



# Engaging the C-Suite: Can We Do It?

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**National Health Leadership Council**

**Charleston, South Carolina  
June 25-27, 2008**

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# Message from the President



October 2008

The National Health Leadership Council (NHLC) of the National Business Coalition on Health (NBCH) brings together leaders from business, health coalitions, and other stakeholders in the health care system to discuss issues at the cutting edge of health care financing, organization, access, and quality. Recent NHLC meetings have explored consumer-centered health care and consumer-directed health benefit models, the uninsured, evidence-based health benefit design, health information technology (IT), physician performance measurement, physician payment reform, the link between employee health and productivity, and consumer financial incentives.

In June 2008 the NHLC met in Charleston, SC to discuss an increasingly important topic—how to engage the “C-suite” (i.e., corporate executives and boards of directors) in promoting employee health and productivity through value-based purchasing and other strategies, including participation in community coalitions and local, regional, and national policy debates. Two days of rich conversation included presentations by a variety of thought leaders, including representatives from pioneering employers and employer coalitions, academia, a research organization, and policy advocacy organizations.

NBCH member surveys suggest that engaging the C-suite is a top priority for employers and employer coalitions, particularly with respect to strategies for encouraging corporate leaders to serve as change agents for improving health and productivity by transforming health care community by community. This NHLC meeting identified the barriers to achieving that goal, along with the steps that are needed to get leaders of corporate America to take ownership of this issue. The key to success is not in convincing leaders to become involved for moral reasons, but rather to convince them that doing so is a business imperative. While there is no doubt that much needs to happen after C-suite leaders are engaged (e.g., building a culture of health, getting buy-in within the organization, and executing and sustaining the strategy over time), the first critical step is to light a fire under leaders to serve as change agents. To that end, the meeting focused on four key dimensions of engaging the C-suite; these four dimensions collectively represent a “design framework” that can lead to sustained engagement by leaders at the company, community, and policy level:

- Identifying barriers that prevent leaders from getting involved or that encourage them to exit quickly after doing so.
- Market and other external forces that encourage leaders to engage in this issue.
- Key factors in making the case to C-suite leaders, including use of data on health and productivity and other strategies for getting leaders’ attention.
- Successful strategies for moving beyond the corporation to promote health and productivity at the community and policy level.

In addition to this report that summarizes the proceedings, another key deliverable from the meeting will be the development of a purchaser guide for C-suite engagement that will follow this design framework. Our hope is that these publications will help in company- and coalition-led efforts to transform health care community by community.

Sincerely,

A handwritten signature in black ink that reads "Andrew Webber". The signature is written in a cursive, flowing style.

Andrew Webber  
President and CEO, NBCH

The National Health Leadership Council (NHLC) of the National Business Coalition on Health (NBCH) is a vehicle for high-level discussions of issues that are important to coalition members and to all major parties in health care, including purchasers, providers, insurers, suppliers, and consumers. The expectation is that NHLC meetings will produce statements of agreement among the stakeholders that will promote the advancement of a more value-based health care system. The goal is to encourage community-based changes founded on market principles.

In June 2008, NBCH held an NHLC meeting in Charleston, SC. The meeting focused on how to engage the “C-suite” (i.e., corporate executives and boards of directors) in promoting employee health and productivity through value-based purchasing and other strategies, including participation in community coalitions and policy discussions. The first day of the meeting included several presentations from employers on how to engage the C-suite along with presentations by representatives of academia and a research organization on how to build a business case for engagement. The first day also included presentations and discussion on engaging corporate leaders in the broader national policy debate on these issues. The second day included additional case studies from one employer and three business coalitions. This report summarizes and synthesizes the key points from the presentations and discussion that took place during the meeting. It is organized into the following sections:

- **Building the Business Case for C-Suite Engagement**  
Dee Edington, PhD, Director, Health Management Research Center, University of Michigan; Thomas Parry, PhD, President, Integrated Benefits Institute; Andy Masetti, Senior Vice President and Chief Financial Officer, Sentient Medical Systems
- **Engaging the C-Suite: Corporate Success Stories**  
Thomas Welsh, MBA, Human Resources Director, Benefits and Services, PPG Industries, Inc.; Cathy Baase, MD, Global Director of Health Services, The Dow Chemical Company
- **Engaging the C-Suite: Coalition Success Stories**  
Barbara Prowe, Executive Director, Oregon Coalition of Health Care Purchasers; Becky Cherney, President and CEO, Florida Health Care Coalition; Louise Probst, Executive Director, St. Louis Area Business Health Coalition
- **Engaging the C-Suite in Community Coalitions: A Case Study**  
Annmarie Higgins, Director of Human Resources, Mitsubishi Polyester Film
- **Engaging Corporate Leaders in the National Policy Debate: A Perspective from The Association of Senior Human Resource Executives and The Business Roundtable**  
Marisa Milton, Associate General Counsel and Director, Health Care Policy, HR Policy Association; Andrew Mekelburg, Vice President for Government Relations, Verizon

## Building the Business Case

The key step in convincing C-suite leaders to become involved is to create a compelling case that doing so is in the economic interests of the organization and its shareholders.

### Health Management as a Serious Business Strategy

*Dee Edington, PhD, Director, Health Management Research Center, University of Michigan*

The University of Michigan Health Management Research Center hosts a consortium of companies that provide health care insurance to over two million Americans. Staffed by approximately 35 individuals, the center has collected data from these and other companies for a minimum of eight years, with some companies having submitted data for as many as 18 years. The group comes together in Ann Arbor, MI every December.

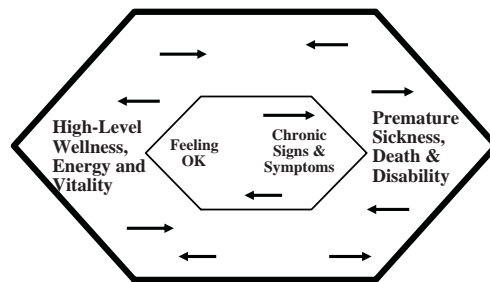
### Changing the Conversation about Health in Corporate America

Since September 1, 2003, the goal of the organization has been to “change the conversation” around health by promoting a new way for companies to manage the health of their employees, a step that is critical to regaining the vitality of corporate America. To achieve this goal, companies need to look beyond the costs of providing health care benefits, focusing instead on the total value they derive from providing coverage, particularly in terms of boosting employee health status and productivity. Key components of this “changed conversation” include the following shifts in conventional thinking about health and health care coverage:

- From health as the absence of disease to health as vitality and energy.
- From focusing on the cost of health care to the total value of health; most current health care reform proposals mistakenly focus on the costs of coverage (and who pays this cost).
- From individual participation to population engagement.
- From behavior change to creating a culture of health. Even if a few individuals change behaviors, the gains will not be sustained if they return to the same culture.

As depicted in the chart below, the focus needs to broaden. Today’s system is almost exclusively concerned with the right side of the chart—treating the signs and symptoms of chronic disease and premature sickness so as to prolong life and delay disability. But attention must also be paid to the left side of the chart—i.e., to individuals who currently perceive themselves as well. These individuals need to be encouraged to work on increasing their energy and vitality so that they remain healthy. The problem today is that all the financial rewards accrue to those health care providers who focus on the right side.

Health Continuum: for Individuals or a Population



Edington. Corporate Fitness and Recreation. 2:44, 1983

Such an approach is short sighted. Companies can enhance shareholder value by fostering healthy and productive employees, who in turn will develop creative and innovative products. Focusing on health per se is not the point—but encouraging healthy employees can improve the economics of the organization.

The strategy, therefore, is to create a culture of health within the organization by partnering with health plans, benefit consultants, primary care physicians, pharmaceutical companies, health enhancement companies, and others. All of these partners can be vital to the future of organizations. (Traditional “vendor” relationships, however, must end, as “vendors” are primarily interested in making money off of an organization.) The goal of the effort should be to get 90 to 95 percent of employees to participate in programs, and to keep 75 to 85 percent of employees in the low-risk category. Once someone gets sick due to poor eating habits, physical inactivity, and other factors, it can be quite difficult to fully recover and return to the low-cost, low-risk category.

**“The key is simple—keep healthy people healthy. In other words, don’t get worse.”**

**Dee Edington, PhD**

**Dee W. Edington, PhD**, is a Professor in the Division of Kinesiology at the University of Michigan, Director of the Health Management Research Center, and a research scientist in the School of Public Health. In addition to his research and teaching, he spent 25 years in academic administration. Trained in mathematics, kinesiology and biochemistry, Dr. Edington received his Bachelor of Science and Ph.D. degrees from Michigan State University and completed his Masters of Science degree at Florida State University. He did post doctoral work at the University of Toronto and taught at the University of Massachusetts before coming to Michigan in 1976. Dr. Edington's research focuses on the relationships between healthy lifestyles, vitality, and quality of life as they benefit both individuals and organizations. He is the author or co-author of over 600 articles and presentations, along with several books, including *Biology of Physical Activity*, *Biological Awareness*, *Frontiers of Exercise Biology*, and *The One Minute Manager*

## The Costs of Doing Nothing

Companies that take a “do-nothing” approach are doomed to failure. As shown in the charts below and to the right, too many people have significant health problems and health risks.

### Estimated Health Problems

Self -Reported	Health Problems
Allergies	33.2%
Back Pain	26.9%
Cholesterol	16.2%
Heart Burn/Acid Reflux	15.2%
Blood Pressure	14.5%
Arthritis	14.5%
Depression	10.7%
Migraine Headaches	9.4%
Asthma	7.0%
Chronic Pain	6.4%
Diabetes	3.8%
Heart Problems	3.3%
Osteoporosis	1.8%
Bronchitis/Emphysema	1.7%
Cancer	1.3%
Past Stroke	0.7%
Zero Medical Conditions	31.9%

UM-HMRC  
Estimated Medical  
Economics Report

### Estimated Health Risks

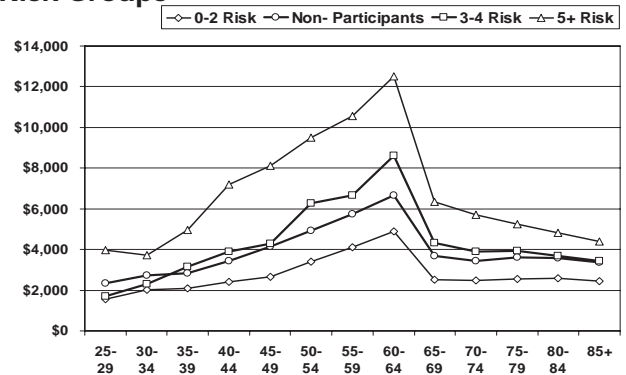
Health Risk Measure	High Risk
Body Weight	41.8%
Stress	31.8%
Safety Belt Usage	28.6%
Physical Activity	23.3%
Blood Pressure	22.8%
Life Satisfaction	22.4%
Smoking	14.4%
Perception of Health	13.7%
Illness Days	10.9%
Existing Medical Problem	9.2%
Cholesterol	8.3%
Alcohol	2.9%
Zero Risk	14.0%

OVERALL RISK LEVELS	
Low Risk	55.3%
Medium Risk	27.7%
High Risk	17.0%

UM-HMRC Estimated  
Medical Economics  
Report

Overall, roughly 17 percent of the population is considered to be high risk (with five or more risk factors), 27.7 percent are medium risk (with three to four risk factors), and 55.3 percent are low risk (with two or fewer

### Company Paid: Medical/Pharmacy, Age and Risk Groups

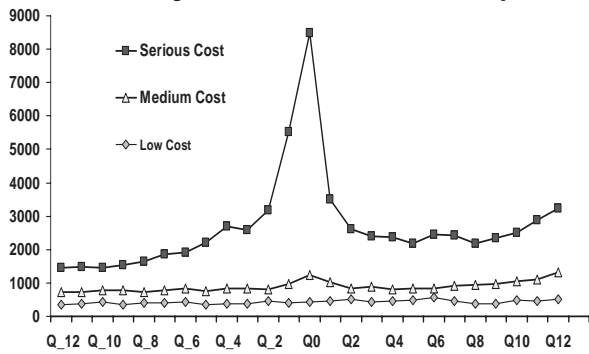


Modified from Edington. AJHP. 15(5):341-349, 2001

risk factors), including approximately 14 percent who have no risk factors. The problem, however, is that risk profiles shift over time, with more individuals “migrating up” into higher-risk categories than “migrating down” into lower-risk categories. For example, a company where 64.5 percent of employees are low risk today will likely find that only 61.4 percent are low risk in three years, with corresponding shifts into the medium-risk (from 24.6 to 26.5 percent) and high-risk (from 10.8 to 12.1 percent) categories. By far the best (and perhaps only) solution to this problem is to stop the flow into higher-risk categories by focusing on keeping people healthy. Efforts can be made to help those who have migrated up improve (and return to low-risk status), but this is a very challenging task.

The danger of focusing only on those at risk can be seen in the charts below, which show the much higher costs of caring for high-risk individuals.

## Total Medical and Pharmacy Costs Paid by Quarter for Three Groups



Musich, Schultz, Burton, Edington. DM&HO. 12(5):299-326, 2004

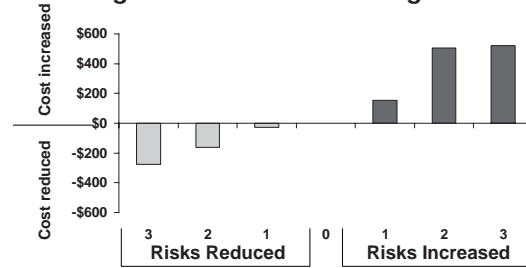
In short, costs follow risks, and there is a tremendous danger in following a “do-nothing” strategy that allows individuals to flow into high-risk, high-cost categories.

