrangements and specialty networks (including preferred tiers and centers of excellence).

In recent years, the traditional marketplace has been disrupted by new entrants — often start-ups with venture capital backing — introducing services that the traditional health plans have been unwilling or unable to bring to market. These include high-performance networks like Imagine Health, onsite service providers like Walgreen's Take Care clinic, cost and quality transparency tools such as Castlight or HealthCare Blue Book, wellness and health improvement offerings like RedBrick, wellness technology innovators like Jiff, and high-value member service facilities like Quantum or Accolade, to name just a few among the many new, highly differentiated and often intriguing service providers.

These new entrants are challenging the long-standing view of sole sourcing nearly all network and related services through the traditional health plans. They are giving rise to employer-curated networks and services that aim to optimize program performance and member experience by leveraging best-of-the-best arrangements. While this phenomenon of employers offering

Key implications for employers

- Precision medicine has the potential to enable true value-based care for the individual, creating unique diagnoses and treatments for each patient. Ultimately, benefits provided for a specific procedure could be determined based on optimal value to the patient using genetic analysis.
- As its cost drops, genetic sequencing can enable optimal treatment for complex cases. Plans will likely move to cover genetic sequencing for more diagnoses and pharmaceutical interventions. (The National Institutes for Health estimate that personal DNA sequencing costs will drop over the next five years and the test will be applied, for example, to over 120 drug regimens and innumerable targeted treatments of cancers.)
- HIPAA-protected genetic sequencing could potentially complement biometric screenings to maximize the outcome of care for the individual patient.
- Nanotechnology will redefine procedures and be covered for defined conditions and treatment regimens where it helps lower cost and improve outcome.
- Plan protocols will play an important role in limiting the use of high-cost/low-value high-technology care.

Today's precision medicine calls for the tailored treatment of an individual, including medications, based on his or her unique genetic makeup rather than that of a broad population.

services outside the health plan is not completely new (namely, pharmacy benefit and health management carve-out vendors), the range of options and the degree of innovation emerging is challenging health plans' historical turnkey dominance. This trend will require the traditional health plans to evolve more rapidly than in the past or face continued growth of the disintermediation process and the employer curation premise. (The concept is further accelerated by Willis Towers Watson's group private exchange (OneExchange) for active employees, which curates best practices and traditional as well as nontraditional partners for optimal active health plan performance.)

While these new entrants create a range of opportunities for employers, they also add to their tensions and decisions, as the curated environment counts on its various partners to coordinate and integrate services with one another. Nonetheless, as employers seek to optimize program performance in the face of annual cost increases and the risks inherent in the 2020 excise tax, they will often need to curate partners themselves or use a high-value, high-performance private exchange. If their goal for high performance is keeping cost trend under 2% (i.e., the CPI) when median trend is 5% to 6% or more, they will need to derive value from all available sources.

Health technology

Technology is reshaping health care delivery and the personal health experience in many ways beyond digitizing health records. Thanks to the explosion in sales of tablets and smartphones, a wide range of apps are being developed to enable remote monitoring, symptom assessment, triaging of needed care and patient support (ranging from diabetes management to neonatal assistance to actual consultations through telemedicine solutions like MDLive, TelaDoc or American Well). In short, today's mobile devices are increasingly able to deliver a "physician avatar" that will be instrumental in helping to address the country's concern about insufficient health care access. They will be used for virtual monitoring and virtual encounters, reducing the need for face-to-face visits for routine diagnoses, treatment and monitoring of patient vitals.

Connecting smartphones and tablets to the "Internet of Things" permits new ways to deliver care and also provides a new tool for engagement by linking to innumerable devices that are enabling digitization of the "quantified self."

First coined by Gary Wolf and Kevin Kelly of *Wired* magazine in 2007, the quantified-self movement applies the concept of "self-knowledge through self-tracking." Those pursuing this approach are tracking activities, diet, heart rate, sleep and other aspects of their lives to learn and improve – especially as they relate to their personal health and well-being. Use of a Fitbit, an Apple watch or any number of available devices illustrates how pursuit of the quantified self can be enhanced through connecting smartphones to devices, enabled via the Internet of Things.

Health technology also enhances employee/patient engagement in another way. It gives employers a cost-effective way to personalize the health experience to a mass population through gamification techniques, social networking and real-time feedback, especially as part of health and wellness improvement efforts. Compared with traditional telephonic outreach and engagement activities for health improvement, this new technology offers a lower cost per intervention, 24/7 access and personalization in ways that were previously impossible, and it's improving every day.

Technology enables greater accuracy, efficiencies and measurement as providers become more connected, e-prescribing becomes more widespread and medical records become digitized. And technology brings the self-service concept to health care as new applications permit the patient to schedule appointments, get a prescription or query a doctor 24/7.

