Strategic Planning for Health Care Cost Controls in a Constantly Changing Environment

Health care cost increases are showing a resurgence. Despite recent years’ comparatively modest increases, the projections for 2015 cost increases range from 6.6% to 7%—three to four times larger than 2015’s expected underlying inflation. This resurgence is just one of many rapidly changing external and internal challenges health plan sponsors must overcome (and this resurgence advances the date when the majority of employers will trigger the “Cadillac tax”). What’s needed is a planning approach that is effective in overcoming all known and yet-to-be-discovered challenges, not just affordability. This article provides detailed guidance in adopting six proven strategic planning steps. Following these steps will proactively and effectively create a flexible strategic plan for the present and future of employers’ health plans that will withstand all internal and external challenges.

by William E. (Bill) Hembree | Health Research Institute

The most effective (yet least used) technique to control employee health care costs is strategic planning.

The absence of strategic planning for the present and future of an employer’s health plan creates disjointed and ineffective actions and results in adopting the “cost control idea du jour”—knee-jerk reactions to events and constantly changing challenges—as well as wildly insufficient cost control.

By contrast, good strategic planning reduces costs or, at minimum, significantly reduces the plan’s historical cost increase trends every year and meets many other goals in addition to affordability. And strategic planning creates a dynamic plan and plan management approach that is able to quickly and appropriately respond to rapidly changing circumstances. All plan sponsor employers and plan advisors/consultants can benefit by conducting strategic planning for their medical plans.

Simply put, strategic planning is knowing, agreeing to and writing down what the plan is seeking to accomplish in the short, medium and longer term (these are time frame-specific targets or goals). In addition, strategic planning is ensuring
the medical plan’s goals are aligned with the employer’s organizational goals and the plan is using metrics to ensure the goals are met. Finally, the same metrics are consulted periodically to determine which adjustments may be needed to stay on track over time and to achieve all of the plan’s stated goals.

**Why Be Concerned?**

Although employers will have questions and concerns about how to accomplish all of the goals they’ll consider (as discussed below), their largest worry is reaching desired affordability levels for their plans (especially with the Cadillac tax looming on the horizon for the majority of employers). And this worry is not without merit in 2015 and beyond. Consider:

- The years since 2011 have seen comparatively modest annual cost increases in medical plans. (These modest increases are the result of employers’ diligent cost-control efforts, the depressed economy over the past several years and other lesser factors.) But recent data shows health care costs are in a considerable resurgence for 2015 and beyond. Consider:
  - The years since 2011 have seen comparatively modest annual cost increases in medical plans. (These modest increases are the result of employers’ diligent cost-control efforts, the depressed economy over the past several years and other lesser factors.)
  - As evidence, survey sources have reported cost increases in 2013, 2014 and estimates for 2015.
  - Taken together, the data in Table I shows a clear upward movement in cost increases since 2012. And the “average of the averages” shows a steady upward movement as well. But most of this data and estimates were produced during 2014, and much has happened since these statistics were produced.
  - The most recently available data describes the resurgence in U.S. health care costs. Although a year or so of increases isn’t yet a definite trend, nevertheless, Altarum Institute is a reliable nonpartisan, nonprofit source of unbiased health cost data and information, so it is worthwhile to be concerned about its findings, summarized below:
    - U.S. spending on health care climbed 6.6% from February 2014 to February 2015.
    - Spending for hospital care increased 9% in the same period (up from 6.1% reported for the year ending in January 2015.) (Hospital spending represents about one-third of U.S. health spending.)
    - Prescription drug spending increased 10.5% in the year since February 2014. Research by IMS Institute pegs the increase at 13%. In April 2015, the Segal Group revised its estimate for pharmacy increases upward to a range of 13-15% for 2015.
    - Health insurance overhead surged 9.6% in the same period.
  - Several sources have predicted 7% cost increases for 2015. The Health Research Institute (HRI) believes health care costs will increase in the range of 6.6% to 7% during 2015 for employers not taking effective and strong cost-control actions to trim these increases. And because inflation is expected to hover between 2% and 3% (or possibly less) in 2015, it appears the nation is resuming the historical era where medical cost increases are at least two to three times greater than underlying inflation. In fact, if inflation in 2015 matches 2014’s 1.6%, the predicted medical cost increase will be more than four times larger than U.S.