## The Benefits of Focusing on Health Status

A new approach is needed by corporate America, one that incorporates a new way of thinking about employee health and productivity. As Albert Einstein once said, “the world we have made as a result of the level of thinking we have done thus far creates problems we cannot solve at the same level of thinking at which we created them.”

The new approach needs to eliminate “silo” thinking and instead consider the total value of health to the organization. Health care coverage and employee health are more than just direct costs to the organization. Beyond the medical and pharmacy costs of coverage, employee health has a dramatic impact on workers’ compensation, absenteeism, short- and long-term disability, and presenteeism (i.e., people coming to work but performing suboptimally due to illness). High-risk employees generate significantly higher expenses than do medium- and low-risk employees, not just in terms of medical and pharmacy costs, but also in disability, workers’ compensation, and absenteeism. Overall, 36 percent of all costs are associated with excess risk levels, including 41 percent of short-term disability costs, 24 percent of workers’ compensation costs, 29 percent of absenteeism-related costs, and 38 percent of medical and pharmacy costs. More importantly, as shown in the chart below, changes in costs follow changes in risks.

## Change in Costs follow Change in Risks

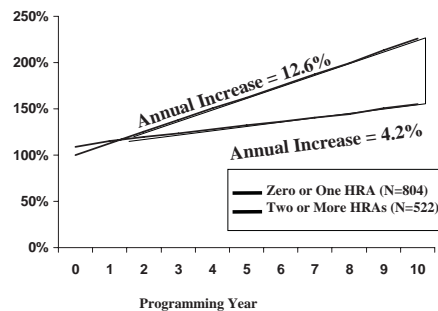


Overall: Cost per risk reduced: \$215; Cost per risk avoided: \$304  
 Actives: Cost per risk reduced: \$231; Cost per risk avoided: \$320  
 Retirees<65: Cost per risk reduced: \$192; Cost per risk avoided: \$621  
 Retirees>65: Cost per risk reduced: \$214; Cost per risk avoided: \$264

Updated from Edington, AJHP. 15(5):341-349, 2001.

If employers can keep employees from getting worse (as compared to the rest of the population), they can reap significant financial benefits, keeping annual cost increases to well below previous trends (see chart below).

## Cost Savings Associated with Program Involvement from 1985 to 1995



In summary, the business case for a focus on health management is as follows--excess costs are related to excess risks, and costs follow the degree of employee engagement and risks. Controlling these risks can get companies close to or at a “zero trend” with respect to cost increases.

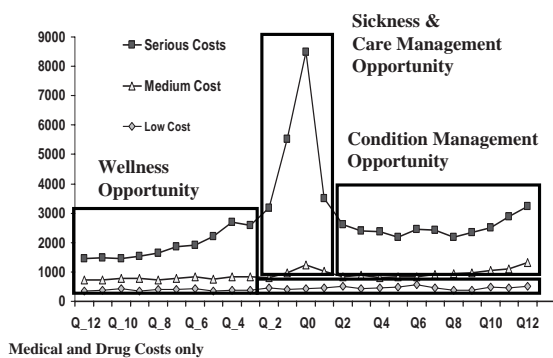
## Making It Happen: Focusing on the Culture of Health

For companies to realize the potential gains, they need to take a “human capital” approach by focusing on the economics of total population engagement and the total value of health, the components of which include medical and drug expenses due to sickness, absenteeism, disability, workers’ compensation, effectiveness while on the job (presenteeism), recruitment, retention, and morale. The University of Michigan Health Management Research Center

conducted an analysis of a large company, estimating the sum total of these costs to be \$1 billion, not including the costs of presenteeism. This analysis captured management’s attention, particularly an estimate that \$200 million of these costs could be affected relatively quickly.

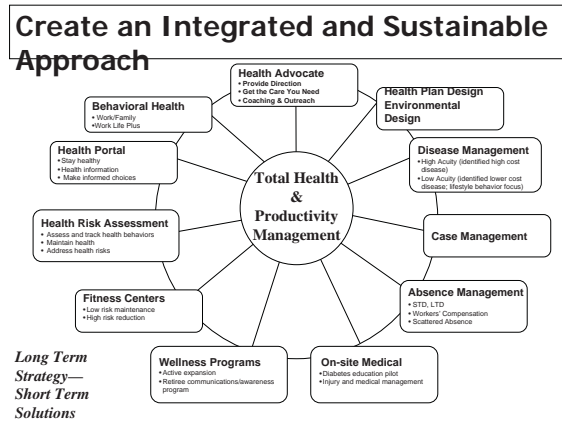
Both existing disease and health risks drive costs. But as noted previously, companies should not wait for disease and health risks to materialize. Rather, as shown in the chart below, companies must focus on the “wellness opportunity” that exists in keeping low-risk employees healthy.

### Total Population Management



As depicted in the chart on the next page, the focus should be on creating an integrated and sustainable approach to total health and productivity management, with an emphasis on making health a part of the culture and the environment. This culture of health and productivity, moreover, must be aligned with the company’s business and economic objectives.

Achieving this goal depends upon leadership (including both management and union leaders), which needs to articulate a vision of a culture that focuses on health, productivity, and well-being, and create an environment that aligns with this culture of health. Healthy people cannot be put in a “sick environment.” Rather, the environment needs to encourage healthy behaviors through benefit design, food choices offered in cafeterias, working hours (which should be flexible), and configuration of stair wells (which should encourage physical activity). Creating this environment requires more than just appropriate human resource policies. It requires a series of actions designed to encourage appropriate behavior and relieve stress and other mental health-related issues, which represent huge threats to corporate America.



Success, moreover, will be driven by use of individual-based strategies (e.g., a health risk appraisal or HRA system, screening, and coaching for all employees, not just those at high risk) that get people engaged and participating (the goal should be 85 to 90 percent population). These strategies should be supplemented with population-based strategies (e.g., “know-your-numbers” initiatives, walking programs). It is important, moreover, to set the initial bar fairly low; not everyone will immediately be able to walk 10,000 steps or reduce their body mass index (BMI). Setting unrealistic expectations sends the strong message to employees that they are “failures” or “losers.” The key is to create a winning environment by starting with more modest goals, such as not gaining additional weight, walking 500 steps, or knowing one’s blood pressure level. Once most people are “winners,” goals can be ratcheted up over time. To support these efforts, a quality-improvement approach should be used, including liberal application of incentives and measurement systems.

### Three Levels of Programs

The University of Michigan Health Management Research Center has observed three different levels of employer-based programs that are designed to achieve a culture of health and productivity. The savings achieved will depend upon the type of program offered; the programs vary in terms of overall objectives and intensity as well as the number of program components.

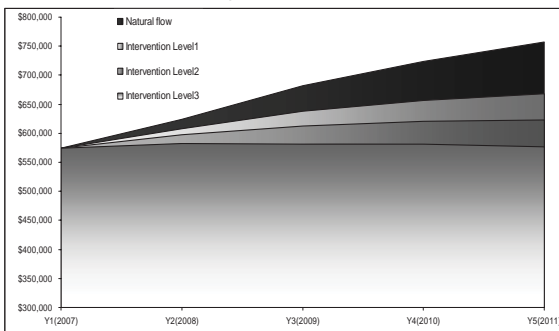
- The Level 1 program targets high-risk individuals through use of an annual HRA, onsite screening, face-to-face counseling, phone-based coaching for high-risk individuals, and wellness classes.
- Level 2 adds an emphasis on maintaining low-risk

status (i.e., keeping healthy people healthy). This holistic approach to population management includes all program components found in Level 1 along with coaching for low-risk individuals, resource triaging, and use of health portals, advice lines, or newsletters.

- Level 3 builds on the foundation laid by Levels 1 and 2 but accelerates the time required to achieve the low-risk goals laid out in these programs. More importantly, level 3 emphasizes policy changes and environmental support with the addition of elements such as management engagement and environmental procedures and policies that are in alignment with a healthy and productive culture.

As shown in the chart below, the savings achieved by each of these strategies is significant (as compared to the continuation of projected trends), with the greatest benefit (by far) being achieved by the level 3 strategy, which allows a company to achieve “zero trend” in terms of healthcare costs.

**Projected Total Healthcare Costs & Benefit for Active Employees('07) Unit=\$1,000**



## Summary

The “do-nothing” strategy is not sustainable. Rather, the definition of health needs to change from the “absence of disease” to “achieving high-level vitality,” and the strategy for promoting health needs to focus on total population management as a means of capturing the total value of health. The business case for this approach centers on keeping healthy people healthy. Modest goals should initially focus on not getting worse and on creating winners, one step at a time. Achieving this vision requires the creation of a culture of health that treats employees and dependents as family by creating a healthy place to work and a healthy community. Partners need to be enlisted to help with this task, including fellow CEOs, YMCAs, schools, local Boy Scout and Girl Scout organizations, senior centers, and local government. These partners should work together to create a coordinated vision for a healthy, productive community. .

## Winning the Support of the Chief Financial Officer

Winning the support of the chief financial officer (CFO) is critical to convincing the leaders of any organization to focus on promoting employee health and productivity.

### How to Reach the CFO with the Value of Health

*Tom Parry, PhD, President, Integrated Benefits Institute (IBI)*

Winning over CFOs requires an emphasis on the value of health as opposed to the costs of health care. Most CFOs know all too well how much money the company is spending to provide health care benefits. But not all of them understand the value the company is deriving from this spending.

### CFOs Understand Link Between Health and Financial Performance

In 2002, IBI produced a report entitled *On the Brink of Change: How CFOs View Investments in Health and Productivity*. Based on a survey of 270 CFOs of large corporations, the report sheds some important light on how best to make the business case for health and productivity to the CFO. Not surprisingly, the survey shows that CFOs are very concerned about rising healthcare costs, with 72 percent of respondents seeing the issue as very important or one of the top issues facing the company, and another 21 percent seeing it as important.

But many CFOs are looking beyond the costs of health care and also focusing on the link between health, productivity, and the bottom line. More than six in 10 (61 percent) CFOs see a strong link between these factors, while another 32 percent see a moderate link. In addition, 55 percent of CFOs understand the role of healthcare providers in minimizing total health-related costs; in fact, sizable percentages of CFOs see the providers’ role as being critical to minimizing medical costs (52 percent), speeding up an employee’s return to work (42 percent), and enhancing employee performance (21 percent). In addition, 62 percent of CFOs believe that prescription drugs can serve to reduce health-related costs. In other words, CFOs “get it”—they are able to look beyond costs and understand the conceptual link between the health of workers and business results. This finding represents good news, as it creates more options for how to address problems related to employee health and productivity.

The 2002 survey, however, makes it clear that CFOs

did not yet understand how benefits programs fit into the company's financial performance, with only four percent seeing such program as a critical factor in the organization's financial performance and 21 percent believing that benefit programs have a great degree of impact on financial performance. Almost one third (29 percent) of CFOs, moreover, are not sure what level of productivity improvement would be needed to motivate a change in benefits programs (these CFOs have likely never thought of the issue in this way). Of the remainder, 69 per cent suggested that productivity improvements of six percent or less would be enough to convince them of the need to change benefits programs.

But there also appears to be a key disconnect in the metrics used to hold CFOs and human resource managers accountable. CFOs are held accountable for cash flow, revenue growth, earnings growth, and operating profits. But human resource and benefits executives are held accountable for program costs and the program's impact on employee satisfaction and retention. Use of these two very different sets of metrics may limit the ability to change the conversation with senior management and

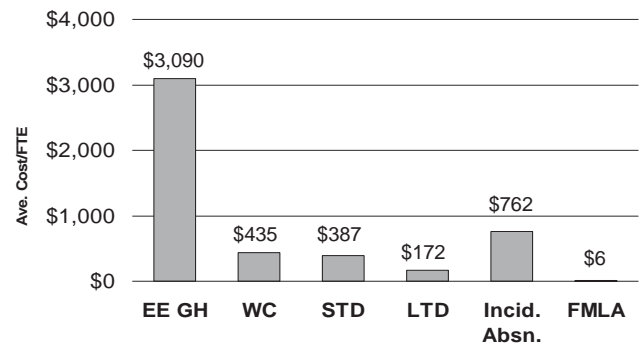
**Thomas Parry, PhD**, is President and CEO of the Integrated Benefits Institute (IBI), a San Francisco-based independent, not-for-profit, national organization that was incorporated in 1995. IBI provides research, employer-focused measurement tools, benchmarking, and educational programs to improve health and productivity management through the integration of employee benefits. In addition to directing IBI's activities, Dr. Parry is heavily involved in the company's research and measurement/benchmarking programs. He frequently speaks on integrated benefits and health and productivity issues at conferences and symposia both in the United States and abroad. Before co-founding IBI, Dr. Parry served for 11 years as Research Director at the California Workers' Compensation Institute, where his research encompassed a wide variety of topics in workers' compensation, including early research and analysis on 24-hour coverage and integrated benefit issues. Dr. Parry also served for five years as research advisor to the Roadway Express Inc. Medical Board. He received his Bachelor's, Master's, and PhD degrees from the University of California, Berkeley.

convince them of the benefits of focusing on employee health and productivity.

