



**A Creative Solution for Today's Health Care Crisis:
Improving Affordability through Health and Wellness
and Improved Efficiency**

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Overview

As we enter a presidential election year, health care reform continues to be a key talking point for all of the candidates. Today's major health care issues are much like those of the past, just exacerbated with today's financial uncertainties. The ever escalating costs above and beyond the rest of the economy, the growing uninsured and related health care access issues, and ongoing quality of care concerns dominant the dialog. These critical issues can be captured by a few poignant questions:

- Can we afford our health care system today and in the future?
- If we improve the affordability of the system, will the issues be mitigated?
- What are the most obvious ways to improve the affordability of the system?
- Is a complete overhaul of the health care system required?

This article focuses on proposed answers to the above questions. This article integrates current information with updated research and analysis presented by the author on these important topics.

Understanding Affordability

Affordability, particularly health care affordability, has been misunderstood and oftentimes confused with cost. Affordability is best defined as a measure of someone's or something's ability to purchase a good or a service. It describes whether a person or organization, with limited resources, is able to make a purchase without unacceptable or unreasonable sacrifices. It assumes there is a limited amount of resources to purchase life's necessities. Health care affordability describes whether a person or organization has sufficient income to pay for or provide for health care costs and not significantly impede their ability to purchase other important services.

Housing affordability is often defined in terms of the ratio of how much it costs to purchase the median priced home in a particular marketplace (i.e.,

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mortgage payment with 20% down) to the average income in that particular market. For example, if the median price for a new home is \$500,000, an 80% mortgage would be \$400,000. The monthly payment for that mortgage at 6% interest would be about \$2,400. If the average annual income in that community is \$75,000, one metric of affordability would be as follows:

$$(\$2,400) / (\$75,000 / 12) = .384 \text{ or } 38.4\%$$

This says that 38.4% of the average person's gross income is required to pay the mortgage payment for the median house. If another region has a lower ratio, their housing would be more affordable, and vice versa.

Health care affordability could be defined in a similar way: how much does health care cost divided by how much is available to spend on health care. Several years ago Axene Health Partners, LLC developed an index to quantify health care affordability known as the **AHP HCAI™** (i.e., AHP Health Care Affordability Index). The **AHP HCAI™** measures the relative affordability of health care for individuals, sponsoring organizations, and the government by comparing both health care costs and available income. The ratio of cost to income provides a valuable metric of affordability. Once normalized to an average or standard affordability level (i.e., 1.00 or 100%), it is possible to compare one region with another, one sector to another, one stakeholder to another, etc.

To reflect all health care stakeholders, the **AHP HCAI™** reflects an average of health care affordability for each of the three key health care purchasers – employers, employees, and government entities. Each component of the **AHP HCAI™** can be reviewed individually to measure affordability for each stakeholder.

Importance of Affordability

A metric such as the **AHP HCAI™** can be used to better understand variations in affordability, key drivers to affordability, and what can be done to improve the situation (i.e., make health care more affordable). When health care is not affordable or needs to be more affordable, individuals have to make hard choices, especially in challenging economic times. With high gas prices, high home foreclosure rates, a tenuous economy, a downturn in the building industry, an unstable stock market, and many other factors many individuals and families are struggling financially. People are asking very hard questions about how they will balance their family budget. Opting out of health insurance entirely is an increasingly more popular option that is raising the number of uninsureds. Fewer employers are offering insurance since they have more difficulty funding it. States are cutting down on some of

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their fringe programs which further increase the number of uninsured. The growth in the number of uninsured focuses much attention on the access to needed care. Without insurance individuals cannot afford needed medical care and often delay care until it can no longer be delayed, oftentimes leading to more expensive urgently needed treatment. The affordability of care has a significant impact on many of our concerns about health care.

Variation in Health Care Affordability

To many people's surprise few studies have reviewed health care affordability. Most analyze cost of health care, not affordability of health care. The **AHP HCAI™** is one approach to analyze health care affordability. Table 1 presents information from the 2008 **AHP HCAI™**.

| Table 1 2008 AHP Health Care Affordability Index | | | |
|---|-------|----------------|-------|
| Alphabetical State | HCAI™ | Ranked State | HCAI™ |
| United States | 1.00 | Delaware | 0.74 |
| Alabama | 1.24 | Wyoming | 0.80 |
| Alaska | 0.86 | Connecticut | 0.83 |
| Arizona | 1.09 | Nevada | 0.85 |
| Arkansas | 1.04 | Alaska | 0.86 |
| California | 0.87 | Virginia | 0.86 |
| Colorado | 0.87 | California | 0.87 |
| Connecticut | 0.83 | Colorado | 0.87 |
| Delaware | 0.74 | New Jersey | 0.88 |
| Florida | 1.12 | Maryland | 0.89 |
| Georgia | 0.94 | Hawaii | 0.89 |
| Hawaii | 0.89 | Washington | 0.91 |
| Idaho | 1.08 | Texas | 0.92 |
| Illinois | 0.93 | Minnesota | 0.92 |
| Indiana | 1.15 | Illinois | 0.93 |
| Iowa | 1.20 | Georgia | 0.94 |
| Kansas | 1.01 | New York | 0.97 |
| Kentucky | 1.24 | United States | 1.00 |
| Louisiana | 1.14 | Massachusetts | 1.00 |
| Maine | 1.40 | Oklahoma | 1.01 |
| Maryland | 0.89 | Kansas | 1.01 |
| Massachusetts | 1.00 | Nebraska | 1.02 |
| Michigan | 1.16 | North Carolina | 1.04 |
| Minnesota | 0.92 | Arkansas | 1.04 |
| Mississippi | 1.39 | Oregon | 1.04 |
| Missouri | 1.18 | Utah | 1.07 |
| Montana | 1.11 | Idaho | 1.08 |
| Nebraska | 1.02 | Arizona | 1.09 |

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| Table 1 2008 AHP Health Care Affordability Index | | | |
|---|--------------|---------------------|--------------|
| Alphabetical State | HCAI™ | Ranked State | HCAI™ |
| Nevada | 0.85 | New Hampshire | 1.09 |
| New Hampshire | 1.09 | Tennessee | 1.09 |
| New Jersey | 0.88 | Montana | 1.11 |
| New Mexico | 1.16 | Florida | 1.12 |
| New York | 0.97 | North Dakota | 1.13 |
| North Carolina | 1.04 | Louisiana | 1.14 |
| North Dakota | 1.13 | Indiana | 1.15 |
| Ohio | 1.17 | South Carolina | 1.15 |
| Oklahoma | 1.01 | Wisconsin | 1.15 |
| Oregon | 1.04 | Michigan | 1.16 |
| Pennsylvania | 1.19 | New Mexico | 1.16 |
| Rhode Island | 1.19 | Ohio | 1.17 |
| South Carolina | 1.15 | Missouri | 1.18 |
| South Dakota | 1.20 | Rhode Island | 1.19 |
| Tennessee | 1.09 | Pennsylvania | 1.19 |
| Texas | 0.92 | Iowa | 1.20 |
| Utah | 1.07 | South Dakota | 1.20 |
| Vermont | 1.27 | Kentucky | 1.24 |
| Virginia | 0.86 | Alabama | 1.24 |
| Washington | 0.91 | Vermont | 1.27 |
| West Virginia | 1.46 | Mississippi | 1.39 |
| Wisconsin | 1.15 | Maine | 1.40 |