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### TABLE I

**Reported Health Cost Increases 2013-2015**

<table>
<thead>
<tr>
<th>Survey</th>
<th>2013</th>
<th>2014</th>
<th>2015 estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segal Carriers Survey</td>
<td>5.7%</td>
<td>7.9% (estimate)</td>
<td>7.8%</td>
</tr>
<tr>
<td>Aon Hewitt</td>
<td>3.3%</td>
<td>4.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Mercer LLC</td>
<td>2.1%</td>
<td>3.9%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Altarum Institute</td>
<td>3.6%</td>
<td>5.0%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Towers Watson/ National</td>
<td>4.1%</td>
<td>4.4%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Business Group on Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Family Foundation</td>
<td>2.9%</td>
<td>4.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Average of the Averages</td>
<td>3.6%</td>
<td>5.0%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>
inflation. These are not sustainable increases.

OK, We’re Concerned. How Can Strategic Planning Help?

Approaches to strategic planning vary, but the proven effective approach HRI has developed and fine-tuned over the past 37 years is outlined in the six-step process shown below:

1. Build a stakeholders coalition.
2. Mine and understand data, educate the coalition and list possible actions.
3. Develop a statement of vision, mission, goals and guiding principles.
4. Choose cost-control actions (within the guiding principles) that meet the vision, mission and goals.
5. Thoroughly plan implementation, communicate and implement.
6. Measure and report, adjust and add new initiatives as needed.

Details and guidance to help employers and advisors use this six-step process follow.

Step 1: Build a Stakeholders Coalition

The purpose of building a stakeholders coalition is to create employee ownership for the planning process, improve the planning results and, more importantly, identify who is/ will be responsible and accountable for actions and results.

Generally, the coalition is comprised of six to ten opinion leaders and benefits professionals who have a direct stake in the success of the strategic planning process and medical plan’s future. Always invite at least one executive-level leader to participate. Senior managers and executives (especially from finance) increasingly are seeking a role for themselves in this type of planning, so make it easy for them to participate. They will provide extremely helpful guidance about meshing the coalition’s directions with organizational goals and parameters. They also will be useful in these six strategic planning steps, and they’ll be especially helpful later in defending/supporting the changes that emanate from the coalition.

Should labor union leadership be included in the coalition if a reasonable number of employees are represented? Yes, absolutely. The coalition, management and labor leaders will all adopt the goals set by the group. Why? Because they all participated equally in the planning/goal-setting process and, as a result, they will own and speak in favor of the goals and the resulting cost-control action steps.

Step 2: Mine and Understand Data, Educate the Coalition and List Possible Actions

Data on a medical plan’s usage is a snapshot in a fairly consistent and constantly moving picture. (This and the following assume the plan is large enough to be at least partially self-funded.) This year’s data is very similar to the past several years’ data and, correspondingly, this year’s data is very predictive of coming years’ utilization data absent effective interventions. (Note: These are observations about utilization data, not cost data. Cost data can fluctuate based on many other factors.)

Utilization data can reveal whether the plan’s challenges are excess hospital admissions, excess emergency room usage, too-little generic prescription usage, etc. The data also reveals the genesis of usage on a medical-cause basis (e.g., heart disease vs. cancer). Using data to diagnose specifically what needs to be corrected allows planners to focus efforts on correcting demonstrated problem(s) instead of using unfocused, broad-brush and ineffective actions. And when the employer uses a vendor with predictive modeling capabilities, this information is also very helpful. Needless to say, the employer’s carrier/health plan representatives (and probably plan advisors or consultants in larger plans) are especially useful in this step.

Once the coalition has reviewed data about the causes of the plan’s challenges and has been educated about the broad range of possible remedies, it should list possibly acceptable actions that might be used to overcome the challenges.