## Quantifying Health-Related Lost Productivity

To make the business case to CFOs clearer, IBI embarked on a study designed to quantify the magnitude of health-related lost productivity. This study reviewed 2002 benefits data from 88 employers that collectively have \$1.4 trillion in annual revenues and cover 3.3 million lives. As shown in the chart below, benefits managers went into this study believing that, by far, employee group health costs represent the single biggest cost item, much larger than workers' compensation, short- and long-term disability, and absenteeism. Given these perceptions, it is no surprise that companies focus on reducing medical costs through increased cost sharing and risk-shifting initiatives. As long as benefits managers are held accountable for program costs, this will be their focus.

### Perceived Costs/Program



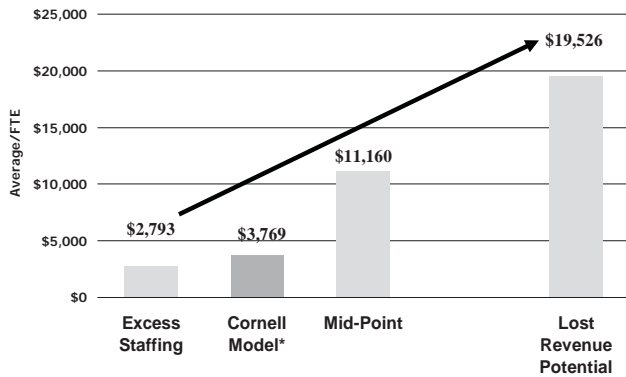
But CFOs do not understand the cost- and risk-shifting emphasis, as they look at the costs for the whole enterprise, which include the costs of lost productivity due to absenteeism, presenteeism, and other factors. Absenteeism-related expenses include the impact on worker replacement (the ease of which varies by company), team work (if one member is absent, the whole team is affected), and the time-value of output (i.e., lost revenues due to an employee's absence, a problem that CFOs are deeply concerned about). Sean Nicholson, PhD, and a colleague at the Wharton Business School developed a model to estimate the cost of lost productivity due to absence, with industry- and occupation-specific multipliers that can be used to estimate the impact.

The degree to which companies are affected by absenteeism depends on whether the company has excess staffing available to make up for the absence.

Many companies, especially smaller ones, do not, which means that absenteeism results in lost revenues. As shown in the chart below, the average per full-time equivalent (FTE) cost of absenteeism will vary from just under \$2,800 for companies with adequate excess staffing to nearly \$20,000 for companies that cannot replace absent workers and consequently lose revenues. Actual costs are typically somewhere in the middle, since most companies can replace some but not all of the lost productivity due to absent workers.

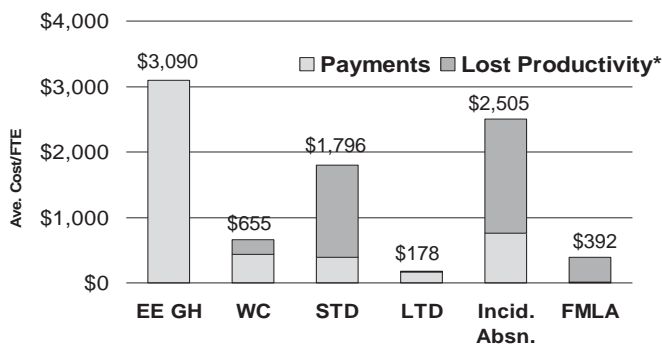
### Cost of Lost Productivity

-- From Absence



In other words, when the impact of absenteeism is considered appropriately, the true costs of various programs are quite different than what benefits managers perceive, with incidental absenteeism and short-term disability in particular becoming very important drains on corporate America.

### Real Costs/Program

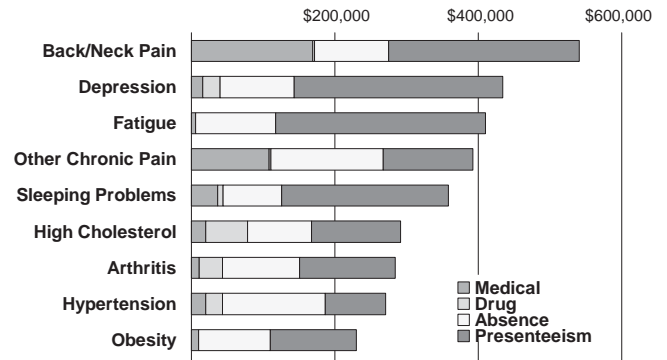


Adding in the costs of presenteeism paints an even more sobering picture, as there are huge productivity losses incurred by companies due to specific conditions, such as sleep disorders, depression, fatigue, back and neck pain, and anxiety. When one considers the total costs of medical/pharmacy costs, absenteeism, and presenteeism, certain conditions appear to be especially costly, including back and neck pain, depression, fatigue,

other chronic pain, and sleeping problems. As shown in the chart below, this analysis suggests a very different picture than if conditions are arrayed simply in terms of their total medical costs, since many conditions exact a small toll on health coverage costs but a large toll in terms of absenteeism and presenteeism. Interestingly, however, employees understand that these are the most costly conditions, as they know what conditions limit their ability to be productive at work and enjoy their lives at home.

### Total Medical, Pharma & Productivity

-- per 1000/FTEs --



### Getting CFOs the Information They Need

IBI conducted a second survey of 340 CFOs in 2006. The resulting report, entitled *The Business Value of Health: Linking CFOs to Health and Productivity*, reinforces the findings from the earlier 2002 survey about the degree to which CFOs understand the issue, but also makes it clear that CFOs are not yet getting the information they want and need to manage health and productivity more effectively.

The 2006 survey confirms earlier findings with respect to CFO views on the impact of ill health on the business, with large majorities of respondents strongly agreeing or agreeing that: ill health drives medical costs higher (96 percent), those in ill health have trouble focusing on the job (90 percent); those in ill health are absent more frequently (86 percent); that ill health affects the bottom line beyond healthcare costs (84 percent), and that ill health adversely affects other benefits costs (71 percent). CFOs also understand the large impact of lost work time, with almost half (49 percent) saying that lost time has currently reached a critical point.

CFOs are not, however, getting the information they want or need to manage employee health and productivity. Only about half (51 percent) of CFOs get regular reports on absenteeism occurrence, while less than one in four (22 percent) receive reports on the financial impact of absenteeism. Corresponding figures for presenteeism are

even lower, with only 22 percent ever getting occurrence reports and 8 percent getting reports on financial impact.

“These costs are real—the fact that employers do not track absenteeism does not mean they do not bear the costs.”—Thomas Parry, PhD

But CFOs clearly want this information, and their failure to get it is a growing problem. In fact, the majority of CFOs would like to use information on lost productivity in a variety of important ways, including to analyze health plan costs (75 percent), reduce absenteeism (75 percent), manage all health-related costs more closely (73 percent), examine the business benefits of health plans (70 percent), and reduce presenteeism (65 percent).

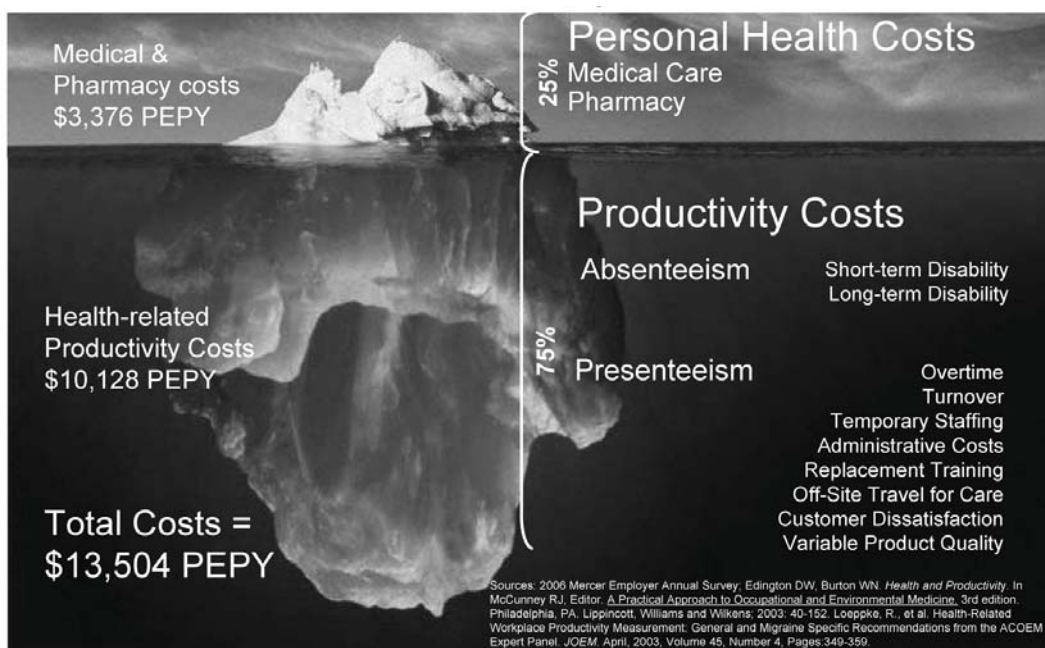
### A Case Study in Engaging the C-Suite: MGM Mirage

MGM Mirage is an entertainment company located in Las Vegas, NV that covers 60,000 lives. The company had been absorbing steeply rising health care costs earlier this decade, with increases that were several points above inflation. These cost increases finally got management’s attention. Company leaders did not want to increase cost shifting to employees because of the negative impact that such strategies have on employee retention. The company’s CFO saw his job as managing and minimizing risk, allocating resources from the resource pool to various activities (e.g., manufacturing,

training), managing and dealing with change, and having fiduciary responsibility for the company. Given these realities, those leaders at MGM Mirage who were pushing for change went to the company’s eight-person executive committee to make the case for an increased focus on health and productivity. Having only 15 minutes of their time, the presentation shied away from providing detailed descriptions of the problem (e.g., describing the costs of specific disease states). Instead, the presenters led with one key slide, which shows that the full costs of employee health are often hidden. Using the “iceberg” motif, the slide demonstrates that actual medical and pharmacy costs represent only the tip of the iceberg, with the majority of costs (e.g., absenteeism and presenteeism) being hidden below the surface.

This slide got the executive committee’s attention, as it clearly showed the true magnitude of the problem. Once the committee was engaged, the next step was to show easy-to-understand data quantifying the costs of productivity and absenteeism. The group was shown IBI-modeled data on the average amount of lost work days per FTE per year due to absenteeism (1.8 days) and presenteeism (6.2 days) and the total costs of this lost time (\$2,598 per FTE per year). The group also saw data quantifying the impact of productivity gains on earnings, with each one-day reduction being estimated to be worth \$18.8 million in profits. To further drive home the point, an analysis was conducted of how much revenue (nearly \$77 million) would be needed to produce the same earnings impact. Finally, the \$18.8 million savings

## The Real Problem: The Full Cost of Poor Employee Health



was converted to a per-share gain in stock price (\$0.84) and to the impact on the net worth of MGM Mirage's principal owner (\$137.4 million).

These analyses captured the attention of senior management, which unanimously agreed that a one day gain in productivity was achievable. The bottom-line lesson here is clear—there is no need for fancy models or high-priced consultants to get the attention of the C-suite. The key to success is to use simple, focused analyses that lay out achievable goals (not outlandish promises) in terms that executives understand (e.g., cost savings, impact on share price). Once the C-suite was convinced of the merits, MGM Mirage conducted HRAs and analyzed group health costs in order to develop and implement a set of health management programs tailored to the particular needs of its workforce. To help other companies with this type of analysis, IBI is creating a template and other tools for identifying problem areas and evaluating the impact of interventions on baseline performance. These two key steps—targeted intervention and measurement/evaluation—are critical to ultimate success.

## A View from a CFO of a Smaller Company

Andy Masetti, Senior Vice President and CFO, Sentient Medical Systems

The C-suite must be involved in workforce health and health care. Health care costs represent five to 10 percent of total costs, making health care the number two or three line item for most companies. But many small and medium-sized organizations lack the resources to address health-related issues on their own. Employer coalitions can help with these issues. In fact, when Mr. Masetti joined Sentient Medical Systems, he insisted that the company join the Mid-Atlantic Business Group on Health in order to take advantage of its many programs, including one on managing diabetes that helps to keep costs down for Sentient, a self-insured employer. At Sentient, the head of human resources reports to Mr. Masetti, who as CFO is very engaged in benefits and costs issues.

### Focusing on Health and Productivity at Smaller Companies

The leaders of smaller companies, especially those backed by venture capital or other sources of private equity, tend to have a short time horizon, and it can

**Andrew Masetti** is the CFO of Sentient Medical Systems, a leading national provider of intraoperative monitoring services. During his nearly 15 years in health care, Mr. Masetti has served as: CFO for Diagnostek, Inc., a diversified pharmacy benefit manager; Vice President of Finance and Principal Accounting Officer for Sun Healthcare Group, an international provider of senior care and ancillary services; CFO for Marriott Senior Living Services, Marriott's independent and assisted living subsidiary; and CFO for Amisys Synertech Inc., a provider of healthcare IT systems and business process outsourcing services. Prior to holding these positions, Mr. Masetti spent 15 years with General Electric (GE), serving in financial management positions in GE's Aerospace and Power Generation Services businesses, as corporate auditor, and as a consultant on government compliance programs. Mr. Masetti is currently on the board of the Mid-Atlantic Business Group on Health, where he has also served on the education committee. He is also on the board of the Choristers Guild and is an active member of the Technology Council of Maryland, serving on the finance forum steering committee. Mr. Masetti is a frequent speaker at forums discussing consumer-directed health plans and telemedicine. He graduated cum laude from Williams College.

sometimes be difficult to get the board of directors (which may be controlled by the private equity firms) to pay attention to these kind of issues. The key, however, is the same as for larger companies—to use metrics that

these individuals understand and care about, such as the impact on return on investment or strike price.

