

The Era of the Person

Placing the individual at the center of the health care ecosystem.

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Executive Summary

Is it critical to get health care right? We believe it is. It is important for society as a whole and for employers, who are committed to helping their employees live healthy and productive lives. Even if we only looked at this from an economic perspective, it's a virtuous cycle where the link between well-being, performance, and health is strong.

And yet, it's clear from many vantage points across the health ecosystem that the traditional way of delivering health benefits—and health care—in the United States is broken. Costs continue to rise unabated and population health continues to decline. For the first time in decades, escalating trends and deeper government involvement are inspiring new solutions to fix a system that is ripe for fundamental change. Today's employers are trying to make sense of an evolving health environment—one that is forcing them to rethink their definition of health and performance and how this translates into a health care strategy.

Each player in the ecosystem is hard at work addressing the challenges from their own perspectives. Indeed, the incremental changes that employers have implemented to create a more consumer-driven mindset for their employees are gaining traction. However, by themselves, these innovations are insufficient to change the dynamics of a system that lacks the self-regulating mechanisms that exist within every sustainable ecosystem. It will take an integrated point of view with mutually aligned interests to bring sustainable solutions to these issues.

We are on the doorstep of a new era in employer-sponsored health care. Over the last two decades we saw a shift from a health system centered on medical providers (the Era of the Provider) to one in which the health plan was primary (the Era of the Health Plan). Today's trends mark a movement to place the individual at the center, the dawn of the Era of the Person in health care. In this new era, all stakeholders will see a change in their role:

- People will understand what it takes to get and stay healthy, and will be better equipped with the tools, resources, and new choices to navigate the health care system when they need care.
- Providers will be better equipped to provide more individualized care, including support for achieving and maintaining physical and mental health.
- Health plans will pay providers differently, not only for care that heals the ill, but also for care that helps the healthy stay well.
- Employers will arm an increasingly diverse workforce with the right balance between tools, resources, and incentives for improving healthy behaviors and choices, along with the guidance, advocacy, and support needed for those with serious and ongoing medical needs.

In this new era, individuals are better equipped to be consumers, and better supported when they are patients. This rise in consumerism is driving a number of trends in the market including the emergence of new entrants in the health space, an increase in the strategic use of data, and an accelerated pace of innovation in areas like exchanges, health and well-being, chronic care management, elective benefits, and cost and payment reform.

The changing landscape for health care is encouraging employers to rethink major assumptions about how they define health and what constitutes value. Progressive employers are expanding their definition of health beyond “insurance coverage”; redefining their value proposition to include a broader definition of wellness; and understanding and measuring the total value of health.

With the U.S. health care system on the cusp of major change, signs are promising that industry-leading solutions will align interests and remove the barriers that have turned health into one of the most complex and consequential issues of our time. But we need momentum. Corporate decision-makers and industry leaders can start by agreeing on three actions: stop paying for things that don't work; focus on the experience we create for the workforce; and push for real market change.

A Broken Ecosystem

The \$2.8 trillion U.S. health care system is an economy unto itself—with entrenched stakeholders, macroeconomic forces, legislative constraints, and a reliance on increasingly antiquated technology. As a result, the system is fragmented, wasteful, and costly. In fact, the United States has the most expensive health care system in the world.¹ Yet in spite of the high cost and unprecedented scientific advancements, our nation’s health outcomes are still mixed. The United States ranks last overall across all relative quality measures in comparison to Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom. The system, fraught with inconsistent and inadequate services and misaligned incentives, does little to get and keep people well. Further, today’s system is non-transparent, clinically inconsistent, and not patient-centric when dealing with those who are ill. Our health care system needs to become more streamlined, efficient, and effective if we are ever to take a global health leadership position.

Health care costs within the United States are inconsistent and not on par with the rest of the world



Pacemaker implant price range in one U.S. market¹



Average cost of care compared to other countries²



The more complex and fragmented the U.S. health system becomes, the more effort and resources are required to manage it.

¹Centers for Medicare & Medicaid Services Medicare Provider Charge Data from FY2011, released 2013.

²2012 Comparative Price Report by the International Federation of Health Plans

¹ “Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally,” The Commonwealth Fund, 2014.

Fragmented Perspectives on a Solution

While many major stakeholders agree on the importance of transforming the system to improve health, reduce waste and fraud, enhance technology, and mitigate cost, their views on the core issues and best solutions are fragmented and sometimes directly in conflict.