The above indices are the combined index reflecting the average of the employer index, the employee index and the government index. Table 1 shows that overall affordability varies widely from state to state. Table 2 compares 2008 results with those in the 2004 version. The ratios shown in the far right column show significant change over this time period.

| Table 2 Comparison of 2008 AHP Health Care Affordability Index with the 2004 version | | | |
|---|-------------------|-------------------|--------------|
| Alphabetical State | 2008 HCAI™ | 2004 HCAI™ | Ratio |
| U.S. Total | 1.00 | 1.00 | 1.00 |
| Alabama | 1.24 | 1.23 | 1.01 |
| Alaska | 0.86 | 0.84 | 1.02 |
| Arizona | 1.09 | 1.01 | 1.08 |
| Arkansas | 1.04 | 1.06 | 0.98 |
| California | 0.87 | 0.82 | 1.06 |
| Colorado | 0.87 | 0.89 | 0.98 |
| Connecticut | 0.83 | 0.81 | 1.03 |

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| Table 2 Comparison of 2008 AHP Health Care Affordability Index with the 2004 version | | | |
|---|-------------------|-------------------|--------------|
| Alphabetical State | 2008 HCAI™ | 2004 HCAI™ | Ratio |
| Delaware | 0.74 | 0.79 | 0.94 |
| Florida | 1.12 | 1.17 | 0.96 |
| Georgia | 0.94 | 0.92 | 1.02 |
| Hawaii | 0.89 | 0.84 | 1.06 |
| Idaho | 1.08 | 0.87 | 1.24 |
| Illinois | 0.93 | 0.94 | 0.99 |
| Indiana | 1.15 | 1.15 | 1.00 |
| Iowa | 1.20 | 1.16 | 1.03 |
| Kansas | 1.01 | 1.06 | 0.96 |
| Kentucky | 1.24 | 1.32 | 0.94 |
| Louisiana | 1.14 | 1.29 | 0.88 |
| Maine | 1.40 | 1.30 | 1.07 |
| Maryland | 0.89 | 0.85 | 1.05 |
| Massachusetts | 1.00 | 0.97 | 1.04 |
| Michigan | 1.16 | 0.99 | 1.17 |
| Minnesota | 0.92 | 0.94 | 0.98 |
| Mississippi | 1.39 | 1.35 | 1.03 |
| Missouri | 1.18 | 1.10 | 1.07 |
| Montana | 1.11 | 1.06 | 1.05 |
| Nebraska | 1.02 | 1.07 | 0.96 |
| Nevada | 0.85 | 0.80 | 1.07 |
| New Hampshire | 1.09 | 1.06 | 1.03 |
| New Jersey | 0.88 | 0.86 | 1.02 |
| New Mexico | 1.16 | 1.13 | 1.03 |
| New York | 0.97 | 1.12 | 0.86 |
| North Carolina | 1.04 | 1.16 | 0.89 |
| North Dakota | 1.13 | 1.04 | 1.08 |
| Ohio | 1.17 | 1.08 | 1.09 |
| Oklahoma | 1.01 | 1.04 | 0.97 |
| Oregon | 1.04 | 0.99 | 1.05 |
| Pennsylvania | 1.19 | 1.20 | 0.99 |
| Rhode Island | 1.19 | 1.01 | 1.17 |
| South Carolina | 1.15 | 1.26 | 0.91 |
| South Dakota | 1.20 | 1.15 | 1.05 |
| Tennessee | 1.09 | 1.17 | 0.93 |
| Texas | 0.92 | 1.00 | 0.92 |
| Utah | 1.07 | 1.06 | 1.01 |
| Vermont | 1.27 | 1.12 | 1.13 |
| Virginia | 0.86 | 0.82 | 1.05 |
| Washington | 0.91 | 0.85 | 1.07 |

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| Alphabetical State | 2008 HCAI™ | 2004 HCAI™ | Ratio |
|--------------------|------------|------------|-------|
| West Virginia | 1.46 | 1.37 | 1.07 |
| Wisconsin | 1.15 | 1.17 | 0.99 |
| Wyoming | 1.00 | 0.77 | 1.04 |

Sorting the ratios in affordability from smallest to largest we find 20 states with an improved affordability index and 30 with a worsened one. Of the 20 improved states they average a 5% improvement. The 30 worsened states averaged a 6.5% decline.

For illustrative purposes we will highlight three particular states through this document (i.e., California, Minnesota and Washington). All three states have a long history of favorable health care affordability, strong managed care presence and health care policy and thought leadership. Table 2 shows:

- California: still more affordable than average, but significant worsening (i.e., .82 to .87)
- Minnesota: still more affordable than average with a slight improvement (i.e., .94 to .92)
- Washington: still more affordable than average, but significant worsening (i.e., .85 to .91)

Any area with an affordability index change over a period of years is significant. This shows meaningful change and it needs to be monitored.

As has been discussed in prior affordability analyses, the major factors correlated with levels of individual state indices are:

- Local hospital utilization rates (i.e., days/1,000)
- Local provider supply (i.e., beds/1,000 and MDs/1,000)
- Employee affordability index (i.e., out-of-pocket cost)
- Government affordability index (i.e., government funded tax burden for health care)

High correlation factors continue for these factors in the 2008 [AHP HCAI™](#). The high correlation with these factors is interesting. Local hospital utilization rates have a direct impact on the affordability of health care. Regions with higher than average inpatient utilization rates have demonstrated less affordable health care. The regions with more health care providers are correlated with less affordable health care. Regions where employees consistently have to pay more for their health care have less

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affordable health care. Regions where the government funds a greater proportion of its taxes towards health care has less affordable health care.

In response to this one might ask a couple of questions:

- If these items are so strongly correlated is there anything we can do to impact the item and eventually improve affordability?
- What can be done to further reduce hospital utilization rates?
- What should be done to impact the supply of providers? What can be done to impact the supply of providers?
- Should we change the way we allocate the cost between employers and employees? Is there a way to introduce lower costing alternatives to reduce the financial burden to employees?
- What more can be done to reduce the cost of government programs? Do government programs drive the cost of other programs? Is there something that can be changed regarding this?

How Much Does Hospital Utilization Vary Anyway?