In some cases, there may be little that can be done to attract the attention of the CFO. For example, the CFO of one small pharmacy benefits firm in Arizona had little interest in these issues, as he planned to leave the company in a few years. By contrast, however, the CEO of a nursing home company in the area was fanatic about health and he spearheaded a variety of programs for employees, including building a corporate headquarters with an Olympic-sized swimming pool, track, and fitness center. Employees who did not work at headquarters were offered subsidized gym

memberships in the community. This CEO clearly believed that healthy people “show up” for work. He believed this as far back as the mid-1990s, long before the term “presenteeism” even existed. His fanaticism, moreover, permeated throughout the entire organization, creating a culture that emphasized health and fitness.

Sometimes CFOs have good intentions but their strategies do not work out. The CFO of a privately held, self-insured healthcare IT company, for example, noticed that many employees were overweight and made poor food choices in the company cafeteria. He approached the company’s food supplier about bringing in healthier food options (e.g., veggie burgers), and the company began subsidizing the salad bar and other healthy offerings. The strategy turned out to be a dismal failure, as changing dietary habits proved to be very difficult. (Changing smoking and exercise habits seems to be a bit easier.)

At Sentient Medical Systems (a supplier of technologists and other support to neurosurgeons), employee turnover was very high, especially among the most experienced staff. The high turnover rates were the result of a perverse health benefit plan, in which older individuals had to pay \$9,000 to \$10,000 per year for health coverage, plus copayments and deductibles, while younger employees paid much less. Not surprisingly, many experienced employees left the company while younger employees stayed. But neurosurgeons value more experienced technologists, and the high turnover was having a significant negative impact on the company. As a result, Sentient began working with a new vendor and changed the benefit plan design to encourage older people to stay. The cost of coverage was cut in half for more experienced staff, while younger employees were asked to pay a bit more. The change had a dramatic, rapid impact on turnover, which fell to almost zero. At present, Sentient is trying to expand its focus to encourage lifestyle changes among spouses and children who are also covered under the health plan. For example, because the company has many single mothers who miss work when their children are sick, Sentient is trying to figure out ways to encourage these mothers to bring their children in for regular check-ups and vaccinations, in hopes that doing so will reduce sick days.

## Lessons Learned for Small Businesses

The following lessons are critical in making the case for

a focus on health and productivity in small businesses:

- Cost is always a driver, and any initiative must be good for employees and help the bottom line. The way an idea is pitched will often determine how much consideration it gets.
- Health and productivity are as or more important for small companies than for large ones, since smaller organizations often do not have excess staff to fill in for absent workers.
- If the CEO is engaged, the rest will follow. The actions of leaders make a difference—for example, if a leader eats healthfully, others may follow.
- Active partnerships with brokers, benefits carriers, and other organizations are important.
- Consumer-directed health plans seem to be fading as an issue, with more attention being given to value-based purchasing.
- Many small companies face significant barriers, including a lack of financial metrics. Sometimes the decision to focus on health and productivity is based on “gut instinct” rather than hard facts.
- High executive and employee turnover can also be a barrier, as many executives of private equity companies have short time horizons and thus may not be interested in focusing on things that will improve the bottom line only over the long term.
- Employer coalitions can be effective in reaching the C-suite of small companies. Mr. Masetti is the only active CFO in the Mid-Atlantic Business Group on Health who consistently shows up for meetings. Coalitions need to reach out to CFOs and treasurers to get them more involved. Sending representatives to meetings attended by CFOs could help in this regard.

## Engaging the C-Suite: Corporate Success Stories

### The PPG Story

*G. Thomas Welsh, MBA, Human Resources Director, Benefits and Services, PPG Industries, Inc.*

Founded in 1883 and headquartered in Pittsburgh, PA, PPG Industries, Inc. is a global maker of paints, coatings, chemicals, optical products, specialty materials, glass, and fiber glass. Owned by 154,000

shareholders, including 20,000 employees and retirees, the company has paid uninterrupted dividends for more than 100 years.

Like many corporations, PPG faced significant barriers in trying to get the C-suite to focus on the health of its employees. Perhaps the biggest barrier was that company management lacked familiarity with health care and did not see it as being directly connected to the fortunes of the business. In addition, managers became frustrated by the seeming lack of actionable initiatives to address the problems.

## Five Enablers to Overcome Barriers

To get around these barriers, PPG set up several “enablers” to help convince the C-suite of the need to take action; these enablers are described in the sections below.

### Enabler 1: Cross Functional Cooperation

PPG is a very collegial company that is run almost like a family. Many employees have been there for a long time. Each week a group of managers, led by the company’s medical director, meet to discuss the role of health, wellness, and safety in the organization. The group includes representatives from various functions, including human resources, corporate medical, finance, communications, and environmental health and safety. The group operates in a very “socialistic, all-for-one, one-for-all” manner. This cross-functional approach helps to break down the barriers that exist between silos. The group has estimated that the burden of

health and productivity on the company was approximately \$500 million in 2007, a figure that proved large enough to get management’s close attention. (The group uses this figure prominently in meetings with the C-suite to keep their attention focused on the issue.)

“When you work with current, accurate data, you are in a position to take control and get management’s attention.”—G. Thomas Welsh, MBA

### Enabler 2: SMART Goals

The cross-functional group sets SMART (specific, measurable, mutually agreed to, reasonable, and time bound) goals for the year related to preventing disease, staying healthy, and becoming better health care consumers in order to reduce overall costs. The overall objective for the company is to reduce the burden on health and productivity to half of the prevailing change in the national average over a five-year period. Specific

**G. Thomas Welsh, MBA**, is corporate Human Resources Director for Benefits and Services at PPG Industries, Inc. After joining PPG in Pittsburgh in 1973 as an internal auditor, he has held a wide range of positions in PPG’s global finance organization, including General Auditor, Controller, and Assistant Treasurer. He has worked in 18 countries, evaluating, controls, implementing financial systems, and establishing financing structures. In his current position, he works in concert with the corporate environmental health and safety personnel and the Corporate Medical Director to bring financial reporting and control considerations to PPG’s existing health and productivity initiatives. Mr. Welsh has designed and currently teaches a master’s level course at Robert Morris University that focuses on financial issues related to pensions, compensation, benefits, and health care. He is a board member for the United Way of Southwestern Pennsylvania, Beginning with Books, and several Robert Morris University advisory boards. He is also on the board of the Health Alliance for Non-Profits, which was formed to provide non-profit organizations with affordable, quality health insurance products and information services. He earned a Masters Degree in Business Administration from the University of Pittsburgh and a Bachelor’s Degree in accounting from the University of Akron.

SMART goals designed to reach this broader objective include the following:

- Within five years, annual growth in the net cost per participating employee will be, on average, half of the rate experienced by companies of like size.
- Total net cost to the company for health care will
- be maintained at 2003 levels; this goal is likely unachievable, but it is included as a statement of the seriousness of the company’s efforts.
- The three-year average HRA participation rate will be maintained at 80 percent of the employee population.
- At least 70 percent of the employee population will be considered at low or no risk.
- At least 80 percent of the employee population will know key health metrics, including BMI, cholesterol,

and blood pressure

### Enabler 3: Importance of Cost

PPG uses several strategies to reduce costs, including encouraging behavior change, promoting prevention and screening, changing plan design (PPG tries to maintain a 30 percent cost-sharing arrangement with employees), enhancing the efficiency of care (e.g., through reductions in misuse, overuse, underuse, upcoding, and too-late care), and enhancing work performance by reducing absenteeism, presenteeism,



Enabler 3: Importance of Cost

	1.BEHAVIORS	2.PREVENTION	3.PLAN DESIGN	4.CARE EFFICIENCY	5.WORK PERFORMANCE
Content	<ul style="list-style-type: none"> <li>Participation</li> <li>Incentives</li> <li>Motivation</li> <li>Knowledge</li> <li>Skills</li> <li>HRA expand</li> </ul>	<ul style="list-style-type: none"> <li>Best in class</li> <li>Promotion</li> <li>Protection</li> <li>Screenings</li> </ul>	<ul style="list-style-type: none"> <li>Consumer driven</li> <li>Accountable</li> <li>Transparent</li> <li>Coordinated PPOs/HMOs</li> <li>Pay for value</li> </ul>	<ul style="list-style-type: none"> <li>Challenge Waste</li> <li>Misuse</li> <li>Over use</li> <li>Under use</li> <li>Up-coding</li> <li>Late Care</li> <li>Business alliances</li> </ul>	<ul style="list-style-type: none"> <li>Total burden on Health and Productivity</li> <li>Lost days</li> <li>Absenteeism</li> <li>Presenteeism</li> </ul>
Measure	<ul style="list-style-type: none"> <li>HRA participation rate</li> <li>Risk reduction</li> <li>Know your numbers</li> </ul>	<ul style="list-style-type: none"> <li>Preventive screening rates</li> <li>Avoidable admissions</li> </ul>	<ul style="list-style-type: none"> <li>Health Care Cost and Utilization Scorecard (PEPY)</li> <li>Comprehensive financial metrics</li> <li>Head to head plan comparison</li> </ul>	<ul style="list-style-type: none"> <li>Quality indicators</li> <li>Avoidable "re-work"</li> </ul>	<ul style="list-style-type: none"> <li>Avoidable STD</li> <li>Lost work Days</li> <li>Presenteeism</li> </ul>
Aim	Shrink Prevent	Shift upstream	Share	Clear waste	The Other face of the moon

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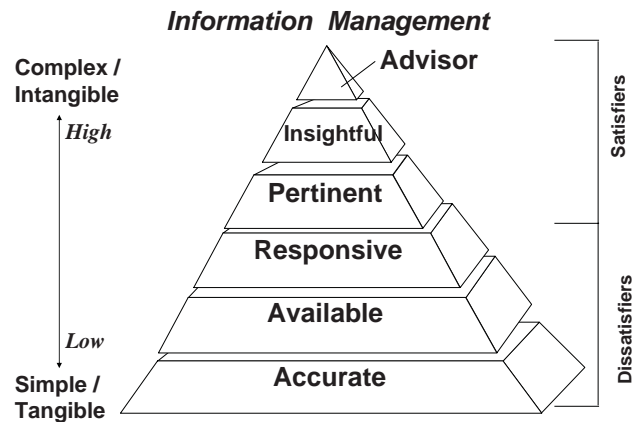
### Enabler 4: Familiar Reporting

PPG uses clear metrics, a familiar construct, and a regular and predictable reporting cycle to provide head-to-head, year-over-year, and period-over-period comparisons of performance related to employee health and productivity. Each quarter the company produces an Active Health Care Quarterly Scorecard that compares various metrics (e.g., cost per employee, a variety of health status metrics) for each plant, along with changes in these metrics from year to year. The 10 worst performing plants are publicly acknowledged on the "hall of shame"—a distinction that every plant manager wants to avoid. The health component of the scorecard helps identify things that can be done to improve health, such as having more employees complete the HRA. The PPG corporate office provides support to the plant managers, but it is up to local plant management to put in place programs, such as

on-site screenings, that they believe will be helpful in improving performance. (Employees often resist corporate-mandated initiatives, and tend to be more receptive to locally based programs, particularly those they have had input into designing.) Because some health metrics (e.g., the percentage of employees classified as low risk) can only be changed over the long term, the short-term focus is often on things that are within the plant's immediate control, such as completing the HRA; the hope is that encouraging more employees to identify their risk factors will ultimately lead those employees to change their behaviors to address those risks.

To facilitate improvement, each plant is encouraged to develop a team that is charged with addressing issues related to health and productivity. Each facility can develop its own web site as part of the corporate site, and information on these plant-specific sites is available to all plants so as to encourage cross-learning.

In its reporting, PPG strives to provide information that is accurate, available, responsive, pertinent, and insightful, so that the information can serve to advise management on the appropriate course of action. As shown in the chart below, accurate data is the foundation of this effort. Without it, a company will never be able to move up the pyramid so as to provide insights and advice. Instead, the vast majority of time and effort will be spent explaining data inconsistencies and/or inaccuracies.



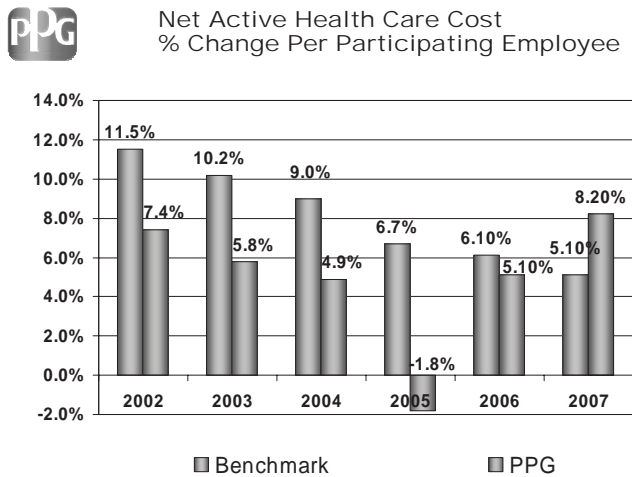
### Enabler 5: Keep it Fresh and Management Engaged

PPG strives to keep its initiative fresh and management engaged through its reporting and through other activities designed to celebrate and recognize success, including an annual event to honor the most innovative health promotion programs. Two people from each

plant are flown in to attend this event, which is patterned after a television award show (the awards are known as the "Alberto" awards, named after the company's medical director). During facility visits, corporate leaders also encourage plant management to engage in community health initiatives.