Today, many **hospitals** are consolidating and vertically integrating their care delivery systems to control operating expenses, gain market share, and negotiate more leverage with insurers. Meanwhile, **health insurers** are reassessing the long-term costs of chronic conditions and are using this insight to redefine disease management programs. They are looking at narrow networks to be more cost-competitive and are pushing providers into outcome-based contracts. Increasingly, hospital systems are seeking to become health plans, as health plans explore ownership of hospital systems.

Meanwhile, **doctors** are consolidating and aligning to major health systems, in part to meet electronic medical records requirements, which are often too expensive and onerous to take on independently. They remain skeptical, however, of insurance models that hold them accountable for patients who may not follow their doctor's orders.

Technology firms are entering the wellness space by promoting health awareness and improvement through mobile apps and wearable devices. They are working to address the need for enterprise technology solutions that provide greater cost transparency and support evidence-based treatment.

Employers are trying to manage rising costs while still meeting their commitment to their employees and their communities to provide health security. And since so much is on the line with health benefits, employers are often slow to embrace new approaches, such as Accountable Care Organizations and private health exchanges, preferring instead to focus on incremental modifications.

So far, **individuals** themselves don't fully understand the implications of the changes rippling through the health care system. For them, it's still a far simpler story. They tend to love their physician, like their health plan, and distrust insurance companies. And while most people recognize the long term health benefits of increased wellness and prevention, we are falling further and further behind in achieving those benefits.

Each of these players in the health care ecosystem is trying to solve the same problems but from their own perspective. While there are many good ideas, it will take an integrated point of view with better-aligned interests to bring sustainable solutions to all these constituents in the health care equation.

Ushering in the Era of the Person in Health

We are witnessing a new era in the U.S. health care system. Over the past two decades we saw a shift from a health system centered on medical providers (the Era of the Provider) to one in which the health plan was primary (the Era of the Health Plan). Today's trends mark the movement to place the individual at the center, the dawn of the Era of the Person in health care. In this new era, individuals will own greater accountability for their health and well-being, drive the development of tools and resources to help them make smarter choices, and influence the way services are delivered and how we pay for services. Several key trends are defining what the future holds for health care.

The rise of health “consumerism”

Mirroring the larger rise in consumerism across society, employers are transferring the responsibility for health decisions to employees. This transfer of accountability mirrors a trend that started decades ago with retirement plans. And while there are many differences between retirement planning and health care, at the heart of both shifts was the transfer of accountability to employees to make smart decisions for their own future. This realignment puts the actual end users of health care in greater control of the choices that can impact them.

Momentum is building behind this movement, especially because the new health consumer is showing a willingness to seek alternatives to traditional care, including telehealth, pharmacy- and retail-based clinics, nurses and physician assistants for routine care, and online medical resources.

Mobile technology makes it easier for individuals to track their health behaviors. Sophisticated programs from employers, health plans, and other vendors are leveraging data to push personalized messaging that helps engage people in activity. The smartphone may well become the new hub for health.

With so many choices in front of them now, today's mobile-savvy consumers demand greater transparency in cost and quality, and they expect it all at their fingertips. They are better positioned than ever to become empowered consumers of health care.

At the core of this evolution is the repositioning of health care as person-centric. In this model, individuals are accountable as consumers for the decisions they make in terms of purchasing insurance coverage, evaluating and selecting physicians, and embracing physical and mental health and well-being activities. At the same time, other stakeholders in the system – providers and health plans – are better equipped for treating and advocating for the best interest of the individual as a patient, when he or she is ill. Both sides of this consumer/patient equation must be person-centric.

The evolving role of the employer

Health coverage has been an important part of the value proposition for most U.S. employers since World War II. But recent market shifts and health care reform may be diluting the power of health coverage as a top talent tool. In fact, several prominently featured predictions have suggested that employers will be rethinking their role in health over the next decade. According to medical ethicist Dr. Ezekiel J. Emanuel of the Center for American Progress, by 2025 less than 20 percent of private-sector employees will receive traditional health insurance sponsored by their employer.² Such predictions are provocative, and perhaps aggressive; nevertheless, they do underscore that many experts believe that the current system is not sustainable.

² *Reinventing American Health Care*, Dr. Ezekiel J. Emanuel. PublicAffairs, 2014.

Aon's own research indicates that the majority of large employers do plan to continue offering health coverage, with only 5 percent of employers indicating a plan to stop offering health benefits in the next three to five years.³ However, these organizations are looking for ways to change the way these benefits are offered by shifting more accountability to employees, helping employees change their behaviors and lowering the risk of rising costs and volatility on their bottom line.