If higher hospital utilization rates are associated with less affordable health care, one might wonder how much hospital utilization varies from one region to another. Table 3 shows some interesting statistics about this.

| Alphabetical State | Days/1,000 (including SNF days) | % of National Average | Estimated Potential For Reduction |
|--------------------|------------------------------------|-----------------------|-----------------------------------|
| U.S. Total | 316 | 100% | 50% |
| Alabama | 357 | 113% | 55% |
| Alaska | 245 | 77% | 35% |
| Arizona | 260 | 82% | 39% |
| Arkansas | 372 | 118% | 57% |
| California | 269 | 85% | 41% |
| Colorado | 251 | 79% | 36% |
| Connecticut | 294 | 93% | 46% |
| Delaware | 304 | 96% | 48% |
| Florida | 322 | 102% | 51% |
| Georgia | 305 | 97% | 48% |
| Hawaii | 320 | 101% | 50% |
| Idaho | 252 | 80% | 37% |
| Illinois | 341 | 108% | 53% |
| Indiana | 310 | 98% | 49% |
| Iowa | 339 | 107% | 53% |
| Kansas | 307 | 97% | 48% |

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| Table 3 Hospital Utilization Levels by State (commercial under-age 65 bed-days/1,000) | | | |
|--|--|--------------------------------------|--|
| Alphabetical State | Days/1,000 (including SNF days) | % of National Average | Estimated Potential For Reduction |
| Kentucky | 322 | 102% | 51% |
| Louisiana | 376 | 119% | 58% |
| Maine | 299 | 95% | 47% |
| Maryland & DC | 310 | 98% | 49% |
| Massachusetts | 335 | 106% | 52% |
| Michigan | 275 | 87% | 42% |
| Minnesota | 270 | 86% | 41% |
| Mississippi | 373 | 118% | 57% |
| Missouri | 310 | 98% | 49% |
| Montana | 280 | 89% | 43% |
| Nebraska | 296 | 94% | 46% |
| Nevada | 299 | 95% | 47% |
| New Hampshire | 265 | 84% | 40% |
| New Jersey | 400 | 127% | 60% |
| New Mexico | 278 | 88% | 43% |
| New York | 454 | 144% | 65% |
| North Carolina | 305 | 97% | 48% |
| North Dakota | 330 | 105% | 52% |
| Ohio | 304 | 96% | 48% |
| Oklahoma | 362 | 115% | 56% |
| Oregon | 228 | 72% | 30% |
| Pennsylvania | 384 | 121% | 59% |
| Rhode Island | 317 | 100% | 50% |
| South Carolina | 315 | 100% | 49% |
| South Dakota | 338 | 107% | 53% |
| Tennessee | 315 | 100% | 49% |
| Texas | 299 | 95% | 47% |
| Utah | 244 | 77% | 35% |
| Vermont | 260 | 82% | 39% |
| Virginia | 297 | 94% | 46% |
| Washington | 246 | 78% | 35% |
| West Virginia | 331 | 105% | 52% |
| Wisconsin | 274 | 87% | 42% |
| Wyoming | 259 | 82% | 39% |

Inpatient hospital utilization ranges from a low of 72% of the national average in Oregon to a high of 144% in New York, a significant variation. Based upon industry best practice performance of highly efficient health care programs as

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documented in the **AHP Best Practice Norms™**, ideal inpatient hospital utilization rates for the typical population described in Table 3 is about 159 bed days/1,000, about 50% of national observed average of 316 days/1,000. This suggests that as much as 50% of the current utilization might be eliminated if potentially avoidable days could be eliminated. The potential reduction ranges from 30% in Oregon to 65% in New York. The ability to achieve these reductions in these communities is impacted by many factors:

- Willingness of providers to change to more efficient practice patterns
- Willingness of patients to comply with more efficient delivery system changes
- Availability of and access to alternative care settings (i.e., sub-acute beds, skilled nursing facilities, rapid treatment units, etc.)
- Maturity of local managed care plan market
- Access to evidence-based practice guidelines focused on efficiency

For our three targeted states, California and Minnesota show a 41% opportunity for improvement with Washington showing a 35% opportunity. This shows that significant opportunity exists to improve the affordability of health care services in these states even though they enjoy a favorable affordability already.

Since actual hospital inpatient utilization rates vary so much by community the opportunity to improve the affordability of health care varies significantly by market. During the late 1990s and continuing into this decade there has been a considerable negative market reaction to programs focused on reducing inpatient utilization. Although much of this has been based upon very few highly publicized cases, a general fear of the unknown, and a significant lack of hard facts supporting the opinion, the realistic potential for such improvement has decreased. The actual potential is as large as ever, however, the willingness to pursue such changes is minimal. Continued higher than average increases in health care costs combined with the ongoing affordability concerns described earlier in this paper have encouraged many more organizations to take a second look at the opportunity for reduced utilization.

How Much Does Provider Supply Vary by Region?

Provider supplies varies significantly by region. Table 4 shows that supplies varies from 70% of the average to almost 150% of the average.

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| Table 4 Relative Provider Supply by State | | | |
|--|---|--|--|
| Alphabetical State | Relative Beds/1,000 Population | Relative MDs/100,000 population | Overall Relative Supply |
| U.S. Total | 1.00 | 1.00 | 1.00 |
| Alabama | 1.26 | 0.81 | 1.03 |
| Alaska | 0.85 | 0.86 | 0.85 |
| Arizona | 0.70 | 0.79 | 0.75 |
| Arkansas | 1.22 | 0.76 | 0.99 |
| California | 0.70 | 0.98 | 0.84 |
| Colorado | 0.74 | 0.97 | 0.86 |
| Connecticut | 0.85 | 1.37 | 1.11 |
| Delaware | 0.93 | 0.93 | 0.93 |
| Florida | 1.04 | 0.91 | 0.98 |
| Georgia | 1.00 | 0.82 | 0.91 |
| Hawaii | 0.85 | 1.17 | 1.01 |
| Idaho | 0.85 | 0.64 | 0.74 |
| Illinois | 1.00 | 1.02 | 1.01 |
| Indiana | 1.07 | 0.81 | 0.94 |
| Iowa | 1.30 | 0.70 | 1.00 |
| Kansas | 1.33 | 0.83 | 1.08 |
| Kentucky | 1.30 | 0.86 | 1.08 |
| Louisiana | 1.37 | 0.96 | 1.16 |
| Maine | 1.00 | 1.00 | 1.00 |
| Maryland & DC | 0.74 | 1.55 | 1.15 |
| Massachusetts | 0.93 | 1.71 | 1.32 |
| Michigan | 0.96 | 0.91 | 0.93 |
| Minnesota | 1.15 | 1.07 | 1.11 |
| Mississippi | 1.67 | 0.67 | 1.17 |
| Missouri | 1.19 | 0.90 | 1.04 |
| Montana | 1.59 | 0.84 | 1.21 |
| Nebraska | 1.56 | 0.90 | 1.23 |
| Nevada | 0.70 | 0.70 | 0.70 |
| New Hampshire | 0.81 | 0.99 | 0.90 |
| New Jersey | 0.93 | 1.16 | 1.04 |
| New Mexico | 0.67 | 0.90 | 0.78 |
| New York | 1.22 | 1.46 | 1.34 |
| North Carolina | 0.96 | 0.95 | 0.96 |
| North Dakota | 2.07 | 0.90 | 1.49 |
| Ohio | 1.07 | 0.98 | 1.03 |
| Oklahoma | 1.11 | 0.64 | 0.88 |
| Oregon | 0.67 | 1.00 | 0.83 |
| Pennsylvania | 1.19 | 1.10 | 1.14 |