## Results to Date and Next Steps

As shown in the chart below, since 2002 PPG has been largely successful in reducing its annual health care cost increases to levels below that of benchmark companies; the only exception to this was in 2007, when a number of high-cost claims led to above-average cost increases. (Without these high-cost claims, the 2007 increase was 5.10 percent, slightly above the 4.7 percent average for



Source: Mercer

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This performance is particularly impressive given that the average age for PPG plant employees is 49, compared to an average age of 41 for benchmark companies in the Mercer survey. PPG estimates that the cumulative savings to the company from 2002 to 2006 was \$85 million, with savings being defined as the difference between actual and average performance. Since PPG's employees are older, however, true savings are likely even higher, since even "average" performance would be considered good for a company with so many older workers.

These kind of cost-savings data continue to get the attention of C-suite leaders at PPG. Looking ahead, PPG seems to be reaching the limits of what can be done through changes in plan design, and thus the net focus needs to shift to changing lifestyle-related decisions. To that end, PPG is working on the following health-focused actions:

- Making the HRA easier to access and update
- Making the HRA more specific and directly linked to claims
- Expanding use of HRAs to spouses and dependents
- Developing initiatives to ensure follow up by providers
- Continuing use of strong reporting metrics to the field so as to encourage comparisons, competition, and action across plants and organizations
- Continuing to use the reporting structure to engage top management and keep them "in the game"

## Overcoming the Challenges

ICER hopes to overcome the remaining challenges to greater incorporation of these types of comparative evidence ratings into coverage decisions and benefit design by doing the following:

- Meeting the demand for a trusted source to come up with evidence, since consumers will not trust the plans or employers to do this work.
- Translating the best science into tangible terms.

**Catherine M. Baase, MD, FAAFP, FACOEM**, is the Global Director of Health Services for The Dow Chemical Company, with direct responsibility for leadership and management of all Occupational Health, Epidemiology, and Health Promotion staff and programs around the world. Previously, Dr. Baase was Director of Health Care Strategic Planning with direct responsibility for U.S. health benefit plans. Dr. Baase is active in a number of associations outside of Dow. In May 2006, President George W. Bush appointed Dr. Baase to serve a two-year term on the President's Council on Physical Fitness and Sports. Dr. Baase also serves on a CDC task force, on the board of the Partnership for Prevention, and on the advisory boards of The Institute for Health and Productivity and the US Cochrane Center. Dr. Baase has been board certified in family practice since completing her residency at Saginaw Cooperative Hospitals, where she served as chief resident. She graduated from the College of Human Medicine at Michigan State University, and completed a post-doctoral fellowship in primary care faculty development. She also graduated summa cum laude from Saginaw Valley State University with degrees in chemistry

- Engaging in a dialogue with consumers both before and after the evaluation.
- Focusing first on “low-hanging fruit” rather than life-or-death issues for the patient or for a physician specialty. The best early targets are areas where both patients and physicians typically have time to consider the alternatives, such as with prostate cancer, congestive heart failure, and COPD. Focus groups suggest that patients do not feel it is unreasonable to be asked to pay more for low-value interventions when higher-value alternatives are available.
- Working with innovative purchasers—both employers and insurers—that are willing to discuss the potential of this approach.

## The Dow Chemical Company Improves Outcomes and Lowers Costs

*Cathy Baase, MD, Global Director of Health Services, The Dow Chemical Company*

The Dow Chemical Company, an international science and technology company with hundreds of global locations, serves customers in around 160 countries. Headquartered in the small town of Midland, MI, Dow has 46,000 employees. Roughly 20 percent or less of employees are represented by a union.

As a 100-year old company, Dow Chemical also provides health care benefits to many retirees (who outnumber active employees).

### The Journey in Brief

Dow Chemical has been successful in getting the C-suite to support efforts to promote employee health and productivity. But it is important to remember that engaging the C-suite is only the first step in a demanding journey. In fact, once the C-suite becomes convinced of the merits, executives become intensely interested in the results. Those who push the plan will be held accountable for delivering the results that were outlined in the business case, and the C-suite will expect monthly or quarterly reports on the progress being made. For the past five years, Dr. Baase and her staff have had their variable compensation tied to their success in achieving population health risk improvements, which has created tremendous focus on executing the plan and delivering promised results.

The first steps in Dow Chemical’s journey began more

than 95 years ago when the company began onsite occupational health programming. In the mid-1980s the company introduced formal health promotion programs, and 10 years later Dow developed an integrated approach to health, bringing together benefits, occupational health, and human resources into an area known as “health and human performance.” (The term “productivity” was not used because it can have negative implications for employees, who think of the term as another name for trying to “squeeze” more work out of them) In 2004, a formal corporate health strategy was developed; prior to this, health-related strategies were made at the department level. Also in 2004, efforts were made to incorporate health into the organization’s culture by clarifying why health is important to the company’s success. To that end, the company developed a number of integrated, reinforcing messages about health and published them in brochures, posters, and other areas in an effort to illustrate to key stakeholders its commitment to health. These messages describe the company’s commitment to product stewardship, healthy products, healthy employees, and healthy communities. With respect to the latter, Dow Chemical is now actively working within the local communities in which it operates to encourage a greater focus on health promotion.

### Key Elements of the Journey

A number of factors have been critical to the journey, as outlined below:

- Reinforcement of the business case and value proposition of focusing on health: The presentation of the business case at Dow Chemical has gotten better over time, as more refined metrics have been used to make a stronger argument. The business case is also starting to be made outside of the U.S., as health care costs are rising even more rapidly in other countries, such as India (30 percent), China (20 percent), Saudi Arabia (16 percent), the United Arab Emirates (14 percent), and Russia (16 percent). While these countries are starting from a lower base, the rapid cost increases are gaining the attention of management.
- Use of health advocacy principles: Dow’s success has been largely driven by keeping the focus on the best interests of the individual. Health is something done with people, not “to” or “for” them. Family members and employees must buy in to the concept and trust that what is being done is in their best interests. Otherwise, they will not participate.
- Measurement: Everything important to outcomes

that can be measured should be measured in the most accurate manner possible.

- Being frugal and accountable: Those involved in health promotion should not ask for more than is needed, as unnecessary investments make achieving a positive return more difficult. Dow Chemical, for example, spends little money on employee incentives, preferring to spend limited resources directly on programs that promote health.
- Being systematic and persistent: Programs should fit together rather than being an ad hoc collection of activities. Program leaders should expect to encounter roadblocks; being persistent and having strong convictions is critical to overcoming these barriers.
- Going beyond the C-suite to the “masses”: C-suite support is necessary but not sufficient for success. Equally or more important is having grass-roots level support for the programs. If results are not achieved, the C-suite will lose interest and withdraw support over time. As a result, program leaders need to “sell” the concept not just to the C-suite, but to the “masses” (e.g., individuals, families, sites) as well.

## Making the Business Case at Dow Chemical

The company’s strategy was to convince the C-suite to view employee health as a global business asset. Doing so required making the case that employee health was important and critical to the company’s long-term strategy. It also required building a strategic plan around employee health, getting leadership involved in the process, and measuring performance along the way.

### Big and Important

To bolster the case that employee health is big and important, Dr. Baase and her staff developed estimates of the total economic impact related to employee and retiree health; their estimate of at least \$750 million annually (including the indirect costs of lost productivity through health-related absenteeism and “presenteeism”) got the C-suite’s attention. Although the term “presenteeism” was new to most people, the concept was embraced as they recognized the impact of health on people while they are at work. They also shared the following key summary points:

- Keeping growth in U.S. health benefit costs at the lower end of trend could save as much as \$0.07/share in 2008. .
- Experts estimate that a third of current benefits spending may be for unnecessary or inefficient care.
- Most experts agree that 30 to 50 percent of conditions and illnesses could be prevented or delayed by use of preventive health interventions.
- Significant legislative and regulatory actions could have an impact on health care, particularly in the U.S.

### Critical to Strategy

The company aligned its health strategy with its corporate strategy, as outlined below:

- Driving financial discipline and reducing costs to serve by improving the total economic impact related to the health of Dow employees, including both direct and indirect costs.
- Setting the standard for sustainability by focusing on standards for protecting human health and the environment, including standards for occupational health and safety program and other health-related initiatives.
- Building a people-centric performance culture by enhancing health and human performance through programs such as Total Rewards.
- Investing for strategic growth by developing a positive brand image and a reputation for leadership in the area of employee health.
- Dow created its 2015 Sustainability Goals, which represented the company’s commitments in areas related to health. These commitments include the following:
  - Collaborate: Local goals related to protection of human health and the environment, and other positive contributions designed to promote community success.
  - Innovate: Commitments to product safety, use of sustainable chemistry, and the development of products designed to solve world challenges.
  - Elevate: Promoting energy efficiency and conservation and addressing climate change.

## Integration with Strategic Plan

Dow Chemical's global health strategy has four pillars: Prevention, Quality and Effectiveness, Health Care System Management (e.g., plan design), and Advocacy. Each of these four areas has a strategic plan along with metrics that are used to align incentives and promote communication.

## Leadership Engagement

The company's CEO is a great champion of health promotion. Through speeches, DVDs, and other vehicles, the CEO promotes the importance of health to company success. Dow uses a model of multilevel engagement and shared responsibility between the employee (through his or her personal behavior), the company (through corporate policies, leadership, resources, and tools), and individual sites (through the local culture and environment). The company has also published a commitment to supporting health promotion as an investment in human capital, including:

- Aligning health and productivity strategies with business goals.
- Educating all levels of management on the link between employee health and productivity.
- Educating employees about the true cost and total value of personal health and its impact on business success.
- Identifying the leading physical and mental health conditions among employees, including their direct and indirect costs.
- Integrating data management systems to capture and elevate direct and indirect health- and productivity-related measures in order to assess the impact on work impairment (e.g., presenteeism).
- Using health benefits to support prevention, risk reduction, and disease management, including eliminating barriers to use of evidence-based interventions.
- Encouraging employees to exercise through onsite fitness centers, walking trails, user-friendly stairwells, and other company-provided facilities.
- Providing healthy food selections in vending machines and cafeterias.
- Providing a safe, clean work environment.

- Developing an employee leadership network to support health management programs.
- Offering health assessments to all employees at intervals of every year to every four years depending on risks and age. These assessments are followed by consultation, with appropriate follow-up and referrals.
- Providing a variety of initiatives to support primary prevention (e.g., preventive health screenings, flu vaccines) and lifestyle management (e.g., physical activity, nutrition, stress management).
- Offering education about medical consumerism and self-care.
- Sponsoring health risk reduction programs, such as weight management and smoking cessation.
- Developing effective disease management programs targeted to conditions with high-cost productivity implications, such as asthma, diabetes, and depression
- Measuring program effectiveness by stated health/productivity goals (e.g., having 70 percent of the workforce categorized as low risk in the HRA; having 80 percent of the workforce participate in at least two company sponsored health promotion programs in the last three years, including completing an HRA and a lifestyle/risk reduction program)

## Creating a Culture of Health

Dow's approach to a culture of health begins with design (i.e., the integration and development of principles) and is supported by communication strategies, leadership involvement (e.g., Leading by Example), programs and services, health service staff, culture, vendors, and providers.

## Measuring Performance

Dow Chemical uses a variety of metrics to gauge progress in different areas, including costs (which is measured by cost of coverage per employee per year and an estimate of the total economic impact of health on the company), culture (through surveys on environment, stress, and well-being), productivity (through data on the incidence and cost of absenteeism and presenteeism, using established tools and country-specific wage rates), health targets (by measuring progress in specific areas, such as reducing stress and depression), health risks (by tracking the percent of employees with multiple risks), quality of providers (using a tool called MedQuery), and advocacy (through processes used by the company's foundation and other measures of progress in priority areas).

During 2004-2006, Dow has seen improvement in overall health outcomes and progress toward the goal of an across-the-board 10-percent improvement in the health of employees. Thus far the company has seen a one percentage point improvement (equivalent to a 14 percent decline) in the percent of employees considered high risk and a corresponding increase in the percent of employees considered low risk. As noted, these results have resulted in an estimated economic contribution to the company's stock price. In addition, increases in health care costs have slowed dramatically. The company has also documented improvements in the corporate culture through employee surveys.

To assist in achieving further improvements, Dow Chemical recently implemented a new measurement tool known as the Healthy Workplace Index. This tool assesses the contribution of an individual site in supporting employee health in the following areas:

- Tobacco policy adherence
- Access to physical activity
- Access to healthy foods
- Stress management
- Case management
- Workplace exposures
- Health surveillance and screening exam participation
- Medical surveillance requirement exam participation
- "Healthy environment" assessment

Targets in each of these areas are established as part of the company's 2015 Sustainability Goals. Sites receive a score in each of the areas to create an established baseline (which helps to identify opportunities for improvement), sets its own cycles and goals for improvement (goals are stated publicly as commitments), and develops action plans for improvement. Sites also receive a cumulative score based on all measures. Subject matter expert support is available to assist the sites if needed. Each site is awarded points based on the degree to which it implements programs to address improvement areas. Those sites achieving certain scores can be recognized for achievement and receive acknowledgement or other awards, designated as bronze, silver, gold, and platinum.