Although external vendors such as the carrier or health plan should have the lead in developing the data findings briefing, the employer’s internal employee benefits/human resources (HR) professionals should lead the educational process (with help from plan partners, of course). Developing this possible actions list is best done as a nonbinding “brainstorming” process. Based on decades of experience, if some employees are represented, two of the possible actions that will be listed early on the brainstorming list are: “Share more costs with employees” and “Don’t increase the employees’ cost share.” While it seems these are irreconcilable positions, by the time the possible actions are narrowed down from what could be done to what should be done, these positions will not be at loggerheads at all.

Once the possible actions list is completed, the coalition should give
it to the carrier/health plan with a request to quantify the expected savings and timing of the savings for each of the possible action steps. These savings numbers will be useful in step 4, where possible actions are narrowed down to what should be done.

**Step 3: Develop Statement of Vision, Mission, Measurable Goals and Guiding Principles**

Plan advisors and consultants are valuable in five of these six strategic planning steps. But outsiders should be excused from the process in step 3. If anyone from the outside is used, he or she should be a highly experienced group-process facilitator with no stake whatsoever in the future of the plan. It is only in this way that coalition members can reach consensus conclusions to questions about the future of their plan that are truly their own. If outsiders with a stake in the plan are involved, coalition members will know they have full responsibility and will make it work.

If an outside group-process facilitator is not used, then the coalition should choose one of its members with good group consensus-building skills to be the discussion leader in setting the statement of vision, mission, goals and guiding principles. Establishing this statement is the most important of the six strategic planning steps. The preceding steps result in an educated coalition that develops a listing of possible actions. But steps 1 and 2 don’t provide a way to narrow down what could be done to what should be done. In this step, the coalition decides what goals and parameters should apply in choosing which possible actions to adopt. This step answers “why” any particular action will be acceptable or not acceptable.

**Vision**

This is a statement of the plan’s fundamental intended direction, an expression of the plan’s basic philosophy. The vision generally is not quantifiable or measurable, and it describes the unique character of the organization’s approach. One example of a vision adopted by some coalitions is they want to convert their medical plan to a health care plan. For example, the output (fundamental purpose) of a medical care plan is reimbursement or coverage of medical expenses. A health care plan creates or improves participants’ health. It is tough to justify wellness program activities and expenditures if a plan’s fundamental goal is to protect employees’ financial security and to reimburse for medical care costs. In contrast, if the coalition decides improving participants’ health is one aspect of its vision, then assertively budgeting for and implementing health improvement/wellness efforts is entirely warranted.

**Mission**

A mission states the most important purposes for the plan. The mission often includes the boundaries that define broad courses of actions, and it usually is reevaluated yearly but seldom revised. Usually at least the following components are addressed in a plan’s mission statement.

- Improve (or maintain) quality of care
- Improve (or maintain) the health of participants
- Improve (or maintain) access to care
- Improve affordability (or moderate trend, reduce actual costs, etc.)
- Maintain (or improve) participant satisfaction.

Starter questions to establish the mission include:

- Are there other components we should be addressing?
- What is the modifier above that best describes what we’re trying to accomplish?
- Are there other words that also describe what we are trying to achieve?

**Goals**

The plan’s goals statement makes each of the mission statements explicit and, to the greatest extent possible, concrete and measurable. Goals include a specific time frame, and they allow communication, coordination and a common understanding of what’s to be achieved. Goals help people know what’s expected—They are significant (but reasonable), challenging (but achievable) and consistent.

Table II is an actual example of the goals statement on affordability from the city of Peoria, Illinois Labor-Management Coalition. Note this coalition chose three time frames within which to measure attainment of its increasingly challenging goals. (Short term is years one through three; medium term is years four through nine and long term is year ten and beyond.)

With good strategic planning, the Peoria coalition signifi-
health care strategies

cantly exceeded these goals in year one and has consistently outperformed the goals in almost all years since they were established over two decades ago. The cost savings in year one was a 20% reduction in year-over-year costs, which represented a $1.2 million reduction in medical costs in 1993. These were actual cost savings, not reduced employer costs because costs were shifted to employees.