As the sponsor of health coverage, employers are an essential connection point between health care consumers, providers, and insurers. As such, their role in transforming the health care system is critical, even as our definitions of health and its value evolve. Part of the answer for employers lies in separating health from insurance coverage. Employers are increasing their involvement in, and support for, services and programs that encourage and support physical and mental well-being, while also pushing health plans to provide better advocacy, coaching, absence management, and patient support to those who are ill. In the future, many employers may focus their role to that of financier and facilitator. This new perspective impacts how businesses look at every aspect of their health and health benefit strategies, including the ways they can leverage data and partnerships to reshape their role, empower consumers, support patients, and minimize costs.

Health care's new market players

This market momentum toward person-centric health is also enticing some innovative new players into the industry. Twenty-four of the 2014 Fortune 500 companies are new entrants into health care, primarily retail, technology, and telecom.⁴ With new models for care coordination and revolutionary new products and services, entrants in this growing arena have the potential to draw billions from traditional health care organizations and create real disruption. The \$267 billion U.S. fitness and wellness industry is also stepping into the fray by creating new paths to market and monetizing new sources of data. Existing industry players realize they must either compete or align with new entrants to make the shift.

More strategic use of data

Better data and more strategic use of that information will ultimately enable the broader changes needed in the delivery system. Our current system pays on volume and pays more for complex cases. Instead, we need to incent prevention and pay for quality outcomes. Both the federal government and large health plans are leading the charge through new contracting models that track outcomes and pay for performance. But these reforms require a level of data transparency and analytical sophistication that is still developing in the industry.

Employers, health plans and increasingly individuals themselves are looking beyond historical claims data to understand the real effectiveness of programs, treatments, and therapies. Businesses must dig into biometric and other health assessment data to understand health risks at the consumer level. It's also important to take into account health attitude data culled from consumer research. Armed with this information, employers can understand not only who has which health risks and where they are located, but also which types of interventions will inspire the behavior change needed to reduce risk and improve health.

By the same token, providers have an opportunity to use data to differentiate themselves, especially as individuals take on more responsibility for selection of insurance plans, coverage levels and networks. Armed with transparent data on provider cost and quality, individuals will make cost/benefit decisions in health care similar to how they purchase other consumer services. For some providers, that may lead to improved cost efficiency and customer service, while other providers may seek to differentiate themselves based on data-driven quality.

³ Aon Hewitt. "Health Care Survey. Future Ready. Real Now." Survey. 2014.

⁴ "Healthcare's New Entrants: Who Will Be the Industry's Amazon.com?", *New Health Economy* report, Health Research Institute, April 2014.

Further, the emerging data analytics landscape will enable better, more supportive patient advocacy models and more effective chronic and complex care management programs. These programs will integrate services from health plans, third party specialists, and medical care providers, centered on the patient. This will ensure that the patient receives the right care, from the right provider, at the right time, and at the right cost.

Increasing pace of innovation

The rise of private health exchanges

As employers seek ways to deliver benefits that address their needs, as well as the needs of their employees, the pace of innovation has increased. Private health exchanges are emerging as a promising solution. In fact, 33 percent of employers recently surveyed by Aon expect to move to a private exchange in the next three to five years.⁵

While the exchanges in the market today offer a range of different features, the most effective models work by aligning the interests of all stakeholders—employers, employees, carriers, and providers—in a way that improves outcomes by creating a dynamic new market that:

- Expands health benefit and network choice at the consumer level;
- Empowers employees as consumers through a transparent marketplace that encourages greater accountability;
- Increases innovation at the solution, carrier, and provider levels by aligning stakeholder interests;
- Lowers risk for employers by creating common goals between carriers and employees to improve health and consume care wisely; and
- Delivers better health care value by trending down the cost curve, improving service quality and simplifying administration.

Growing popularity of employee-funded benefits

Today's workforce represents multiple generations, races, ethnicities, and financial states. Employers are increasingly looking to meet this expanding range of needs by providing access to a broad menu of voluntary, or employee-funded, benefits. It doesn't take much imagination to envision add-ons well beyond auto and homeowners policies, pet insurance, and life insurance. Targeted coverage like critical illness and accident policies may emerge in the mix, too. The future health consumer will expect to access a wide variety of tools to stay healthy in the type of retail shopping environment they have grown accustomed to for all other services.