In addition to measuring the performance of individual sites, members of Dow Chemical's health staff (e.g., physicians, nurses, health educators) have their variable pay tied to the health status of the population being

**Barbara Prowe** is Executive Director of the Oregon Coalition of Health Care Purchasers (OCHCP), a non-profit advocacy organization representing about 400,000 commercially insured Oregonians. She previously served as a vice president for Working Solutions, Inc., a Portland-based employee assistance program and work-life balance firm, now part of UnitedHealthcare. Ms. Prowe began her professional career as a pharmacist and has also served as the Director of Pharmacy for a Massachusetts hospital. She has held various positions at Baxter Healthcare's home infusion division, including in sales, training and development, and general and regional management. During this time she earned her Master of Management degree from the Kellogg Graduate School at Northwestern University. Prior to moving to Portland, Ms. Prowe served in management positions at several home infusion companies throughout the Midwest. An active community volunteer, Ms. Prowe is currently a docent at the Portland Art Museum and a member of the City Club of Portland.

served. The company divides the world into 13 regions and tracks the health status of each employee in every

region in a database. Health status is measured by evaluating 12 risk factors (e.g., measuring BMI, blood pressure, lipid levels; collecting self-reported data on smoking and seat belt usage) and measuring year-over-year improvements in each. The level of variable payout depends upon the degree to which the population's health status improves, with different tiers of payouts. A minimum one percent improvement is required to qualify for any payout; in some years for some regions, progress falls short of this mark and thus there is no payout.

## Lessons Learned

The Dow Chemical experience highlights the following lessons learned:

- Establish a clear business case to engage the C-suite; no other step is more important.
- Align the program to company priorities and strategy.
- Be persistent and never give up.

- Measure performance and provide feedback.
- Build confidence in both management and employees by starting in areas where clear success can be achieved relatively quickly.
- Hold those in charge of the initiatives accountable by tying personal pay to success; very few individuals are willing to use this type of “fierce” accountability.
- Use a multi-pronged approach

## Engaging the C-Suite: Coalition Success Stories

Several employer coalitions shared their stories of engaging the C-suite in the promotion of employee health and productivity.

### Oregon Coalition of Health Care Purchasers

*Barbara Prowe, MBA, Executive Director*

#### Background

The Oregon Coalition of Health Care Purchasers (OCHCP), founded in 1998 by two precursor organizations, has 25 purchaser member organizations from the public and private sector that collectively provide health care coverage to 420,000 Oregonians. OCHCP also has 25 affiliate members. OCHCP is not a purchasing organization; rather, its mission is to improve purchasers’ ability to contract for high quality and cost-effective health care for employees/members, and to help purchasers steer their employees/members toward optimal health and high value health care providers. OCHCP works to accomplish this mission through networking, education, tools, shared initiatives, and advocacy.

OCHCP founded the Oregon Health Care Quality Corporation, which was spun off in 2002. OCHCP became an Aligning Forces for Quality participant through this organization. Key accomplishments achieved by OCHCP include the following:

- An OCHCP initiative resulted in the creation of the Compare Hospital Costs state website.
- OCHCP initiated legislation that created the Oregon Patient Safety Commission.
- OCHCP is a co-leader in the Leapfrog Group’s regional rollout (along with Intel Corporation).

### The Environment Facing Oregon Purchasers

Many CEOs in Oregon are afraid that the employer-based system may be eliminated; this fear and ever increasing costs have been significant motivators for the C-suite to get involved in trying to transform the health care system in Oregon. Their involvement is designed to meet the following needs:

- Development of a healthier workforce, which should lead to higher productivity and lower health care costs
- A competitive compensation package
- Cost control over health benefits provided
- Value in the purchase of health care
- A defensible mechanism to make and validate plan selections
- Demonstrable due diligence and accountability to the corporate board and to employees, particularly as a means of controlling growing risks (including liability risks)
- Major issues facing Oregon purchasers include the following:
  - Current contracting arrangements are not containing costs or improving health, and trends are going in the wrong direction.
  - Simply increasing member cost sharing does not address the underlying issues that are driving up costs.
  - Many Oregonians (16 percent) are uninsured, and the number of underinsured individuals is also growing.
  - Medicare enrollees represent 12 percent of the state’s population, but Medicare reimbursement rates in Oregon are \$1,400 per enrollee per year lower than the national average, which has a tremendous negative impact on providers. The Oregon Health Plan for Medicaid recipients is also underfunded.
  - The factors cited above are leading to a significant cost shift to Oregon employers, a situation that CEOs can no longer ignore.

#### Engaging the C-Suite

OCHCP has use a number of strategies to engage the C-suite in the issue of promoting employee health and productivity.

## Senior Team Conferences

OCHCP has held conferences with teams of senior leaders from member corporations. One conference was held in conjunction with IBI and the Oregon Health Forum and included presentation of two case studies. One case study was of an Oregon company called Burgerville, a fast-food chain that provides health care coverage for its employees, which has led to high retention rates. This company changes its menu seasonally and aggressively advertises its use of locally grown and produced ingredients in its food. This approach has brought in customers. The second case study is of Legacy Health Systems, which integrated its employee health, disability and workers' compensation benefits in an effort to reduce costs, with considerable savings having been demonstrated. Another team conference was held in partnership with the Oregon Business Council (OBC); it featured David Hom leading a session on value-based purchasing.

## Partnering with Other Business Organizations

As demonstrated in the team conferences, OCHCP works closely with other business organizations, including OBC, which was founded in 1985 and is patterned after the national Business Roundtable and affiliate organizations in other states. OBC directors are CEOs of Oregon-based companies, senior executives of Oregon-based divisions of national companies, and individuals in the business community who play a significant role in developing public policy in Oregon. OBC is the lead organization for development of the Oregon Leadership Summit & Business Plan, a statewide initiative launched in 2002 to provide a strategic framework for Oregon's business and elected leaders to work together to build a stronger, more competitive state economy. (See [www.oregonbusinessplan.org](http://www.oregonbusinessplan.org) for more information.)

OCHCP and its business partners have been highly active in the health care arena since 2004; major initiatives and actions are described below:

- In 2004, a task force was launched to analyze the critical issues of health care and health care costs. In December 2004, this task force published a white paper on the state of health care in Oregon, and in January 2005, the Initiative to Improve Health Care and Control Its Costs was launched.
- In 2005, the Public Employees' Benefit Board issued a request for information (RFI) that included the principles of value-based purchasing. This RFI was a spark

that engaged the health plans in value-based plan design.

- In 2006, the task force supported the work of OCHCP to encourage employers to use more effective health benefits purchasing strategies, including use of a common RFI (NBCH's eValue8 program). This was a huge step forward that really put OCHCP "on the map" in Oregon.

OBC has been a highly valuable partner in these activities. For example, in 2007, in partnership with the Oregon Health Care Quality Corporation, OBC developed a proposed operational and funding plan to establish a pilot project to enhance the exchange of health information among providers. OBC also supported Aligning Forces for Quality through the Quality Corp initiative to develop and use improved quality measures, and has supported the work of OCHCP in encouraging employers to use more effective health benefits purchasing strategies, including use of eValue8. In 2008, OBC released its annual Policy Playbook & Initiative Guide, which for the first time included a separate tab on health care. The guide encouraged use of value-based purchasing strategies by public and private sector purchasers, investment in health care information infrastructure, and the development of a comprehensive reform plan to improve access to quality, affordable health care and coverage for all Oregonians. In 2008, the chair of the OBC health care task force sent a letter to OBC directors encouraging them to join OCHCP and use eValue8. OBC's health care task force has included other business organizations in its meetings, and is actively engaging with the Oregon Health Fund Board, which was created during a previous legislative session.

## Legislative Initiatives

In 2007, Oregon Senate Bill (SB) 329 mandated development of a comprehensive plan to ensure access to health care for Oregonians, contain health care costs, and address issues of quality in health care. The legislation created the seven-member Oregon Health Fund Board (which is charged with heightening awareness about value-based purchasing principles), seven additional committees, and an exchange workgroup. The legislation promises to keep the employer-based system in tact (which is in contrast to legislation proposed in the U.S. Senate by Oregon Senator Ron Wyden). A report to the legislature is due in November 2008.

## Other Initiatives

**Becky J. Cherney** is President and CEO of the Florida Health Care Coalition (FHCC) in Orlando, Florida. Before founding FHCC (which was originally known as the Central Florida Health Care Coalition), she spent many years in the private sector. In November, 2004 Florida Trend magazine named Ms. Cherney one of the 60 most influential business executives in Florida. She is a member of many local, state, and national committees and societies, including the National Quality Forum, the National Advisory Committee of the Robert Wood Johnson Foundation-funded Depression in Primary Care project, the Primary Care Access Network, the editorial board of Biotechnology Healthcare, and the board of the VHA Foundation. She has received numerous awards including Business Woman of the Year, the Summit Award, and the Arthritis Foundation's Community Leadership Award. A Paul Harris Fellow, Ms. Cherney is the past Chair of NBCH and a charter member of eValue8. She currently serves as Chair of the Central Florida Regional Health Information Organization. Ms. Cherney received her Bachelor of Arts Degree from the University of Wisconsin.

OCHCP and its partners are actively engaged in eValue8 site visits (which are attended by health plan representatives and community board members), promoting the Leapfrog Group's activities by recruiting hospital trustees who are corporate senior managers, and encouraging coalition members to become more involved through peer-to-peer recruiting.

## Summary

The "fear factor" (i.e., fear of losing the employer-based system), along with a set of forces that are leading to increased cost-shifting to employers, have been important motivators for CEOs in Oregon to become actively involved in trying to influence the system, both within their organizations and in the community and legislative arenas.

## Florida Health Care Coalition

*Becky Cherney, President and CEO*

## Background

The Florida Health Care Coalition (FHCC) is a coalition

of Florida employers in central and south Florida. Like other employer coalitions, FHCC faces a fundamental challenge in trying to engage the C-suite—CEOs will not be receptive unless a clear case can be made as to why they should care about health and health care, but getting the information needed to make that case can be quite difficult. To address this challenge, FHCC has adopted four guiding principles:

- Quality is king, and information is the key to the kingdom.
- Things that cannot be measured cannot be managed or rewarded, and recognizing quality differences with higher payments is increasingly becoming necessary.
- Higher quality care leads to lower costs, due to fewer readmissions and complications.
- Standardization—i.e., the elimination of unwarranted variation—is critical, as there are not 10 "best ways" to do something. The C-suite understands the need to standardize, but doing so remains the biggest challenge in health care today.

## How Coalitions Can Engage the C-Suite

A good example of how coalitions can work with the C-suite comes from Florida Power & Light. Florida Power & Light asked FHCC to expand its presence into South Florida, but the coalition lacked the resources to recruit new members in south Florida on its own. The CEO of Florida Power & Light recruited senior executives from other organizations in South Florida and brought Ms. Cherney in to give a 15-minute presentation making

the case for C-suite engagement. Shortly after the 30-minute meeting, the CEOs in attendance joined FHCC. For its part, Florida Power & Light's CEO has led by example in transforming health care, giving responsibility for one health care issue to each of the company's five divisional executives. This kind of top-down leadership is critical to success.

To assist in its efforts to influence providers, FHCC has also turned to its CEO members. For example, FHCC often invites member CEOs to attend meetings of the coalition's provider council, which serves as a policy group. CEO presence at these meetings helps to create additional "leverage" in getting providers to listen. For example, when the executives of Disney and Orange County Public Schools, the area's two largest employers,

attended a meeting with providers on “never events” (i.e., an established list of errors that should never occur in a hospital setting), the CEOs informed the providers that they did not want to pay for these events any longer. They also made it clear that they did not want any negative publicity associated with making the decision not to pay for them, and did not want to wait for legislation to pass mandating non-payment. That meeting set the stage, and the coalition and the hospitals are now working out the arrangements to stop paying for medical errors.

## Lessons Learned

Getting the C-suite involved often requires ingenuity and creativity. Lessons learned in this area include the following:

- Understand when CEO presence is required and only ask for it when necessary; do not overuse CEOs, or they will simply stop responding to requests.
- Provide information that grabs attention and convinces them of the need for C-suite participation. For example, to engage CEOs in the issue of cost-shifting to employers (which is something they do not really understand that well), FHCC proposed including a “surcharge” on hospital bills that shows what portion is really a cost-shift to employers. The coalition even mocked up a sample of what the bill might look like.

**Louise Probst** is the Executive Director of the St. Louis Area Business Health Coalition, which represents St. Louis employers in their efforts to enhance the quality and overall value of their investments in health benefits and to improve the health of employees. Ms. Probst began her career in health care as a critical care nurse and has experience within the industry as a clinician, educator, hospital administrator, and purchaser advocate. Ms. Probst serves on the National Committee for Quality Assurance’s (NCQA) Committee on Physician Programs and in recent years has served on the National Quality Forum Committee to develop standards for the reporting of health care-acquired infections, the Standards Committee and Physician Recognition Committee, and the eHealth Initiative’s Purchaser Advisory Board. A past chair of NBCH, she is also an active participant in other initiatives to enhance health care value. Ms. Probst received a Master’s Degree in Business Administration from the University of Denver.

- Do not speak a “foreign language,” bogging C-suite leaders down in mundane details such as HIPAA (Health Insurance Portability and Accountability Act) requirements or problems with billing codes. Instead, the focus needs to be on the “pearl” of information that will grab their attention, and that they can repeat when speaking in public.
- Reach out to CEOs at the right time, which is usually just before they are in a position to network with their peers. Good times to approach CEOs include right before the summer barbeque season or the holiday party season.
- Make invitations nontransferable. CEOs like to be seen and interact with their peers, so if a handful of CEOs accept an invitation, the rest will follow. But if a few send replacements, the rest will start doing so as well.
- Keep meetings short, usually to an hour or less, and always end on time or early. Have only 20 minutes of planned activity, and let CEOs network with each other during the remaining time.