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| Table 4 Relative Provider Supply by State | | | |
|--|---|--|--|
| Alphabetical State | Relative Beds/1,000 Population | Relative MDs/100,000 population | Overall Relative Supply |
| Rhode Island | 0.85 | 1.35 | 1.10 |
| South Carolina | 1.00 | 0.86 | 0.93 |
| South Dakota | 2.04 | 0.82 | 1.43 |
| Tennessee | 1.22 | 0.99 | 1.11 |
| Texas | 0.93 | 0.80 | 0.86 |
| Utah | 0.67 | 0.79 | 0.73 |
| Vermont | 0.78 | 1.37 | 1.07 |
| Virginia | 0.85 | 1.02 | 0.93 |
| Washington | 0.63 | 1.00 | 0.81 |
| West Virginia | 1.48 | 0.87 | 1.17 |
| Wisconsin | 0.93 | 0.96 | 0.94 |
| Wyoming | 1.48 | 0.70 | 1.09 |

Lower supply doesn't always imply under-supply, and in many cases might imply "right" supply. Table 1 shows that California, Washington and Minnesota have more affordable health care. Of these three states, two have lower than average supply rates. Minnesota's higher than average provider supply is partially caused by significant in-migration of patients to both the Twin Cities and Rochester. Both California and Washington have a much lower hospital bed supply rate and a more normal physician supply rate. Local efficiencies drive down the hospital bed supply rate much more than the physician supply rate.

How Much Does Employee Affordability Vary?

In addition to being one of the three factors used to derive affordability index values, individual employee affordability itself is highly correlated with health care affordability. Regional personnel practices, labor negotiation practices and trends, individual and corporate expectations all influence how much cost is passed on to employees in the form of both premium sharing and cost sharing. Table 5 shows the variation in the **AHP Employee HCAI™** by state.

| Table 5 2008 AHP Employee Health Care Affordability Index | | | |
|--|--------------|---------------------|--------------|
| Alphabetical State | HCAI™ | Ranked State | HCAI™ |
| United States | 1.00 | Connecticut | 0.73 |
| Alabama | 1.22 | New York | 0.80 |
| Alaska | 1.01 | Hawaii | 0.80 |
| Arizona | 1.09 | California | 0.82 |

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| Table 5 | | | |
|--|--------------|---------------------|--------------|
| 2008 AHP Employee Health Care Affordability Index | | | |
| Alphabetical State | HCAI™ | Ranked State | HCAI™ |
| Arkansas | 1.25 | New Jersey | 0.83 |
| California | 0.82 | Washington | 0.87 |
| Colorado | 1.07 | Pennsylvania | 0.90 |
| Connecticut | 0.73 | Massachusetts | 0.91 |
| Delaware | 0.92 | Maryland | 0.91 |
| Florida | 1.15 | Delaware | 0.92 |
| Georgia | 1.17 | Wyoming | 0.93 |
| Hawaii | 0.80 | Nevada | 0.95 |
| Idaho | 1.26 | Virginia | 0.96 |
| Illinois | 0.98 | Michigan | 0.97 |
| Indiana | 1.12 | Illinois | 0.98 |
| Iowa | 1.29 | United States | 1.00 |
| Kansas | 1.14 | Alaska | 1.01 |
| Kentucky | 1.16 | Texas | 1.02 |
| Louisiana | 1.19 | West Virginia | 1.06 |
| Maine | 1.31 | Rhode Island | 1.07 |
| Maryland | 0.91 | Colorado | 1.07 |
| Massachusetts | 0.91 | Ohio | 1.08 |
| Michigan | 0.97 | Arizona | 1.09 |
| Minnesota | 1.14 | Oregon | 1.09 |
| Mississippi | 1.18 | Indiana | 1.12 |
| Missouri | 1.12 | Missouri | 1.12 |
| Montana | 1.16 | Oklahoma | 1.13 |
| Nebraska | 1.22 | North Carolina | 1.13 |
| Nevada | 0.95 | South Carolina | 1.14 |
| New Hampshire | 1.14 | Kansas | 1.14 |
| New Jersey | 0.83 | New Hampshire | 1.14 |
| New Mexico | 1.20 | Minnesota | 1.14 |
| New York | 0.80 | Tennessee | 1.15 |
| North Carolina | 1.13 | Florida | 1.15 |
| North Dakota | 1.33 | Montana | 1.16 |
| Ohio | 1.08 | Kentucky | 1.16 |
| Oklahoma | 1.13 | Georgia | 1.17 |
| Oregon | 1.09 | Mississippi | 1.18 |
| Pennsylvania | 0.90 | Wisconsin | 1.18 |
| Rhode Island | 1.07 | Louisiana | 1.19 |
| South Carolina | 1.14 | Vermont | 1.20 |
| South Dakota | 1.41 | New Mexico | 1.20 |
| Tennessee | 1.15 | Alabama | 1.22 |
| Texas | 1.02 | Nebraska | 1.22 |
| Utah | 1.37 | Arkansas | 1.25 |

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| Alphabetical State | HCAI™ | Ranked State | HCAI™ |
|--------------------|-------|--------------|-------|
| Vermont | 1.20 | Idaho | 1.26 |
| Virginia | 0.96 | Iowa | 1.29 |
| Washington | 0.87 | Maine | 1.31 |
| West Virginia | 1.06 | North Dakota | 1.33 |

Values range from .73 to 1.33 showing a wide range of employee affordability by state. For the three states we have been tracing we find that both California and Washington have much more favorable than average employee affordability at .82 and .87, respectively. Minnesota's employee affordability is much higher at 1.14. Minnesota's employees pay a much higher portion of the costs of their health care than similarly situated employees in California and Washington.

How Much Does the Government Health Care Affordability Vary?

