



“Wellness and the Agent’s Client”

Atlanta Association of Health Underwriters Benefits Forum 2004

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PHM International

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AAHU Benefits Forum 2004

Do you have...The Right Stuff?



Outline

- ⌘ Introduction & Evolution
- ⌘ Demand
- ⌘ Components of Wellness Programs
- ⌘ Agent Advantages
- ⌘ Quality Vs. Marketing Hype
- ⌘ Action Steps

Introduction

- ⌘ Basis in employer self-funded market
- ⌘ 1980s organized efforts
- ⌘ Mom & Pop vendors
- ⌘ Primary focus:
 - ☑ Productivity, absenteeism, workplace injuries, feel good
- ⌘ Simple plan designs
- ⌘ ROI: participation

Introduction

⌘ Late '80s, through 90s

☒ Rising insurance and HMO costs

☒ Impact of community efforts

⌘ Program design changes

☒ Driven by MCOs and employers

⌘ Organized efforts to quantify results:

☒ Johnson & Johnson, Aetna studies

⌘ ROI: Changes in participation

Introduction

⌘ Late '90s on to today

☑ Rising insurance and HMO costs

☑ Impact of federal/state legislation

⌘ Program design changes

☑ Driven by health plans, employers & hospitals

⌘ Combining disease & case management, wellness, community efforts, productivity

⌘ ROI: ???

Demand

- ⌘ Majority of benefit managers believe insurance carriers should include wellness at zero costs.
- ⌘ Insurance companies, MCOs & hospitals offer routinely
- ⌘ Fully established in most hospitals' outreach programs