Evolving cost containment solutions

Other innovations are being developed that will transform the health care marketplace. One step employers are taking is to reduce risk by capping cost, a strategy borrowed from the traditional stop-loss risk approach of property and casualty and reinsurance markets. Self-insured employers are managing volatility by defining their financial commitment up-front. For example, through the use of data-enabled reference-based pricing models, employers can cap reimbursement for common procedures that vary widely in cost but not in care quality, such as major joint replacement, which varies in cost by as much as 50 percent.⁶

The methods and locations for delivering medical care are also evolving to contain costs. As they increasingly integrate services, health systems and doctors are developing new offerings targeted directly to the consumer. The growing acceptance of alternative care settings is sparking the emergence of telephonic and video interventions and on-site clinics in many retail establishments.

⁵ Aon Hewitt. "Health Care Survey. Future Ready. Real Now." Survey. 2014.

⁶ Centers for Medicare & Medicaid Services Medicare Provider Charge Data from FY2011, released 2013

New approaches to paying for care

The ways we pay for care are transforming as well. As the industry focus shifts to delivering higher-quality care at a lower cost, pay-for-performance models are transforming the revenue models of hospitals and health systems from fee-for-service to payment for outcomes.

Consumer interest is growing for transparency in both price and quality, and this is a thriving growth area for both traditional care organizations and new entrants. Recently Medicare announced that it will start providing detailed information about what it pays individual physicians, despite long-standing resistance from the American Medical Association and other industry groups.

With health care costs at their highest levels already, there is no new money to add to the system. That means cost-related changes will create winners and losers within the health care system. For example, if primary care physicians start getting paid for delivery of health improvement, the specialists and hospitals that used to treat the same patients for chronic conditions will see a decline over time.

Medicare and the major health plans are all approaching the payment question differently. But since providers cannot deliver care differently based on the payer, one model will ultimately win out. In the near term, though, this uncertainty creates significant financial risk, especially for hospitals and large health systems. It will require new industry approaches to risk mitigation and insurance.

Three Key Implications for Employers

The changing landscape for health care is encouraging employers to rethink major assumptions about how they define health and what constitutes value. Progressive employers are expanding their definition of health beyond insurance coverage, redefining their value proposition to include a broader definition of physical and mental wellness, and understanding and measuring the total value of health.

1. Expand the definition of health

Broadening our definition of health beyond insurance is imperative. Employers are now spending more time and resources to focus on creating a healthy culture and positive experience for employees. Employers are helping employees navigate the new health ecosystem more effectively and contributing not only to health insurance but also to overall well-being.

While well-being may be the new catchphrase, it is strongly linked to health and performance. Aon recently completed a detailed analysis for a large global company and found that employees with strong overall well-being were nearly six times more likely to be engaged in their jobs than those at risk for adverse health conditions.

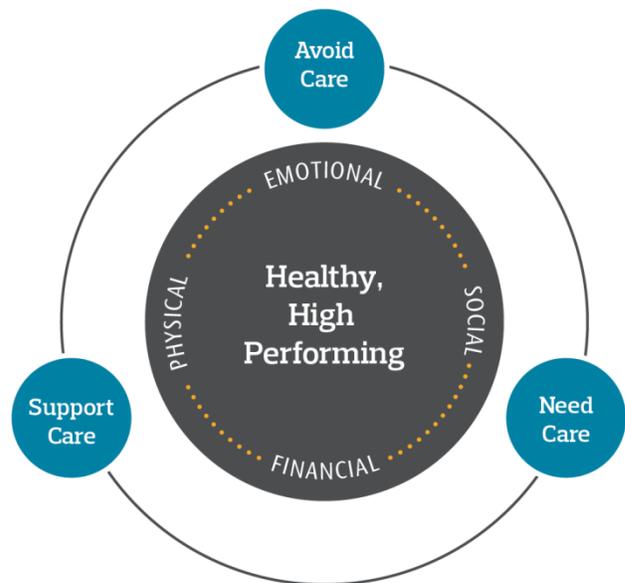
Our engagement research shows that an engagement score improvement of even 10 percent can yield up to 27 percent growth in total operating income.⁷ Engaged employees also have 46 percent fewer unhealthy days as a result of physical or mental illness and are 39 percent less likely to be diagnosed with a new disease in the next year.⁸

As a result, organizations need to view health as a continuous cycle, with different experiences, and therefore different needs, for individuals at different points on the cycle.

For many of us, we are in the “avoid care” mode, working to prevent the need for care by maintaining optimal health; alternatively, some individuals at this stage are engaging in unhealthy behaviors and not seeking care to correct those behaviors. Employers need to provide services, programs, and incentives to inspire and empower the right types of “avoid care” behaviors.