By design we would expect the government affordability index to vary significantly from one state to another. Certain states regularly pay into the system far more than they consume. Indices range from .48 to 1.74 a very wide range.

| Alphabetical State | HCAI™ | Ranked State | HCAI™ |
|--------------------|-------|--------------|-------|
| United States | 1.00 | Delaware | 0.48 |
| Alabama | 1.59 | Minnesota | 0.59 |
| Alaska | 0.97 | Colorado | 0.65 |
| Arizona | 1.34 | Nevada | 0.68 |
| Arkansas | 0.91 | Connecticut | 0.72 |
| California | 0.89 | Virginia | 0.74 |
| Colorado | 0.65 | Wyoming | 0.75 |
| Connecticut | 0.72 | Illinois | 0.75 |
| Delaware | 0.48 | Washington | 0.75 |
| Florida | 1.23 | Utah | 0.76 |
| Georgia | 0.81 | Nebraska | 0.78 |
| Hawaii | 0.84 | Georgia | 0.81 |
| Idaho | 0.98 | Texas | 0.83 |
| Illinois | 0.75 | New Jersey | 0.83 |
| Indiana | 1.13 | Hawaii | 0.84 |
| Iowa | 1.26 | Maryland | 0.88 |
| Kansas | 0.98 | Wisconsin | 0.88 |
| Kentucky | 1.45 | California | 0.89 |
| Louisiana | 1.48 | Arkansas | 0.91 |

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| Table 6 2008 AHP Government Health Care Affordability Index | | | |
|--|--------------|---------------------|--------------|
| Alphabetical State | HCAI™ | Ranked State | HCAI™ |
| Maine | 1.74 | Oklahoma | 0.95 |
| Maryland | 0.88 | Alaska | 0.97 |
| Massachusetts | 1.04 | Idaho | 0.98 |
| Michigan | 1.12 | North Carolina | 0.98 |
| Minnesota | 0.59 | Kansas | 0.98 |
| Mississippi | 2.18 | United States | 1.00 |
| Missouri | 1.22 | New Hampshire | 1.02 |
| Montana | 1.31 | Oregon | 1.03 |
| Nebraska | 0.78 | Massachusetts | 1.04 |
| Nevada | 0.68 | South Carolina | 1.10 |
| New Hampshire | 1.02 | Tennessee | 1.10 |
| New Jersey | 0.83 | Ohio | 1.10 |
| New Mexico | 1.60 | Michigan | 1.12 |
| New York | 1.27 | Rhode Island | 1.13 |
| North Carolina | 0.98 | Indiana | 1.13 |
| North Dakota | 1.23 | Missouri | 1.22 |
| Ohio | 1.10 | North Dakota | 1.23 |
| Oklahoma | 0.95 | Florida | 1.23 |
| Oregon | 1.03 | Iowa | 1.26 |
| Pennsylvania | 1.32 | New York | 1.27 |
| Rhode Island | 1.13 | Montana | 1.31 |
| South Carolina | 1.10 | Pennsylvania | 1.32 |
| South Dakota | 1.33 | Vermont | 1.33 |
| Tennessee | 1.10 | South Dakota | 1.33 |
| Texas | 0.83 | Arizona | 1.34 |
| Utah | 0.76 | Kentucky | 1.45 |
| Vermont | 1.33 | Louisiana | 1.48 |
| Virginia | 0.74 | Alabama | 1.59 |
| Washington | 0.75 | New Mexico | 1.60 |
| West Virginia | 2.26 | Maine | 1.74 |

The results from the three states we have been tracking show California at .89, Minnesota at .59 and Washington at .75. These metrics have a 1/3rd weight in determining the overall affordability index. Minnesota's .59 significantly drives its favorable overall score, offsetting some of the higher than average affordability of the employee index.

Intermediate Observations

It is informative to draw some intermediate observations from the above information to potentially identify broad initiatives and/or issues that might improve overall affordability. Some of these are:

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- Affordability varies significantly by state.
- Local conditions significantly impact affordability potentially limiting national/universal solutions
- Even in our three “favorable” affordability states significant uniqueness emerge demonstrating divergence of concern
- Improvements in hospital inpatient efficiency continue to be a major source of improvement, with potentials for at least 30% improvement.
- Provider supply management doesn't provide an obvious and clear solution. Many areas continue to have unfortunate undersupply
- Employee participation in the cost of care and its related affordability impact varies widely by region. More affordable regions tend to be associated with lesser employee cost sharing.
- The role of government has a major impact on affordability and has great variability by state.
- The results do not present a logical solution, we need to look elsewhere.

Emergence of Health and Wellness Programs As a Solution

For many years wellness has been viewed from somewhat of a skeptical perspective. However recent studies and improved implementation programs are showing considerable health cost savings are associated with health and wellness programs. Our firm's most recent estimates show that an effectively implemented health and wellness program can reduce aggregate health care costs by as much as 20% - 35%. In addition, these costs savings continue for more than one year. Health and wellness provides a meaningful solution of the affordability crisis. Although there continue to be significant opportunities for efficiency improvements within the health care system, the emergence of the health and wellness solution is encouraging.

| Table 7 Illustrative Impact of Health and Wellness Changes | | | | | | | |
|---|----------------|--------------|----------|--------------|----------|-------------|----------|
| Health & Wellness Level | Current Dist.* | % of Ave \$* | \$ Dist. | Modest Shift | \$ Dist. | Major Shift | \$ Dist. |
| Well | 50% | 20% | 10% | 52% | 10% | 55% | 11% |
| Low Risk | 20% | 50% | 10% | 22% | 11% | 23% | 12% |
| Moderate Risk | 25% | 100% | 25% | 23% | 23% | 20% | 20% |
| High Risk | 4% | 750% | 30% | 2.5% | 19% | 1.5% | 11% |
| Complex | 1% | 2500% | 25% | 0.5% | 13% | 0.5% | 12% |
| Total | 100% | 100% | 100% | 100% | 76% | 100% | 66% |

* Source: Dee W. Eddington, Ph.D., Director of the Health Management Research Center at the University of Michigan

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Table 7 shows that with a modest shift in health and wellness level health care costs are reduced 24%, and with a more significant shift costs are reduced 34%. These shifts are very possible under an effectively implemented health and wellness program. These projected savings compare favorably with the potential for efficiency improvements. However, they bring a much more important quality to the table, these are politically correct and desirable initiatives. The efficiency savings although real savings have become less desirable for a variety of reasons.

The Change Management Connection

Health and wellness programs are really change management initiatives, focused on personal behavior change management, perhaps the hardest of all changes to make. Traditional change management focuses on moving an entity from its "current world" to a more desired "future world". Current world in the health and wellness environment is the individual's current health status. Future world is the hoped-for positive outcome of the health and wellness program (i.e., the individual's ideal health status). The key ingredient to measure success is determining how to successfully transition the individual from today to the future, from their current world to their future world, from "interested" in true health and wellness to becoming genuinely committed.