Demand

⌘ 2,680 Worksites of 15 - 99 employees

☒ 25% had worksite health promotion

☒ Majority had health insurance

⌘ Blue-collar Vs. white-collar

American Journal Health Promotion, 7/8, 1999

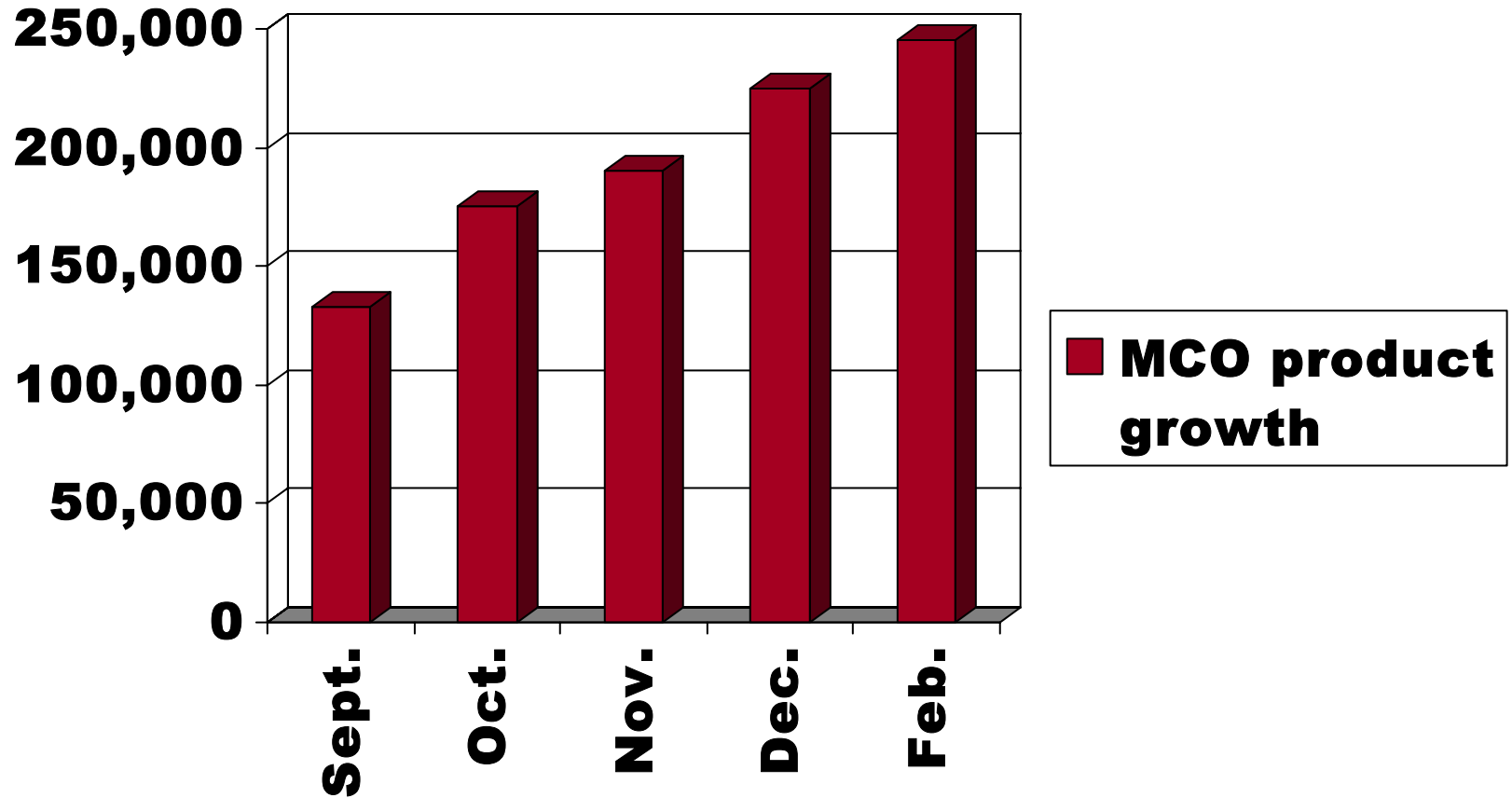
Demand

⌘ < 50% of US with private insurance get the insurance through the workplace

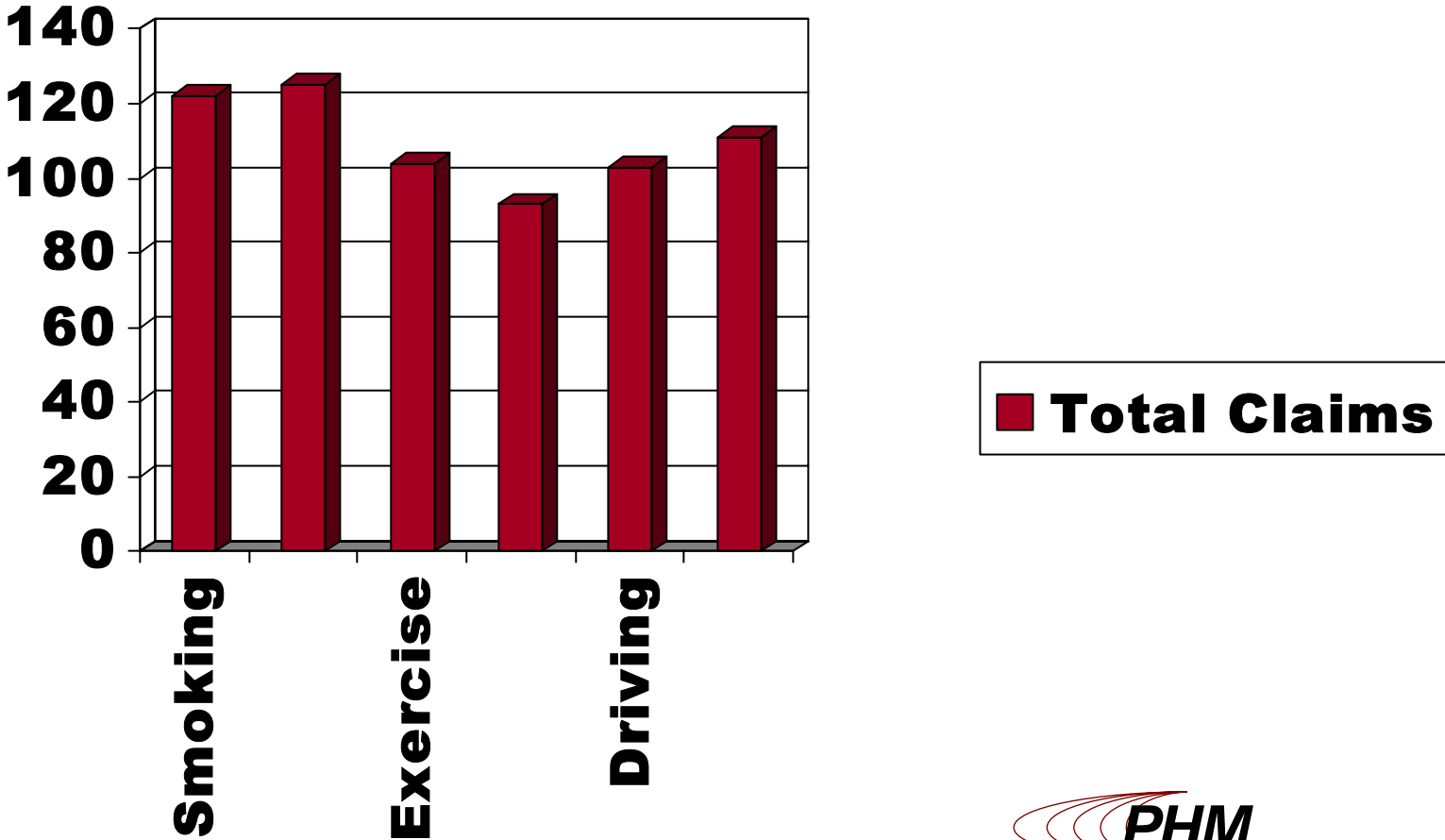


Bureau of Labor Management, 2003

Demand



Cost of Unhealthy Behavior



Program Components

⌘ Minimums

⌘ Broad & Shallow aka...