## St. Louis Area Business Health Coalition

*Louise Probst, Executive Director*

### Background

The St. Louis Area Business Health Coalition (BHC) was created in 1982 by St. Louis’ leading employers with funding and guidance from Civic Progress, a civic organization of the CEOs of major corporations. The coalition was designed as a business organization with a singular focus on health care and no financial ties to the health care industry. Membership is open to any employer whose primary business purpose is not the financing or delivery of health care.

The organization’s mission is to support employers in improving the health of their enrollees and the quality and overall value of their investments in health benefits. To that end, the organization serves as a shared source of information and knowledge; as a means to leverage employers’ buying power; and as a vehicle to promote the employer voice on health care issues and to advocate for medically appropriate, cost-effective, and affordable care. The coalition recognizes the need for health care

reform at the community level and the importance of community partnerships and local commitments to those

partnerships in achieving change. BHC and its members work to align incentives toward greater accountability for value in their benefit offerings as a mean of supporting community-based reform.

When the coalition was founded, St. Louis ranked third in terms of the number of Fortune 500 companies headquartered in the city. But during the “merger” mania of the mid 1990s the city slipped to 13th place. These mergers also created significant turnover in the C-suite and human resource departments of the region’s corporations, which reduced the coalition’s long-term relationships and ties to community leaders. During the same time period, health care cost increases slowed, leading many senior executives to put health care issues on the “back burner.” Human resource executives began focusing on national health plan purchasing strategies, while interest in local health care issues declined. A few early adopters, however, began investing in health improvement. At the same time, local hospitals began merging and became the largest employers in the area.

## The Coalition’s Policy Agenda

In 2005, BHC developed the following policy agenda:

- To improve health through health literacy, wellness, and consumer engagement.
- To increase transparency through public access to comparative cost and quality data on treatments and providers.
- To correct misaligned incentives, away from further duplication of capital intensive services and toward improvements in health and health care value.

The vision was to create a community where comparative cost and quality information on health care treatments and providers is freely available to consumers, physicians, employers, and health plans. Achieving this vision required outreach by leaders to businesses, physicians, consumers, and policymakers; hospitals were generally already informed and organized.

## Engaging the C-Suite (A Work in Progress)

Realizing the vision outlined above requires the engagement of the C-suite, which continues to be a work in progress for BHC. BHC’s approach is to welcome as many opportunities for engagement within the corporation as possible. BHC has a goal of engaging a

minimum of three individuals from each employer in some aspect of its activities, including human resource executives, medical directors and wellness coordinators, and representatives from occupational health/safety, finance, risk management, labor relations, purchasing/strategic sourcing, communications/organizational development, and public affairs.

“You can never have too many insiders on your team.”—Louise Probst

BHC’s ongoing approach to engaging the C-suite includes the following steps:

- Working constantly to build capacity and bench strength across member corporations.
- Keeping communication materials updated and ready to go, with issues framed appropriately.
- Seeking briefing opportunities (e.g., among hospital board members).
- Publishing an annual health industry overview that is widely read in the C-suite and receives significant press coverage. Among other things, this publication measures the degree of cost shifting by each hospital and publicizes the level of hospital profit margins and charity care. Recent data show that hospital margins and profits have risen much more quickly than has the level of charity care, which has led BHC to urge the community to rethink the “cost shift” and hospitals to become more efficient as a means of improving access to health insurance. This tougher stance has been taken at the direction of board members and with the support of corporate CEOs.
- Promoting press coverage highlighting key issues, such as cost shifting.
- Submitting letters to the editor on specific issues.
- Sponsoring and hosting community forums.
- Making speeches to targeted audiences, such as corporate CFOs and large community forums. For example, the CEO of Virginia Mason Medical Center will keynote BHC’s 2008 annual meeting and share his organization’s efforts to eliminate waste and become more efficient. Local hospital leaders will also be invited to share their success stories.

In the spring of 2008, BHC approached several key CEOs and civic leaders, asking them for support in the

following areas:

- Removing barriers to transparency.
- Providing \$300,000 in funding (\$100,000 a year for three years) to finance initial data collection.
- Assigning executive oversight to hold the coalition accountable for fair and meaningful results for the community.
- So far the message has been well received and early results are promising; the key is to be clear about the request and the return that CEOs can expect on their investment of time, money, or political capital. To that end, BHC promised the following “deliverables” to the community:
  - Before the end of the first year, more than 70 percent of the region’s primary care providers will receive a report on their performance on the Ambulatory Quality Alliance’s quality measure set, with the ability to verify the data.
  - Hospitals will receive a report on their performance on key safety, quality, financial, and utilization performance metrics with relevant benchmarks.
  - A community report will be issued on high prevalence diseases and variations in quality, resource utilization, and cost, with relevant benchmarks and opportunities for improvement identified.
  - Variations in resource utilization and the costs of like services will be analyzed across hospitals.
  - A service will be offered to physician specialists, allowing them to self-select measures (e.g., from specialty societies and other national groups) relevant to their practice and receive a private performance report on those measures.
  - A public website of information for consumers that provides comparisons of quality and cost performance for select measures will be developed and implemented over the next several years.

## Lessons Learned

The BHC experience has led to the following lessons learned about engaging the C-suite:

- Be prepared and flexible when seeking support, as every company is different. Some companies may require a formal grant request, while others want a

**Annmarie Higgins** is Director of Human Resources at Mitsubishi Polyester Film. She graduated from the University of Virginia as a Chemical Engineer and joined the company in 1991 (which was then known as Hoechst Celanese), working in the Bay City, TX plant as a process engineer. From there she transitioned into an organizational effectiveness role within the Human Resources Department, leading the organization through a change management process and organizational redesign. In 1995, she transferred to the Greer, SC plant. When the company was acquired by Mitsubishi Polyester Film in 1998, Ms. Higgins was made responsible for redesigning the Human Resources Department. In 2004, Ms. Higgins led a healthcare reform effort within Mitsubishi, targeting improvements in the health of employees and families while simultaneously controlling costs. Ms. Higgins has been actively involved in the community, including with the United Way Young Philanthropist Board, Building a Healthy Community Impact Council, Vision 2025 (which is looking at improving health care in Greenville, SC), the South Carolina Business Coalition on Health, Opportunity Greenville, Leadership Greenville, and many other organizations. .

brief (three-page) proposal or presentation.

- Figure out what is needed before approaching the C-suite. Trust one’s connections within a company to design the best approach for their organization.
- Develop and focus on simple “takeaway” points; health care is complicated, particularly to those not involved in it on a day-to-day basis.
- Trust that the dialogue will be rich, and leave time for it. The goal is engagement, not education. C-suite executives are smart and will ask the right questions.
- Use every opportunity to build capacity and bench strength throughout the organization.
- Do not forget about the internal champions for change within corporations who support C-Suite engagement everyday.
- Remember that engagement is a journey and not a destination. Once the conversation commences, it

must be continued, including timely responses to any follow-up requests from the C-suite.

## Engaging the C-Suite in Community Coalitions: A Case Study

*Annamarie Higgins, Director of Human Resources, Mitsubishi Polyester Film*

### Background

Mitsubishi Polyester Film (MPF) is a global company, headquartered in Japan, that makes polyester film that goes into computer screens, flat-panel televisions, window film, and other products. A mid-sized manufacturer with 530 employees, the company has operations in Japan, Germany, Indonesia, and the U.S. (South Carolina). The company was instrumental in getting the South Carolina Business Coalition on Health (SCBCH) started

### South Carolina Situation

As leaders of a Japanese company, Mitsubishi executives see many American workers as being overweight. The problem is particularly severe in South Carolina, where obesity rates among adults have increased by 10 percent since 1990. In 2006, between 25 and 29 percent of South Carolina adults were obese, with a BMI above 30. In addition, South Carolina has above average rates of diabetes (8.3 percent, versus 7.0 percent nationally), hypertension (28.8 versus 24.8 percent), overweight/obesity (61.3 versus 59.9 percent), and smoking (24.3 versus 20.8 percent). In addition, South Carolinians are more likely to die of cardiovascular disease than is the average American (325.4 annual deaths per 100,000 residents in South Carolina, compared to 305.8 nationally). South Carolina's smoking-related productivity losses are estimated to be almost \$2 billion a year.

### The SCBCH Story

The roots of SCBCH began in 2004 when the need for action began to be identified. A meeting of corporate leaders found lots of pain and complaining about employee health and productivity, but a vacuum when it came to addressing the issues. Ultimately a tipping point was reached and words led to action.

In 2004 and 2005, a few passionate human resource executives, with the support of corporate leaders (including the CEO of MPF), developed a strategic plan that laid out a vision for the future, one in which

corporations would begin to make a difference. These leaders identified key leadership organizations and began recruiting and gaining the commitment of human resource executives and CEOs. In April 2006, SCBCH was established with 10 founding members. One might think that the CEOs who supported the coalition did so due to personal considerations (CEOs and family members also get sick), an/or for "causal" reasons (CEOs often feel a sense of obligation to do something for the community and the nation). However, the real support was due to professional reasons—i.e., healthcare is a business issue that can affect profits. SCBCH used its core group of CEOs to identify and sell other CEOs in one-on-one and group meetings. Greenville, SC is home to many international companies, enabling the CEO of a German automobile manufacturer to convince his peer from a French rubber company to support the effort. CEOs also "sold" other stakeholders on the idea, including Furman University, which hosted a kickoff meeting where everyone talked about their problems and helped to chart a course of action for the future. This group developed the following goals for SCBCH:

- To improve the effectiveness and efficiency of health care
- To promote greater consumer responsibility for health and health care.
- To improve the health status of the population.
- To improve economic competitiveness by promoting greater price transparency and competition, which in turn drive down costs and improve quality.

Today SCBCH has 17 purchaser members from the public, private, and not-for-profit sectors. The coalition also has a set of provider members that includes area hospitals, health plans, physicians/medical facilities, and brokers/consultants.

Current coalition initiatives include participation in eValue8 to improve health plan performance, working with a prescription benefits manager to control drug costs, reaching out to small businesses, and participating in a diabetes management program (known as THRIVE) and the Leapfrog Group's hospital performance improvement initiative. Progress on each of these initiatives is regularly reported to member CEOs.

Looking ahead, SCBCH plans to continue "painting the picture" and expanding the coalition's membership across the state. Consideration is also being given to the development of a physician performance measurement system and a shared clinic for chronic care management. Members come together each year to discuss and

share ideas for how to make progress in achieving the coalition's goals.

## The MPF Story

In Japan, the government and companies have long been involved in promoting the health of employees. For example, the Japanese government has put in place a “waist line” regulation—every employee over the age of 40 must have his or her waist measured. Fines are placed on companies if employee waist lines are too large. While this kind of approach would not work in the U.S., it illustrates an important lesson—CEOs will care about something if it becomes in the company's financial interest to do so.

To engage MPF executives in promoting health and productivity, therefore, there was a need to sell the business case for change. The case was not difficult to make, since health care costs had doubled between 2000 and 2004 (from \$4.2 to \$8.5 million), with projections of reaching \$11.7 million by 2007 if historical trends continued. One-on-one discussions with the CEO convinced him of the merits of moving forward, but the company's chief operating officer (COO), who had recently returned from being overseas for a few years, was not as convinced. Health care costs had not been an issue when he left, and he was surprised to see so much attention being given to the issue when he returned. Eventually, however, the COO came around, once he was persuaded of the potential ROI from action.

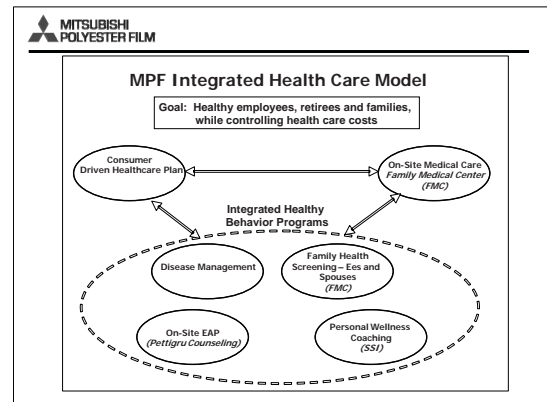
Once executives were sold on the idea, the next step was to develop a solid, detailed implementation plan that included the following key elements:

- A decision making matrix (including technical analysis).
- Health plan involvement, to ensure that claims continued to flow properly.
- Use of voluntary programs, with ties to incentives and/or disincentives for employees.
- No cost shifting; while most companies reduce benefits and/or increase employee contributions, MPF did not.
- The final step was to sell the idea to employees, who went through the normal reactions to proposed change (shock, anger, renewal, and ultimately acceptance). The key to making this process smooth was to:
- Be realistic while selling positive features; for example, the company was honest about raising

costs for tobacco users and announced that the campus was going to be tobacco free as of January 1 of this year.

- Include employees in key decisions; for example, the company created task forces that included smokers and former smokers to discuss how to implement the program. Employees, in fact, came up with the idea of developing tools and incentives to help people quit and holding people accountable through random nicotine screening.
- Avoid third-party involvement.
- Emphasize the imperative to change in order to remain in business.

Once employees accepted the idea of change, MPF began rolling out its Integrated Health Care Model in 2005; the model was designed to promote healthy employees, retirees, and families while controlling health care costs. As shown in the chart below, the model consists of a consumer-directed healthcare plan, onsite medical care through a family medical center, and integrated healthy behavior programs, including disease management, family health screening, an on-site EAP, and personal wellness/coaching.



The consumer-driven plan is designed to have the biggest impact on costs; this plan is now the only coverage that MPF offers to employees and dependents. (The plan had been offered along with other options since 2003, and roughly one third of employees had voluntarily enrolled in it.) As shown in the chart on the next page, employees can opt for any of three versions of the consumer-directed plan—employee only coverage, employee plus one dependent, or employee plus family.