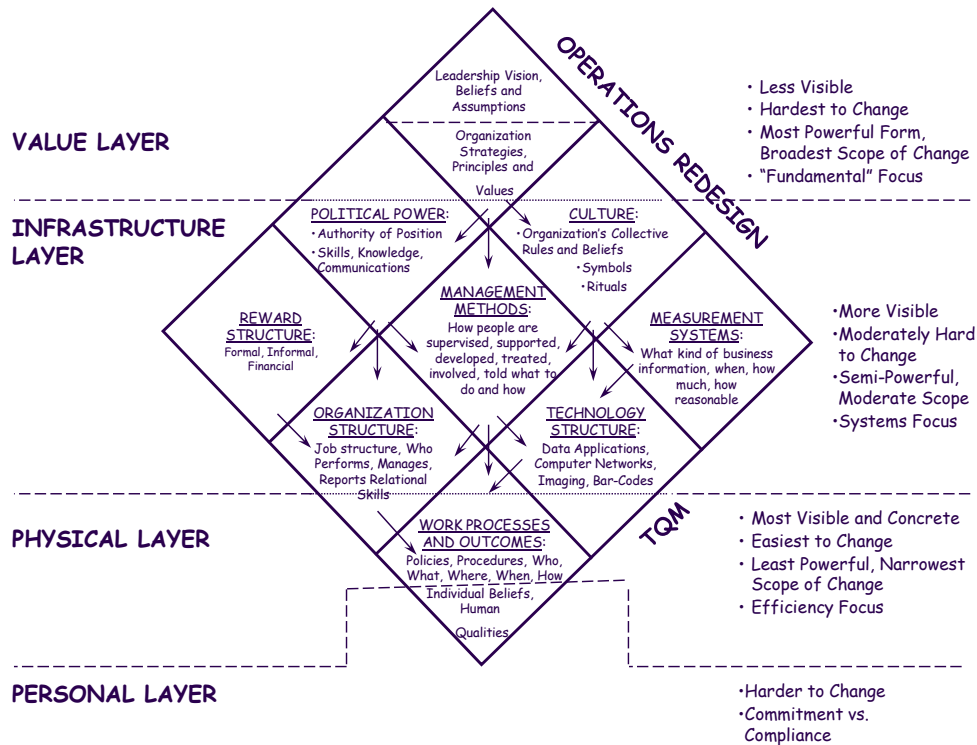
It is helpful to look at this from two distinct perspectives: organizational change management and individual change management.

Organizational Change Management

Classical change management principles offer useful ideas and concepts that can be directly applied to the organizational side health and wellness programs to better understand potential success and to design successful programs. A good example of this is shown in Exhibit A. This describes key factors in an organizational change management process. As Exhibit A shows, there are far reaching factors that impact the success of the change management process including leadership, management methods, measurement methods, organizational structure, technology, etc. Only when all are appropriately considered will the organizational change management process achieve its goals. Exhibit A's overlay of four layers with the individual pieces further demonstrates the forces which can disrupt the change management process.

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**Exhibit A
Organizational Change Management Grid¹**



Even the diamond shape of the change management grid is philosophically significant. Organizational and change management experts regularly use the management principle known as “tight-loose”. Exhibit A visually presents an extension of this “tight-loose-tight”. The first tight refers to a tightly defined vision/ mission, one that everyone buys into. The second tight refers to a tightly managed execution or process. The loose refers to flexible design and organizational process. Note that the top of Exhibit A comes to a point (i.e., tight, narrow), the middle part is wider, and the bottom again comes to a point. Visually it demonstrates “tight-loose-tight”, which we believe to be the most effective approach.

In terms of Health and Wellness, both the organization’s programmatic health and wellness approach and the individual’s personal interaction with the approach (described in more detail later) can be described in similar terms to that presented in Exhibit A and be mapped to this grid to demonstrate the key success factors. If an organization designs the right strategic program for implementation, the individuals who are participating will respond

¹ Change management grid initially developed by Dutch Siedentopf, change management consultant.

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accordingly. Historically, most health and wellness programs have focused on what the individual should do. The more ideal approach for organizations and individuals is to really focus on and develop the why and how considerations.

The most effective health and wellness programs are ones with the tightest vision and mission statement. This is where the program clearly identifies, incorporates and strengthens the appropriate motivations for change (“the why”). When an organization is truly committed to the process, amazing things can occur. Very specific and definite goals result in the best results. (i.e., Tight and non-negotiable).

We believe a tightly defined health and wellness program vision should include the following three items:

- A focused program – a program that begins with a particular aspect of health and wellness, rather than trying to be everything to everybody
- A hope-filled program – a program that provides hope to participants, showing that it can be done and success is likely
- A redemptive program – a program that encourages participants who participate, motivates them along the way, and incentivizes them to continue their transition. It is a program that gives “partial credit” for sincere participant efforts.

In addition, the most effective health and wellness programs incorporate a loose and flexible process or path. There are so many ways to structure and present programs, many with very similar results, that it is mandatory that the program incorporate flexibility. It is critical that the program tailor the specific application to best meet the needs of the individuals. Historically, this is where most of the narrow focus has occurred, rather than a “loose”, flexible approach. The exact structure and strategy (“the what”) need not be central in the context of genuine commitment and motivation. There is the capacity to customize and design specific strategies based on a host of unique and distinct considerations and preferences (i.e., Loose and flexible).

Finally, the most effective health and wellness programs have attracted highly committed individuals totally invested in the process (i.e., tight commitment). The sustained implementation (“the how”) is key for both short term and long term benefits and outcome. Predictably, having the appropriate commitment in the context of a customized strategy can lead to the implementation of a process that will lead to lasting change and benefit (i.e., Tight and mandatory).

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Unfortunately, we find that far too many health and wellness programs are structured Loose-Tight-Loose. There is a very loosely and poorly communicated program vision and goal, nebulous at best, combined with a rigid and tightly defined inflexible structure, and a loosely structured connection with the individuals resulting in less than desired results. A complex and rigid program presented in an apathetic environment will likely lead to extensive expended resources without much meaningful benefit. In contrast a tight-loose-tight program has a much greater likelihood of success, far above the general programs seen today.

For example, certain weight loss programs provide a rigid manual with points and/or limits forcing people into cookie cutter diet plans while doing little to effectively grow commitment to the end goal. These are clearly loose-tight-loose programs. Yes they oftentimes generate significant revenues to the sponsoring organization through membership and or meeting fees, with less than desired results and discouraged participants.