At some point, we all reach the “need care” stage, where we become focused on accessing the health care system for preventive, acute, chronic or catastrophic care. Here, employers must ensure that the health care system – plans and providers – works with the patient at the center, driving cost efficient, clinically effective care.

Given certain medical conditions and circumstances, our need from the health experience will, at times, center on “support care.” This includes easy-to-navigate resources, tools, services, and programs that support and guide the individual who needs care and enhances or facilitates a quality outcome.



⁷ Aon Hewitt. “Trends in Global Employee Engagement.” Survey. 2013.

⁸ Gallup. “State of the American Workplace. Employee Engagement Insights for Business Leaders.” Survey. 2013.

2. Update the value proposition for employees

For mature and developing countries, such as the United States, Spain, Germany, Taiwan, and Japan, the skill gap is widening. And this trend will continue through the next five years. Retention of key talent tops the list of issues of CEOs and their CHROs.

While benefits have been a differentiator in the United States, we expect much less variation in the future. Employers are already scaling back plan designs to avoid the pending excise tax. They are increasing employees' cost share and rapidly adopting consumerism strategies, such as high-deductible plans. The excise tax pushes down the value of benefit design, and the Affordable Care Act requirements set a new floor that will lead to a narrower range of differentiation. So how can employers continue to leverage health benefits as a talent attractor and retention tool?

By 2020, the standardization of health insurance will make it more of an entitlement than an employment incentive. By 2020, Millennials will make up 50 percent of the workforce, and this generation places a high value on their experience.⁹ Even if an underlying health insurance program is not owned by the employer, the company will still want to ensure that navigation of the system is a positive experience exceeding what employees could find on the open market.

To succeed within this future state, we believe employers need to offer a value proposition that balances traditional rewards with experience. Employers will need to offer a culture of health that encompasses a much broader definition of health that includes emotional, social, financial, and physical well-being.

3. Understand the total value of health

Progressive organizations are focusing on the total value of health versus the cost of health. Consider the real value of health to organizations:

Attracting talent	88% of employees say access to health and wellness programs help define an employer of choice. ¹⁰
Improving engagement	87.4% of employees say wellness programs positively influence company culture. ¹¹
Increasing productivity	The indirect costs of poor health can run two to three times direct medical costs. ^{12,13,14,15}
Lowering cost	The annual productivity cost related to health problems is \$1,685 per employee. ¹⁶

⁹ PwC. "Millennials at work: Reshaping the workplace." Survey. 2011.

¹⁰ Virgin Pulse and *Workforce Magazine*. "The Business of Health Employees: A Survey of Workplace Health Priorities." Survey. 2014.

¹¹ Aon Hewitt. "Trends in Global Employee Engagement." Survey. 2013.

¹² Edington DW, Burton WN. Health and productivity. In: McCunney, RJ: *A Practical Approach to Occupational and Environmental Medicine*. Philadelphia: Lippincott Williams & Wilkins. 3rd ed. 2003:140-152;

¹³ Burton WN, Pransky G, Conti DJ, Chen CY, Edington DW. The association of medical conditions and presenteeism. *J Occup Environ Med*. 2004;46(6) suppl:S38-S45:

¹⁴ Pelletier B, Boles M, Lynch W. Change in health risks and work productivity over time. *J Occup Environ Med*. 2004;46(7):746-754:

¹⁵ Goetzel RZ, Long SR, Ozminkowski RJ, Hawkins K, Wang S, Lynch W. Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting U.S. Employers. *J Occup Environ Med*. 2004;46(4):398-412;

¹⁶ Stewart WF, Ricci JA, Chee E, Morganstein D. Lost productive work time costs from health conditions in the United States: results from the American productivity audit. *J Occup Environ Med*. 2003;45(12):1234-1246.

Steps to Build Momentum

With the U.S. health care system in the midst of major change, all signs are promising that industry-leading solutions will align interests and remove the barriers that have turned health into one of the most complex and consequential issues of our time. But we need momentum.

Corporate decision-makers and industry leaders can start by agreeing on three actions:

1. **Stop paying for things that don't work.** Imagine if employers and health plan providers worked together to pay for outcomes and value. This likely means less or no coverage for services and treatments that add little value.
2. **Focus on the experience we create for the workforce.** Putting the individual at the center of the health care system is foundational to achieving change. A distinctive experience will help engage employees to be healthier, more present, and more productive. All of these aspects are critical to our businesses and the overall economy.
3. **Push for real market change.** In health care, one person's cost savings are another's lost income; as a result, substantial change in the U.S. health system is challenging and slow. But once incentives become aligned and players are working in a more integrated way, meaningful change can happen.

About Aon

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