Other elements of the new model introduced in 2005 include the following:

- An onsite family health center opened in August 2005.

- Employees and spouses were required to participate in family health screening at the onsite center in order to receive health reimbursement account dollars; 99 percent of employees did so.
- Incentives were developed to encourage employees who also got coverage through their spouse to end their coverage with MPF; those who opted out entirely received \$1,000. In addition, surcharges were levied on those MPF employees who signed up for spousal coverage when the spouse had other coverage available to them.
- MPF contracted with a health fitness coach, a registered dietician with expertise in exercise physiology, to conduct “boot camps, holiday weigh-ins, tobacco cessation programs, weight reduction programs, and lunch-hour exercise classes.

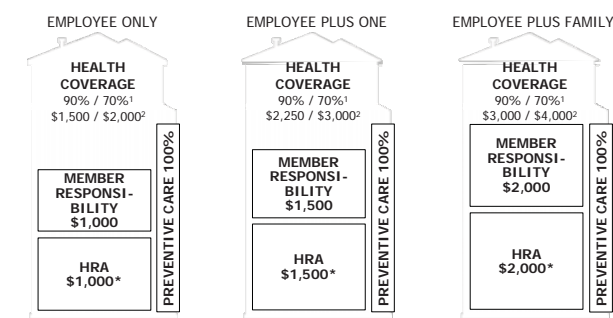
costs falling slightly (to just over \$8 million), well below the projected trend of \$10.7 million.

In 2007, MPF switched to another carrier in order to get deeper discounts and performance guarantees; introduced disease management; became tobacco free; developed an onsite EAP for mental health (employees still have the option of going to downtown Greenville for EAP visits as well); and introduced onsite health coaching, including wellness assessments and lifestyle suggestions for employees and dependents. Costs continued to come down in 2007, with no increase in employee contributions.

In 2008, MPF switched to CIGNA due to the insurer’s focus on consumerism and improving patient health. The company also hired a disease management specialist to provide face-to-face counseling at the onsite medical center, with a focus on diabetes, nutrition, and obesity. This specialist complements the work of CIGNA in chronic obstructive pulmonary disease, asthma, diabetes, and heart disease. Also in 2008, the company began requiring that anyone referred by the onsite family medical center to a program (e.g., disease management, EAP, wellness coaching) attend at least the introductory counseling session in order to receive health reimbursement account dollars. The company officially went tobacco free on January 1, 2008. Looking ahead, as of January 1, 2009, employees with a BMI of 25 or lower will get an additional \$300 (\$150 each for the employee and spouse). If BMI is still below 25 by July, 2009, the employee will get another \$300. Alternatively, any employee who can lower his or her BMI by two points (roughly 10 pounds) can qualify for \$150. MPF also recently released its Vision for 2013, which includes expanding the onsite family medical center significantly.

MPF has been communicating its success to key stakeholders, emphasizing the substantial ROI that has been achieved due to reductions in annualized costs. These savings, which have been achieved without increases in employee contributions, are depicted in the chart below.

**MITSUBISHI POLYESTER FILM Consumer Driven Plan Design**



<sup>1</sup> In- / Out-of-network coinsurance.  
<sup>2</sup> In- / Out-of-network coinsurance maximum (excludes Member Responsibility).  
 \*Upon completion of Family Health Screening

Note: Consumer Driven Plan Design has not changed.

The net impact of these 2005 initiatives was significant. While total health care costs were projected to increase to \$9.5 million, they actually remained flat at \$8.5 million, including the additional operating costs of the on-site doctor’s office, with no increase in the amount employees paid in their premiums.

In 2006, MPF built on its success by implementing the following: mandatory mail order for maintenance drugs; announcing the creation of incentives for families who do not use tobacco (tobacco users were not required to pay more until 2008); creation of company-financed tobacco cessation drugs and other programs (79 employees participated and 42 quit as a result); and development of onsite exercise classes (e.g., boot camp, yoga, pilates, body sculpting). As a separate initiative to reduce fixed costs, MPF encouraged people to retire by April 1, 2006 by announcing that retiree premiums would go up for those who retired after this date. These initiatives also had an impact, with 2006



**SSI**  
Sports Spine & Industrial  
Physical Therapy and  
Performance Training Center

"I like the fact that you're not just a number. —Elaine Kirby

## Summary

As President Johnson once said, "the hardest part of my job is getting other people to do what I want them to do." Getting CEOs to do what is needed with respect to employee health and productivity can also be difficult, but the key is to show them it can have a positive impact on the bottom line. Once this is done, the business community can play a critical role in transforming health care by promoting consumerism, competition, and transparency through increased use of the following:

- Consumer-driven health plans
- Systems to educate employees and families about: the real cost of health care, where and how to shop based on quality and price, and how to avoid healthcare costs
- Coverage of preventive examinations and immunizations
- Systems, including financial incentives and disincentives, to change the culture and to encourage healthier lifestyles

The overall objective is to promote value (the sum of quality and cost) by working with health plans (e.g., through eValue8), hospitals (e.g., through the Leapfrog Group), and physicians (e.g., by promoting development of a physician measurement system).

## A Perspective from The Business Roundtable

### A Perspective from the Association of Senior Human Resource Executives

*Andrew Mekelburg, Vice President for Federal*

*Government Relations, Verizon, on behalf of the Business Roundtable Consumer Health and Retirement Initiative.*

## About Verizon and The Business Roundtable

Verizon provides coverage to roughly 900,000 individuals, including 240,000 active employees and 200,000 retirees and their dependents. Health care benefits are the company's third largest expense (after salaries/wages and depreciation/amortization), costing roughly \$4 billion a year. The company's executive leaders are focused on the need for standards and interoperability to drive down cost and improve quality. Ivan Seidenberg, Verizon's CEO, served on the Commission on System Interoperability (as the only non-health care person on the Commission) and also serves as Chairman of The Business Roundtable's Health and Retirement Task Force. His leadership has helped to focus the commission and the task force on the needs of the consumer and on how technology can help improve health and reduce costs.

The Business Roundtable (BRT) unites roughly 165 top CEOs, amplifying their diverse business perspectives and voice on solutions to some of the world's most difficult challenges, including health care. Combining those global insights with policy know-how, BRT promotes innovation and works to expand economic opportunity for all Americans. BRT member companies employ nearly

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10 million employees and provide health care coverage to 35 million Americans, or roughly one quarter all Americans with group coverage.

## Need for Reform

Health care expenses are the number-one cost pressure facing BRT member companies; costs have risen at a double-digit pace for several years, with no corresponding increase in quality. Rising health care costs affect all individuals, employers, and the government. Because of these cost pressures, CEOs have become the drivers of change. They want their employees to be productive, but feel they are spending lots of money on health care without any value being created. To create real change, business and government have to work together, as the employer-sponsored system remains the single most important vehicle by which people secure coverage and health care today. BRT members are not trying to get out of health care; they want to preserve ERISA and continue to provide coverage. Only if there were a stable, viable alternative to employer-based coverage would most companies even consider getting out of health care.

## Barriers to Engagement

Health care is like a foreign language to CEOs who are not in the business, and many CEOs are reluctant to speak about issues that are outside of their comfort zone. The complexity and magnitude of the issues can be daunting, and there can be political complications inside and outside the company. There are also inherent risks in investing in an unproven system.

But there are some similarities between health care and telecommunications—both industries used to be heavily regulated and characterized by relatively little product innovation. Verizon's CEO and others believe in the power of the marketplace and competition, and are convinced that the same benefits can be realized in health care.

## BRT: A Successful Engagement Model

BRT engages CEOs by providing them with a forum to discuss challenges and share best practices. The group allows CEOs to come together to innovate and advocate for real change, and fosters high-level, cross-industry discussions of the most pressing issues facing corporations and the nation today.

Within health care, BRT CEOs have identified efficiency, transparency, and quality as the top priorities. BRT members believe in the power of IT, an area where health care remains far behind. While not a "silver bullet," IT can help to spur badly needed changes in processes in health

care. Transparency is also critical, as those who purchase and receive health care must understand something about the price and quality of the product being received. Today, consumers can learn much more about the cars they buy than about the health care they receive.

BRT CEOs believe that innovation and advocacy can combine to stimulate real change. When CEOs of large corporations get involved, they push intensely for change through a variety of vehicles, including Congressional testimony, communications to employees, press conferences, web casts, and the like. Within the area of advocacy, BRT works with many other groups, including the National Coalition on Benefits, Divided We Fail, Partnership for Value-Driven Health Care, and Health IT Now, an organization founded in 2007 to push for adoption of health IT. Advocacy efforts are critical, as there is strength in numbers. To achieve lasting change, BRT seeks to find common ground on issues with non-traditional partners, a process that is critical to making real progress. These partnerships may be broad-based or issue-specific, and often include "strange bedfellows" who come together around a single issue in which they have a shared interest. The overall goal is to increase awareness and concern for issues by utilizing new media platforms.

## Moving Forward Together

BRT members believe there may be a chance to do something positive after the 2008 presidential elections. The best chance for reform lies in a plan that does not completely disrupt existing processes, as it is too easy for one powerful group to derail the reform effort. The key is to bring together unusual alliances to forge consensus, and to reach out to political leaders, driven by the voice and needs of consumers. Key issues that need to be addressed include the current payment structure in health care (CEOs recognize this as a problem), medical liability reform, and interoperable standards for health IT (which should encourage adoption by providers, especially physicians). BRT members believe that, contrary to conventional wisdom, physicians who implement IT can derive significant benefits from it, including enhanced productivity.

## Wrap-up and Key Take-Home Lessons

At various points during the two-day meeting, participants engaged in a freewheeling discussion designed to draw out the key lessons related to engaging the C-suite. Insights from these discussions include the following:

## Revisiting the Design Framework for Engagement

Key lessons related to the four elements of the design framework for engagement are summarized below:

- **Identifying barriers:** Key barriers include the fact that health care represents complex and unfamiliar terrain and is often perceived to lack quantifiable business data and actionable initiatives. In addition, CEOs and CFOs often lack the time necessary to give health care adequate attention. For smaller companies (particularly those backed by venture capital), leaders' time horizons may be too short to view health care as important. To overcome these barriers, leaders need to see a strong business case and specific initiatives that can produce a positive return on investment. Once the C-suite is on board, one key challenge relates to changing the culture of the organization to focus on health, particularly those organizations that are spread out in multiple locations, including service organizations (e.g., the local police force) where employees work out in the community. Another barrier relates to the community—employees may work in an organization that focuses on health, but may return home to live in a community that does not. As a result, connections need to be made to community health, including engaging spouses and family members in behavior change. The key is change the focus of the dialogue and mindset away from treating sickness to emphasizing health.
- **Making the case:** It is critical to quantify the dollars at stake through use of familiar reports and metrics, such as the impact on costs and share price. Goals should be achievable and easy to understand, such as shooting for “zero trend,” “not getting worse,” or “keeping healthy people healthy.”
- **Successful strategies:** Successful strategies include use of cross-functional teams, having leaders set the vision, and using simple scorecards to track progress.
- **Market and other internal and external reinforcers:** Reinforcers include measuring the impact on share price, employee retention (the goal should be to become the “employer of choice” by creating a culture of health), and positive publicity, both within the company and in the local or national press.

## Other Lessons Learned

Other lessons highlighted during the general

discussion include the following:

- **The stakes are high throughout the process:** When going to the C-suite, it is critical to use the right language (e.g., business metrics) and to articulate a clear strategy, particularly if one is requesting capital investment. Once the C-suite is convinced, moreover, the “real work” begins, as corporate leaders will hold those advocating for change accountable for delivering results. Because the stakes are high, it is critical to have champions who are courageous and willing to be held accountable.
- **The end goals are multifaceted:** The overall goal is not only C-suite engagement within the company, but also their engagement to work at the community level and in the local, regional, and national policy arenas. Most CEOs, however, are less comfortable working outside of the company's four walls. The key is to use business coalitions and other membership organizations to get involved at the community level and in policy debates. These coalitions can act as change agents within communities, states, and the nation as a whole.
- **There is an important role for public health:** Much work needs to be done to integrate public health agencies into this work. Public health agencies need to understand the broader base of community health, and they need to realize that the business community is not the “bad guy” in this process. To that end, NBCH has forged a five-year agreement with the Centers for Disease Control & Prevention to bring businesses and public health agencies together in local communities and to develop a common language that can be used between these two stakeholders.
- **Even small employers can make progress in this area:** Smaller employers can focus on health and productivity, particularly if they link up with larger companies and/or coalitions. There is a need, however, for the development of common metrics for these companies.
- **Peer-to-peer connections work best:** The best way to engage CEOs is to have another CEO make the case to them, as there is a social network within the C-suite community. It is critical, therefore, to bring CEOs together and to give them time for networking. The key to getting them together, moreover, is to respect their time. The best vehicle for reaching CEOs is through established organizations that cater to them, such as BRT.

- Check one's ego at the door: Sometimes champions have to be willing to put their egos aside and let others take credit for things that they may have initiated. It does not matter who gets the credit as long as something positive gets done.
- Public reporting is likely a key component: Change may not occur unless there is tremendous pressure for reform, and often that pressure comes in the form of public reporting on performance. For example, CEOs in the Pittsburgh area became involved in a regional initiative that provided a collegial, safe environment in which to review provider performance data that were not reported to the public. But the initiative had no impact on provider performance until the CEOs delivered a clear message on the need for public reporting.

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## National Health Leadership Council Attendees

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