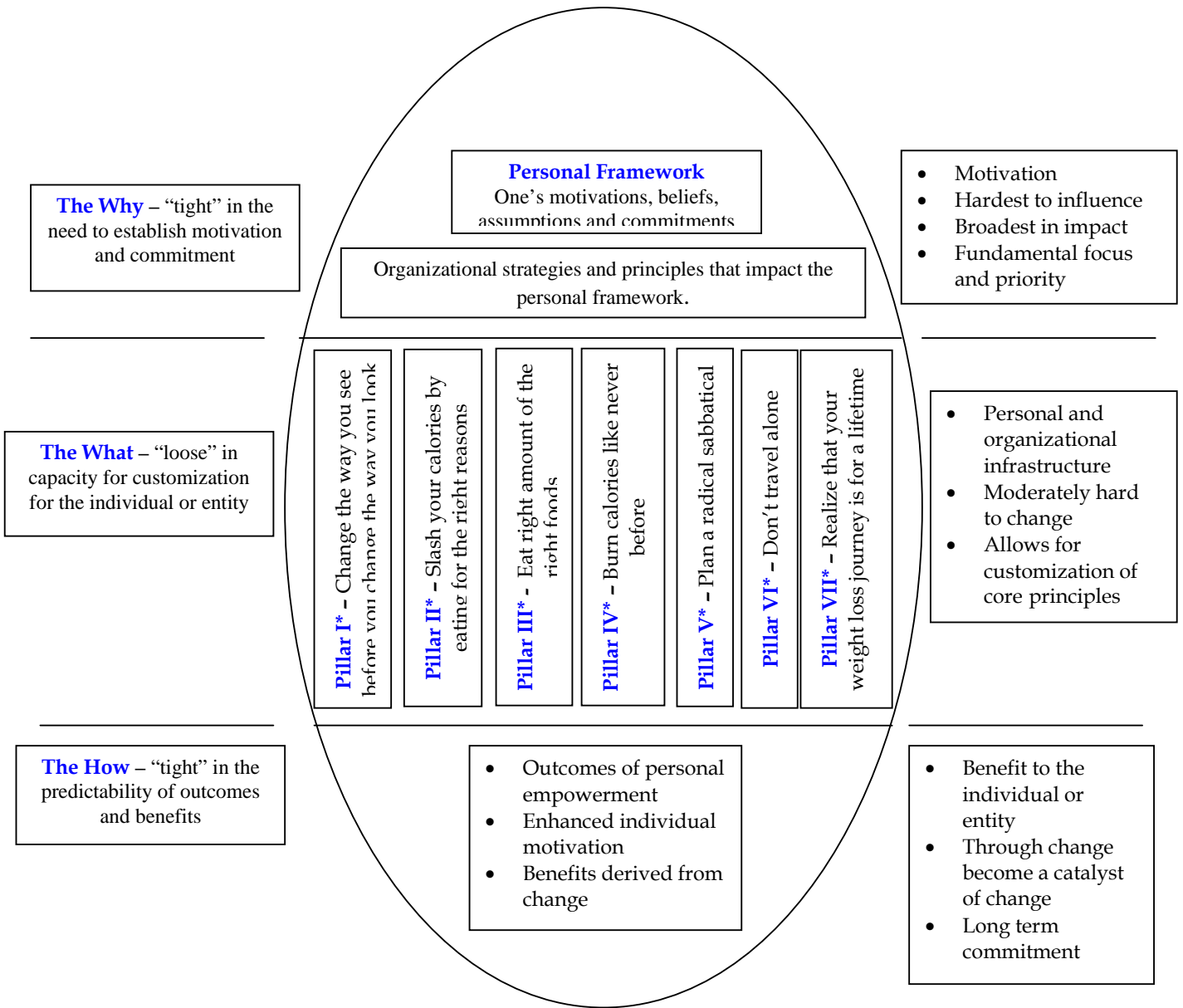
Individual Change Management

Just as with organization change, focusing on change management is key for any real impact to be made on one's current health status. Where as traditional health care for the most part focuses on treating illness and curing diseases, effective health and wellness programs focus on individuals becoming more committed to changing their behavior and hence improving the quality and potential for greater quantity of life. Personal change management principles offer valuable ideas and concepts that individuals can directly apply to improve the very quality of their lives. Exhibit B describes our model of the individual change management process as it relates to obesity. Just like with organizations, there are far reaching factors that impact the success of a person's journey into new found health and wellness.

The egg shape of the personal or individual change management model is again philosophically and symbolically significant. Symbolically, unhealthy personal behavior often leads to carrying around extra weight around our midsections (i.e., egg-shaped physique). Philosophically, like organizational change the proposed individual approach is a tight-loose-tight model but with gentler, softer edges and curves in comparison to the sharp edges of the diamond grid. The top of the egg, being the tightest refers to the need to have tightly defined personal motivation and commitment. The second tighter region at the bottom of the egg refers to the tightly defined outcome of personal empowerment. The larger, "loose", wider middle of the egg model refers to the customized and flexible design of a personal approach that encompasses certain core healthy pillars that anyone can adopt into the context of their lives. Exhibit B comes to a point of sorts at both ends with a

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**Exhibit B
AHP Health and Wellness Model**



*Source: Yphantides, Nicholas, “My Big Fat Greek Diet”, Nelson Books, 2004, ISBN 0-7852-6025-0

large wider middle area which visually demonstrates the tight-loose-tight of personal change management.

In terms of personal Health and Wellness, an individual’s personal approach can be mapped to this model to demonstrate the key success factors. Just like

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with an organization, most individuals respond in a very similar way. Most adults who are relatively informed do not just need to be told "what" to do. They may already know at various levels. What they do need the most is the support, encouragement and accountability to just do it. What they need is the inspiration and hope to know it's possible. Too many times we focus on instruction and neglect inspiration. We prioritize giving people help without adequately providing a sense of hope that change is possible. We emphasize technique and neglect motivation. The ideal approach to individual change management is one that develops motivation, develops sincere commitment to the process, develops hope for the potential that it can be done and builds inspiration about the consequences of it actually occurring.

On the personal or individual level motivation is key! What often is lacking is appropriate and meaningful motivation which translates to a greater sense of commitment. The concepts of health and wellness change are not that complicated. It's the application of the simple principles into the complexity of an individual's life which take thoughtful and strategic consideration. The tight-loose-tight structure directly applies here. The individual needs to clearly know (i.e., tight):

- Why am I part of this program?
- What is the end goal or outcome?
- What will I achieve?
- What are the benefits of me participating?
- How much personal effort it will take? Too often this is inadequately presented and high recidivism or failure rates result from not buying in up front to what will likely occur.
- What is the required process to be successful?
- What are my chances of success?
- Is this program clinically sound? What are the program's credentials?

On a loose perspective, the individual needs to know what specific rewards or incentives are involved. Whether personally established by the individual or part of the overall program structure, the participant must value the rewards and let these motivate them in their transition process. There is a wide variety of incentives that could be used and uniquely tailored to each individual. Different individuals respond to different incentives, are motivated differently, and will perform differently. The program needs to react to these different perspectives.

Measurement systems are key to the individual, but their precise structure is less important. The individual needs to see that they apply to their lifestyle

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and normal thinking process. They have to be comfortable with what is going on.

On the bottom tight perspective, the individual needs to be closely held accountable and encouraged to continue the process they have begun. Without this the individual may give up, stop the program, lose heart and assume it is hopeless.