Key implications for employers

- Employers will face a continuing need to optimize plan performance by creating a curated network rather than relying on a major health plan to deliver all services.
- New entrants to the health care space are creating attractive high-value solutions by disintermediating traditional health plans.
- This new array of choices creates new and challenging decisions for employers but can help them gain greater value than traditional solutions.

Key implications for employers

- The explosion of tablets and smartphone sales coupled with hundreds of new health apps for these devices allows the creation of a physician avatar, which has the potential to reduce costs, improve efficiency, ease access concerns and manage cost for a variety of procedures as well as create opportunities for patient self-service.
- Telehealth is growing rapidly for patient monitoring, coaching, wellness and virtual physician visits. It will be a critical component of addressing access concerns and managing cost for a variety of procedures.
- Health apps leveraged by employees who pursue the goal of a quantified self can enhance patient engagement through gamification and social networking with the ability to personalize and connect tracking devices.
- Technology, including mobile applications, use of social media and the introduction of gamified techniques, is creating a powerful new engagement tool across all age demographics.

A realignment of patient care and health management

It is widely accepted that the best way to ensure patient adherence and management of a patient's health throughout an episode of care, or over a lifetime of chronic condition management, is through the oversight and active involvement of the person's primary care physician or a primary care team. However, physicians have not been motivated or compensated for being engaged, except for the brief period of managed care's heyday back in the 1980s and early 1990s. And even then, compensation was inadequate and constraints were many, generating limited results and patient outcry.

With the PPACA's passage and the focus on providers assuming more end-to-end responsibility for care either through full risk assumption or risk sharing, as well as renewed calls for the patient to have a primary care medical home, a slow shift is now occurring where individual patient health management will gradually transition from third parties and traditional health plans to a particular provider. This shift, which will gradually grow in the years ahead, is presently limited as the medical home concept continues to emerge and provider reimbursement begins to recognize quality measures, efficiency improvements, and longitudinal care or condition management.

Providers are now developing care coordination teams through physicians' offices, including nurses and coaches to help with conditions or risk factors, drawing on third-party resources today as an adjunct to their activities. Based on discussions with industry leaders, Willis Towers Watson anticipates more and more chronic condition management and longitudinal care management will reside with primary care leadership in the years after 2016, with the transition likely to take five to seven years. The shift will be more rapid where the provider group or health system is assuming risk for longitudinal health outcomes for the members the entity serves (for example, an ACO). In addition, we expect a dramatic expansion in procedure-specific centers of excellence.

Key implications for employers

- Over the next five to seven years, providers will assume a growing role for lifestyle coaching, condition management and care management, but they will coordinate with or rely in part on the resources of health plans or other third parties. In addition, physicians will increasingly prescribe the use of personalized digital coaching as the application continues to mature and more health conditions are added to the coaching portfolio.
- Employers will continue to have a strong interest in these core health management resources and will complement them with other targeted workforce health and productivity initiatives.
- Health plans will often support – if not fund – this expanded provider role as contracting arrangements shift more to value-based arrangements.

While it is unlikely that all health management will be absorbed by providers, the key elements of care coordination, chronic condition management, risk factor reduction and complex case resource management will increasingly be part of the provider's role as contracting and reimbursement arrangements shift.

The emergence of exchanges

Health care reform and recent private marketplace offerings have created the opportunity for employers to utilize multiple approaches for delivering health benefits to unique segments of their health plan population. Cohort

value optimization (see page 4) enables employers to consider segmenting their covered population to connect people to value, rather than being constrained by merely offering a self-managed, employer-sponsored plan through one source for all segments of their population.

The public exchanges (health marketplaces) now operating in each state provide the opportunity for individuals to purchase guaranteed-issue health insurance with a choice of options and the potential for subsidized coverage, depending on income level. These public exchanges have endured a rocky start. As they mature, employers will likely consider encouraging their use by COBRA participants, early retirees (especially those for whom they are providing access only or a nominal subsidy), and seasonal or part-time workers employed under 30 hours a week.

A third-party navigation resource is available to help transition these individuals to the public exchanges with web-based and telephonic support that aids individuals in deciding among options and determining any available subsidies. Although not a prevalent view among employers today, the public exchanges provide a possible vehicle for employers to exit offering health care at some point in the future. (Willis Towers Watson estimates that less than 1% of large employers plan to do so for full-time active workers in the future.)

Public exchanges are not available on a group basis to large employers until 2017. Then, public exchanges will have the option of adding larger employers as groups. Will the public exchanges be a viable alternative after 2017 for all employees? It remains to be seen, just as the possibility of long-term employer exit is unknown.