☑ Middle of the road

☑ Most common

⌘ Viable and Effective

Minimums

- ⌘ Subsidized or discounted health club memberships
- ⌘ Health education material at work-site
 - ☑ Newsletters, payroll stuffers, lunch `n learn
- ⌘ ER sponsored sports

Broad & Shallow

⌘ Blanketing employees with health promotion activities *most common to their needs*

Broad & Shallow

- ⌘ Components of “Minimum Program”
- ⌘ Health/Risk Assessments
- ⌘ Multi-media outreach
 - ☒ Payroll, Health magazine, On-line, Phone triage, Self care material, Video
- ⌘ On site health fairs
- ⌘ Employee financial incentive
- ⌘ Family involvement

Viabile & Effective

- ⌘ Strategy of defining a set of disease states or health problems that warrant additional *medically focused* interventions.
 - ☒ Integration of wellness & clinical care services
- ⌘ Collaborative efforts with MCO/Insurance Carrier/TPA/Employer

Viabile & Effective

- ⌘ Components of “Middle of the Road”
- ⌘ Data reporting by risk, claims, ICD-9, etc.
 - ☒ Health, psycho demographics,
- ⌘ Intervention by clinicians
- ⌘ Integration with WC, EAP, Health plan’s disease management (NEW?)
- ⌘ Risk sharing with MCO/Insurance Co.
- ⌘ Local hospital/clinic involvement
- ⌘ Targeted ROI

Viabile & Effective

⌘ Asthma

⌘ Back Injuries

⌘ Diabetes

⌘ Absenteeism...



Challenges

⌘ Duplication of efforts

⌘ Cost benefits

⌘ Poorly Defined ROI & Disparate goals

☐ Employer

☐ Carrier/MCO

☐ Agent

ROI

- ⌘ Client acquisition
- ⌘ Client retention
- ⌘ Employee satisfaction & retention
- ⌘ Improved health status
- ⌘ Improved employee productivity, absenteeism... "presenteeism"

ROI

⌘ Reduced premium?

NOT



Costs

⌘\$ 0

⌘\$20. per ee/year

☒\$0.50 - 2.00 pmpm

⌘\$200+++ per ee/year

⌘\$2,000+ per targeted member per year

Funding

Show Me The Money

Funding

⌘ Per Unit Delivered

- ☑ Minimum program development
- ☑ Local wellness provider

⌘ PMPM - PSPM - PEPM

- ☑ Vendor partnership
- ☑ Broad & Shallow program development

Funding

⌘ Capitated with risk

- ☒ Narrow & deep program development
- ☒ Outcomes based
- ☒ Strategic partner development
 - ☒ Shared ROI development
 - ☒ Financial risk sharing
- ☒ Large employee pool
- ☒ Admin fees remain flat
- ☒ Program costs = medical expense

Quality or Hype?

⌘ Quality Service or Marketing Hype?

☑ Case Study & Best Practices:

☑ Well America Group

☑ Integrated Health & Productivity Management



Case Study

⌘ Well America Group - WAG

- ☒ Sold to “large” employers
- ☒ Collapsed in August 2000
- ☒ \$3.7 million in unpaid claims
- ☒ Principals charged w/transacting
- ☒ Agent named

Case Study

⌘ Well America Group - WAG

- ☑ Marketed self-insured with wellness
- ☑ WAG arranged TPA, stop-loss, trusts, SPD, benefit booklets, etc.
- ☑ 2 Year rate guarantee
- ☑ Rapid sales growth

Case Study

⌘ Well America Group - WAG

☒ Plan Structure:

- ☒ Wellness controlled losses
- ☒ Self-insured portion
- ☒ GAP
- ☒ Stop-loss insurance

Best Practices

- ⌘ Wellness Councils of America welcoa.com
- ⌘ Integrated Health and Productivity Management: www.ihpm.org
- ⌘ Local cases?

Benefits for Agents

⌘ Improved brand awareness

☑ Competitive advantage

⌘ Customer loyalty

⌘ Speed to market



Benefits for Agents

⌘ Warning.....

... At \$20.00 per ee per year, not a profit center for agents.



Agent Responsibilities

- ⌘ Wellness product & service knowledge
- ⌘ Promotion of wellness benefits
- ⌘ Ongoing service



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