An Ideal Health and Wellness Program

Based upon our actuarial analysis we find that as much as 75% - 85% of the potential savings from health and wellness programs can be directly attributed to six specific and objectively measured factors:

- Obesity (i.e., as measured by the BMI or Body Mass Index)
- Fasting blood sugar
- LDL cholesterol (i.e., bad cholesterol)
- Blood pressure
- Smoking/non-smoking, and
- Personal fitness

Ironically, all of them with the exception of smoking/non-smoking are directly related to BMI. As individuals solve their BMI problem, they gradually solve most of their other problems. Some individuals with genetic predisposition to certain conditions may require ongoing medications to keep one or more factors in control, but the vast portion of problems can be significantly improved and eliminated by eliminating obesity and achieving an ideal BMI or by at least improving it and moving closer to the ideal level. This suggests that significant gains can be made by creating a BMI-focused health and wellness program. Since smoking/non-smoking is somewhat independent, perhaps a two pronged program (i.e., BMI and smoking cessation) is the best way to implement a program. This "tight" focus enables the program to quickly succeed, where other "loose" focus programs have failed or had significantly less results.

Although the actual results are significantly impacted by characteristics of the studied population (i.e., the population's average BMI scores and the proportions of smokers to non-smokers), we find that in a fairly typical population overall health care costs can be reduced by as much as and possibly more than 20% - 30% if each of the individuals in an overall population advance to their ideal health status. On an individual by individual basis the cost reductions on some is much more than this. A

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tangential benefit of this improvement is that the cost savings continues to occur for many years, not cost savings in just one year.

Every health and wellness program needs reliable ways of accurately measuring the program's effectiveness. Each of the above six factors can be objectively measured through relatively inexpensive means. For example, a simple blood test can be used to measure blood sugar or LDL levels. Blood pressure can easily be measured by a trained individual or even by automated machines. Fitness can be broadly defined as the ability to function efficiently and effectively, to enjoy leisure, to be healthy, resist disease and to be able to cope with emergency situations. The health related components of physical fitness that could be measured include body-composition, cardiovascular fitness, flexibility, muscular endurance and strength. There are various ways to measure fitness depending on available resources and facilities. There are several available Health Risk Appraisal (HRA) packages that can give a report that incorporates both objective measures as well as subjective responses to a set of questions.

As mentioned earlier, it is also critical to provide hope to the participants. A believable example or champion is always beneficial to motivate participants. One interesting example of this is one of the author's of this article.

Nicholas J. Yphantides, MD, Dr. Nick as he is known, the author of "My Big Fat Greek Diet"², used to weigh 467 pounds, has lost more than 270 pounds and has successfully kept it off for almost seven years. His significant and relatively quick weight loss journey is chronicled in the book. Dr. Nick outlines Seven Pillars of Weight Loss Success, which are critical to successful weight loss and are integrated in the Individual Change Management Model. They can be summarized as follows:

Pillar I: "Change the way you see before you can change the way you look." As discussed change is at the core of what is needed but rather than focusing on changing specifics, first one has to undergo a change in their perspective which will naturally lead to a change in habits and behavior.

Pillar II: "Slash your calories by eating for the right reasons." Way too much focus is spent on diets and what to eat. Critical to healthy living is having a healthy relationship with food and rediscovering its role as fuel and not as a means of dealing with any number of other personal emotions or needs.

² Yphantides, Nicholas, "My Big Fat Greek Diet", Nelson Books, 2004, ISBN 0-7852-6025-0

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Pillar III: "Fill your tank with the right amount of the right foods." Rediscovering an appropriate sense of satiety by responding to the body's signals and as a result eating an appropriate amount of the right kind of food is core to learning how to eat to live healthy.

Pillar IV: "Burn calories like never before." It is imperative and necessary not only to lose weight but not to rediscover it again once lost (i.e., gain it back). As individuals become more physically active they will keep it off. Strategies to have fun and pleasure burning calories are important for it to be a sustainable habit.

Pillar V: "Plan a radical sabbatical." Most need to take some kind of a break from the routine if we are going to establish a healthier lifestyle. Combining pleasure and benefit and carving out time that one can focus on their health as a priority for lasting vitality is core to successful weight loss.

Pillar VI: "Don't travel alone." The assumption is that this is an ongoing journey for most. There are times where initial momentum is present but for many, the notion of support, encouragement and some level of accountability are going to be key factors to long term success. It is so important to people committed to the group nature of accountability and healthy co-reliance on healthy living.

Pillar VII: "Realize that your weight loss journey is for a lifetime." Many people see weight loss interventions as a temporary lifestyle modification where in reality it is a life long commitment to a new set of habits and behaviors. Its not about losing the weight. Its about losing it and not rediscovering or finding it again that really counts.

Weight loss programs (i.e., BMI improvement programs) aligned with these key principles have demonstrated much greater success than those missing these. Most current efforts fall short of lasting impact in that they target the stomach. Many overweight people who have health related consequences for their extra weight do not have a problem with their stomachs as much as they do with their "heads and hearts."

Focusing first on those with BMI concerns accomplishes the greatest value in the health and wellness program. Dr. Nick's approach proves to be quite effective in making those changes. The second focus is on those currently smoking, using traditional smoking cessation programs and interventions. This approach could be called wellness triage, focusing on those who need it the most. The prioritization in such a program is as follows:

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- BMI improvement
- Smoking Cessation
- Blood pressure reduction and control
- LDL reduction and maintenance
- Fasting blood sugar reduction and maintenance
- Fitness improvement

Integration With Health Benefits Program

The above health and wellness approach can be further enhanced through the integration of it with the health benefits program. Combining an organization's change management model along with the individual model could lead to a radical transformation in the workplace and in the individual's lifestyle. There are several approaches that can be used to effectively accomplish this, however, one popular approach is linking the six key health status indicators to a health and wellness points system, and then linking the points system to a particular benefit level.

One effective approach provides individual incentives for improvements in each of the targeted health and wellness categories. Linking benefit design, employee cost, and health and wellness results provides strong motivation for health and wellness change. This type of program builds on the concepts discussed earlier:

- Incentive driven – the better the wellness scores the lower the deductible, best benefits are given even if one bad area
- Redemptive – encourage those who are trying by giving partial credit.
- Hope-filled – build wellness program around concepts that work
- Focused – BMI centric with wellness triage.

It is critical that programs of this kind consider federal anti-discrimination regulations. It is our understanding that current regulations permit health and wellness programs which reduce deductibles/copays for improved health status. Regulations impacting this are continually changing and it is critical to keep this in mind when designing such programs.

Summary

Health and wellness programs can be structured in many different ways. As health plans and plan sponsors decide to impact the wellness of their customers, it is critical that the programs achieve the financial success they were intended to get. Since so much change is happening today, it is important to track these issues very closely to assure the greatest health cost savings possible.

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There is a significant potential for health cost reductions from appropriately implemented health and wellness programs. Not every program will be able to achieve the entire 20% - 35%, however, in the current economy, a minimal savings of 5% - 10% would be significant to most health care planners. Additional savings can be achieved if health and wellness principles are strategically combined with effective care management principles.

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