The best way to consider the value of setting goals in furtherance of the coalition’s mission is to remember a remarkable passage in *Alice in Wonderland*. Recall that Alice was lost and asked the Cheshire cat for directions. The cat asked, “Where are you trying to go?” Alice answered, “I don’t rightly know.” The cat responded, “Then it doesn’t matter which way you go.” The goal-setting process allows the coalition to decide where it is trying to go.

The other critical ingredient (discussed below) is establishing personal accountabilities for accomplishing the goals. And why quantify or use other measures of goal attainment? The answer is that which gets watched is that which gets done. In shorthand, accountability creates commitment.

The coalition should set and, to the greatest extent possible, include measures of success for all mission statements adopted.

In cases where a goal can’t be quantified as easily as an affordability goal, using a report card grading system is the next best bet. For example, participants can be surveyed about their preimplementation satisfaction with their plan, administrators, providers, personal understanding of how to use the plan effectively, etc. They can mark A, B, C, D or F to represent their personal satisfaction and knowledge levels, and a preimplementation grade point average (GPA) can be computed to reflect their overall satisfaction. At some future point, participants can be resurveyed with essentially the same questions, and the resulting GPA can be compared with the preimplementation GPA to determine if the satisfaction improvement goal has been met.

Most coalitions wisely conduct their participant satisfaction survey prior to setting goals so that they later can determine changes in the level of participant satisfaction. In some plans, participants are already fairly satisfied, so achieving large improvements is improbable. (Improvement on the order of a quarter or half grade point frequently is used as a short-term goal.) When there is greater dissatisfaction shown in the survey, it is reasonable to set an improvement goal of 75% of one grade point or even a full point. Don’t forget to set satisfaction improvement goals for medium and longer terms; these may be less ambitious, as gains in satisfaction are easier in the short term.

In addition to creating a means to measure satisfaction gains, the coalition discovers exactly what is causing dissatisfaction (*actionable intelligence*) so it can focus improvement efforts on what needs to change and, correspondingly, leave alone the areas where participants are reasonably satisfied. And, of course, when the followup satisfaction survey is conducted, the coalition has a new inside picture of what dissatisfaction needs to be tackled next.

Goals can be set for health improvement and quality of care as well. Simply identify certain (measurable) actions the plan should accomplish, measure the status before and after results, and assign grades and a GPA to attainment of the health and quality goals. Examples include percentage of smokers in the covered population, percentage of participants engaging in wellness activities and changes in participants using providers with higher quality ratings.

Access goals can be measured by assessing the before and after use of nonnetwork providers. (Nonnetwork use usually is a reflection of participants’ unwillingness to use the plan’s in-network providers.) More than a small amount of use of nonnetwork providers is a reflection of participants’ lack of satisfaction with or access to the plan’s current network. With this knowledge, the coalition can set in place action steps to remedy participants’ lack of acceptable access.

Starter questions for goals setting:

- What short-, medium- and long-term goals should be met by our actions?

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**TABLE II**

| Plan Affordability Goals Will Be Achieved by Meeting or Exceeding the Following: |
|---------------------------------|------------------------------------------|
| Short Term                      | Hold cost increases to 50% of past five years’ cost trend. |
| Medium Term                    | Hold cost increases to no more than Consumer Price Index changes. |
| Long Term                      | Reduce costs by 1% per year for ten years, then hold cost increases at no more than general inflation. |
• What time frames should be used for accomplishment of the goals?
• By what yardsticks should results be measured?
• What are the components of cost that should be affected by our efforts?

Guiding Principles

Developing the plan’s and coalition’s guiding principles is one of the most important of the strategic planning steps. Guiding principles answer the question, “What’s OK and not OK to do to accomplish our vision, mission and goals?” Often, the coalition will start with a few guiding principles for consideration, then expand them as the coalition proceeds through its strategic planning process.