Key implications for employers

- New benefit delivery channels enable cohort value optimization – connecting people to value (see page 4).
- Public exchanges can offer an attractive alternative for COBRA continuees, part-timers, seasonal workers and pre-Medicare retirees.
- The private Medicare exchange provides proven greater value than employer plans, resulting in a rapid migration of employers to this approach.
- The active employee private exchange has many variations. A high-value, flexibly configured, private exchange may be a viable alternative for many employers seeking to optimize health plan performance and the employee experience – especially where they are unable (or simply don't desire) to deploy their own resources to build a sustainable high-performance plan.
- The active private exchange is quickly growing beyond health benefits to embrace a full suite of group benefits with an emphasis on decision support and greater subsidy transparency.

On the other hand, private health exchanges have been available for Medicare retirees for nearly a decade and have proved to be an attractive alternative to the traditional employer-sponsored retiree plan.

For Medicare retirees, the private exchange has fast become the vehicle of choice for large employers. These arrangements offer concierge-style support to retirees for selecting from among a variety of Medicare supplement and Advantage plans, typically with equal or better coverage at lower costs. For pre-Medicare retirees, options now exist as part of active private exchanges and also on the public exchanges (especially where the employer provides access only or low subsidy).

The availability of a private exchange for active employees is a more recent phenomenon. The active private exchange is a topic of considerable interest and one that employers view with high expectations. Numerous arrangements exist, ranging from limited single-carrier approaches to multicarrier, multiplan offerings that offer a greatly expanded consumer experience for both health and non-health benefits. For the employer, an active private exchange can be very interesting if the employer:

- Seeks a solution that can deliver greater value than its current self-managed approach
- Desires to offer more choice often via a multiplan/multicarrier arrangement
- Desires to introduce greater subsidy transparency
- Wishes to have enhanced outside assistance for plan management, vendor management and administration to deploy its time, money and resources differently
- Seeks a springboard to effect change in its health care employee experience or its broader benefits EVP

Key implications for employers

- A rethinking of total rewards, generational shifts and a desire to change the benefit experience are rekindling discussions on choice and flexibility in benefits.
- Technology enables transforming the employee experience to meet employee expectations of consumer grade.

The active exchange approach creates new opportunities for employers to consider, with the potential for greater value when compared with self-managed health plans, depending on the employers' needs and priorities.

Change and the EVP

Many employers indicate they are rethinking their health benefit strategy in a broader total rewards context. Employers are now often considering health benefits in a different manner, exploring different arrangements for different segments of their population and assessing the use of a private exchange – or the principles introduced by the private exchange concept – to introduce more choice for active employees (both in terms of plan and carrier-network options, as well as use of employer-provided dollars).

Some are debating the premise of adopting a defined contribution strategy where the employer subsidy is fixed and either remains constant or escalates at a modest rate regardless of year-over-year health benefit plan cost increases, then employees assume the difference or rethink their health plan options. Most recently, Willis Towers Watson has seen a renewed interest in flexible benefits or flexible compensation arrangements as employers focus on how to optimize benefits and compensation in this new environment. A sub-theme receiving considerable attention is the expansion of voluntary benefit offerings to give even greater choice to the workforce.

The fundamental question is this: How will health care fit in the total rewards strategy, and how will it align with the broader EVP and employer brand image. The complexity of the decision is great as employers assess overall program value, program mix, competitive positioning, organizational culture and commitments, and the urgency for change as each concurrently gauges the business risk associated with the excise tax and broader cost concerns and positioning of the employer-employee deal to a changing workforce.

The question of urgency is unique for every employer based on its current cost base, rate of cost increase, competitive positioning, culture and need for change. The range of annual costs for active medical and drug coverage alone varies dramatically both among and within industries. This creates a new competitive dynamic as employers with high-cost plans face the need to enact change faster than a lower-cost peer. The 2020 excise tax has put a time clock on an uncertain cost management imperative.

The rethinking of the total rewards package, a generational shift in the workforce, affordability and robust administrative technology are all driving the discussion among many employers regarding how to optimize the total rewards portfolio, how to create more meaningful choice and how to enhance the employee experience. Some are in the early stages of revisiting flexible benefits and compensation, ranging from increased employee health benefit choices to expanded employee choice in how to utilize employer-provided benefit dollars. This is creating a renewed interest in pursuing both redesign and the potential for more employee choice.

Reflecting on the VUCA world of employer health care

In 2005, Thomas Friedman wrote *The World Is Flat,* in which he described the seismic shifts caused by globalization. In the same way, the health care world is shifting due to the macro-trends described here. As he reflected on globalization, Friedman noted, "The great challenge of our time will be to absorb change in ways that does not overwhelm people, but also does not leave them behind. None of this will be easy, but this is our task. It is inevitable and unavoidable." This is true as well in the world of employer-sponsored health care – and indeed, the broader realms of benefits and total rewards.