Guiding principles vary considerably from plan to plan because they are selected and defined by coalition members for themselves and their plan. But the following represent the most frequently discussed guiding principles:

Proactive vs. reactive? This is a good guiding principle to start discussions with. By the time the coalition has reached this point in its strategic planning process, almost everyone will agree their ambitious and to-be-measured goals could not possibly be achieved without a proactive approach.

Cost sharing vs. cost shifting vs. no changes in sharing/shifting? This is also a fairly easy guiding principle to set by the time the coalition has reviewed the data analysis and participated in the education process. Most coalitions define cost sharing as giving participants options to use the plan in cost-effective ways and to gain a personal reward for prudent use. One example of cost sharing that is acceptable to almost all coalition members (union leaders included) is use of different levels of copays for generic and brand-name prescription drugs. Participants understand they can choose to use a brand product if they wish but that their fellow plan participants shouldn’t have to subsidize the brand choice. The same goes for different levels of out-of-pocket cost depending on whether an in-network provider is used vs. a more costly nonnetwork provider. By contrast, cost shifting often is defined as simply increasing the percentage share paid by employees with no expectation for a behavior change (and a resulting claims cost savings). Increasing the proportion of monthly premium payments paid by employees is an example of cost shifting, and external competitive practices is a far better reason for cost shifting than expecting that premium sharing will change behaviors.

Innovative techniques vs. proven actions? This is one of the most important of the guiding principles. At the fundamental level, are we willing to take steps and actions that haven’t been taken before, at least in the coalition’s plan? Or are we restricted to taking only actions that have fully proved themselves effective elsewhere? There is an important interplay here. If the coalition has set reasonably ambitious cost-control goals (that are realistic and achievable), then the coalition likely will be willing to consider and possibly adopt innovative means to accomplish its cost-control goals. If the coalition has set fairly unimpressive “safe” cost-control goals, chances are it will be unwilling to adopt savings steps that haven’t proved themselves elsewhere. This tends to continue use of “more of the same” techniques that are unlikely to create more savings in the future than the (unacceptable) results they have created in the past.

An example of an innovative action step is end-of-life (EOL) care planning, which the author believes will become a widespread practice over the coming years.1 First, employers need to decide to participate as a beta test site to prove its effectiveness. Plans and coalitions that restrict themselves to adopting only proven actions probably would take a wait-and-see attitude toward EOL care planning. Coalitions with a guiding principle that they will consider and possibly adopt well-vetted innovative actions might offer EOL care planning as part of their cost-control strategy.

As background, studies show that most people, when expressing wishes for care in their final days or weeks, want an in-control, pain-free death at home, surrounded by loved ones. Despite this, only about 30% of deaths occur in patients’ homes. Part of the reason for this disconnect is that patients have not completed and communicated about an advance directive specifying their final care wishes. Hospital-bound deaths often cost $50,000-$100,000 or more, whereas hospice assistance for a death at home usually costs less than $10,000. The result is the same in either place. But patients’ families report the quality of life for the patient who passed away at home was far superior compared with being tubed-up and wired to machines in a hospital intensive care unit. Coalitions could decide to educate seriously ill patients (especially), as well as all employees, about the importance of completing and communicating about an advance directive.

Extent of commitment, measurement, accountability? And extent of “will” to invest budgets and human power as needed to meet goals? By the time a coalition has dis-
cussed and decided on its vision, mission, goals and other guiding principles, this will be a very easy guiding principle.

It simply codifies in writing the coalition’s level of commitment toward accomplishing the plan’s goals and future. It also deems what else is necessary to make the coalition’s plans work (adequate budget, human power, etc.). Finally, this principle helps establish metrics that will be used to monitor and show the extent to which the plan’s goals are being met over time.

Once the vision, mission, goals and guiding principles are set, the discussion leader should distribute a narrative draft recapping the decisions the coalition has reached. After several iterations of changes to the draft by coalition members, the next-to-final activity in this step is for each coalition member to sign the cover page of the statement of vision, mission, goals and guiding principles showing he or she concurs.

Then, as the final action in step 3, it is very important to seek review of the work-in-progress statement by the plan sponsor’s leadership. Senior leaders may have valuable insights that could be added to the statement and, even more importantly, they might have reservations about certain specific aspects of the statement that should be addressed before actions are chosen in step 4.

The most effective way to ensure senior leadership’s ultimate agreement is for the coalition to brief leaders face to face on its work and findings. At this time, the coalition would formally present the signed statement of vision, mission, goals and guiding principles to senior leadership.

This presentation need not be lengthy, nor should it be. It just must show senior leaders that much work has been invested in the statement and that their visible concurrence and support is needed. The coalition needs to ask for leadership’s visible support by giving examples of how this support could be displayed. Often, senior leaders will volunteer ideas about their visible support the coalition hadn’t even considered. In addition, included in the leadership briefing is the coalition’s promise to report results regularly (probably quarterly) and its pledge both to revisit the statement every few years and present the revised statement to the senior leaders anytime the statement changes.

**Step 4: Choose Cost-Control Actions (Within the Boundaries of Guiding Principles) That Meet the Coalition’s Vision, Mission and Goals**

Once steps 1-3 are complete, this becomes a straightforward and relatively easy step that asks whether each possible action listed in step 2 is acceptable (i.e., fits within the guiding principles), whether the possible action would help meet the coalition’s stated goals (and how) and whether the action is consistent with the stated vision and mission. For recordkeeping purposes, it is a good idea to write brief proceedings notes showing why each action does or doesn’t qualify for inclusion in the approved cost-control plan. Also, it is a good idea to schedule another senior leadership briefing to discuss the chosen cost-control actions and how they fit the plan sponsor’s/coalition’s vision, mission, goals and guiding principles.

**Step 5: Thoroughly Plan Implementation, Communicate and Implement**

This step thoroughly plans all aspects of the implementation and communication process—Who does what by when is noted for every action. Accountability for each action are publicly announced, reinforcing the commitment needed to ensure success of the implementation plan. In addition, the expected savings and other results from each step are forecast for each action, and the potential savings also are shown in aggregate in the short-, medium- and long-term time frames.

It is especially important for the coalition to designate who will be responsible for overall plan management to ensure goals are met on an ongoing basis.

And one of the most important aspects of the implementation process is to develop (and write) all steps needed to support and communicate the changes emanating from the actions agreed to in step 4.

Finally, the coalition needs to adopt a “war room” mentality to ensure there is very early feedback to the coalition to detect any aspect of the implementation plan that may be falling short of expectations so a remedy can be developed early. This avoids letting any potential problem fester into a larger, tougher-to-solve problem.

**Step 6: Measure and Report, Adjust and Add New Initiatives as Needed**

Measurement of results is a key ingredient in the success of strategic planning. Metrics will be developed in step 3 for all of the goals the coalition will set. Some goals are easier to
objectively quantify (affordability, for example). But quality, access, health and participant satisfaction can be measured with a combination of objective and subjective metrics. And remember, most of the measures need to be assessed before the changes are implemented so pre- and postimplementation comparisons are possible. Therefore, special attention is needed on prechanges measurements in the implementation planning step outlined above.

Over time, external impacts on the plan, as well as varying levels of effectiveness of implemented actions, will necessitate changes in the current actions, and new initiatives will be needed as well. The decision-making process described in step 4 should be used to decide on both subsequent changes and new initiatives.

Another means to ensure accountability and commitment in strategic planning is to follow up on the coalition’s promise to report results to senior leaders and employees. In the first year or two, all stakeholders should receive quarterly updates. After the early years, senior management should still receive quarterly reports, but semiannual or annual reports to employees should be sufficient.

Bottom line: Albert Einstein said we shouldn’t be surprised by the same result if we keep doing the same things. Similarly, our future health cost-control results will be no more successful than the results of the past unless we choose to start taking actions that are more effective than the actions of the past. Strategic planning creates far better cost-control results for a health plan than old-fashioned “more-of-the-same” actions and missed opportunities.

Endnote