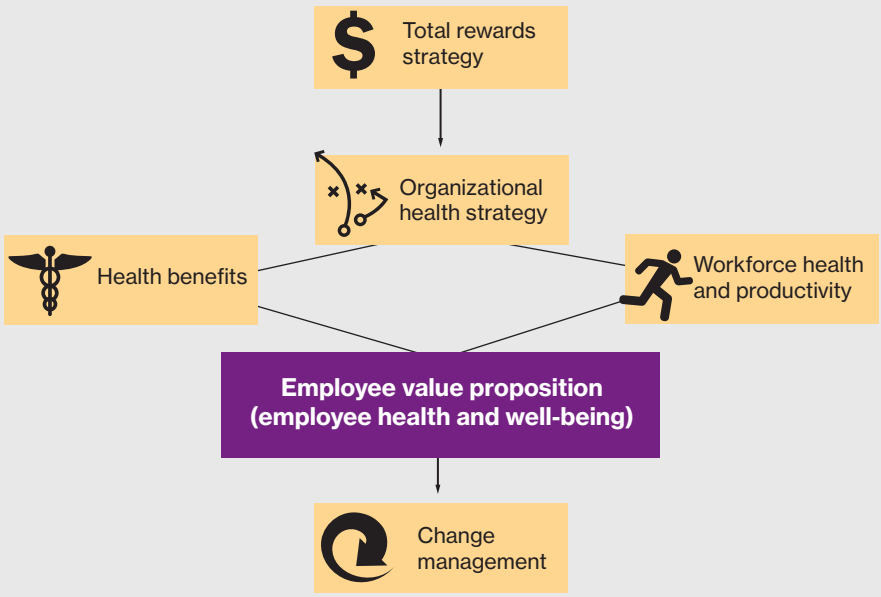
Future-proofing health care strategy is impossible, but by recognizing the forces at work and their implications, forward-thinking employers can transcend traditional thinking and frame their outlook and future state in a dynamic way. In a VUCA world (page 2), one needs clear intent, clear direction, a clear vision and most of all, the agility to adapt to a changing world.

This vision must recognize the business risks; the competitive environment; the total rewards perspective; and the ultimate impact on the organization's culture, readiness for change and EVP. Increasingly, employers will be compelled to rationalize their total

rewards program portfolio to determine the optimal mix to deliver value to both the organization and employees, especially as new generations enter the workforce with different needs and expectations, and rewards are redesigned in this context.

And regardless of decisions made concerning the delivery of health benefits for illness or injury, employers must still recognize the need to maintain — and likely expand — their commitment to workforce health, as *Figure 2* describes.

Figure 2. **Achieving high-performance health care in a VUCA world**



Conceptualizing the future

The VUCA world is with us, and agility, flexibility and a continuing monitoring of these trends will be an imperative in the years ahead. The forward-looking employer is well advised to follow six straightforward guidelines:

- *Accept uncertainty*, and think of strategy as a desired goal that likely will be achieved only by a constant flexing of focus and direction.
- *Strive for value,* not just current cost reduction. Recognize that median trend is no longer the goal. The new gold standard is managing to the CPI or below while achieving greater value.
- *Recognize that cost in health care is driven by unit price,* severity of conditions and utilization of services. Reducing severity through workforce health improvement, and reducing unit cost and utilization through more-effective, higher-value care via hybrid network configurations, will improve cost trend and the base cost of benefits, as will reductions in unit cost and cost variation.
- *Embrace health technology,* new entrants and new benefit models. The old way may not be the best way.
- *Position health strategy* to be consistent with your organization's brand and desired EVP, and assess emerging generational differences, the potential need for workforce segmentation and the need to upgrade the overall benefit experience. Anticipate and proactively communicate change and the accountability for specific behaviors you will demand of employees. Align subsidy strategy with those desired values and behaviors.
- *Recognize that inaction is not an option.* The complexity of the challenge requires decisive action.

Bob Johanson at the Institute for the Future put it this way: "The kind of strategy that works is to be very clear about where you are going but very flexible in how you get there." Well said, indeed.

Randall K. Abbott is a senior strategist and a North America leader at Willis Towers Watson. He has over 35 years of experience consulting to many of the nation's largest and most complex employers on health care strategy, including health benefits and workforce health as well as employee benefits in the broader total rewards context. The author gratefully acknowledges the support and insights of his colleagues: Jeff Levin-Scherz, M.D.; Trevis Parson, FSA; Julie Stone, M.P.A.; David Popper; and Steven Nyce, Ph.D.

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