Finding the Value in Health

RESULTS FROM THE INTEGRATED BENEFITS INSTITUTE'S 2015 CFO SURVEY

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Founded in 1995, the **Integrated Benefits Institute** (IBI) is a national, nonprofit research and educational organization committed to helping business leaders and policymakers understand the business value of workforce health and recognize the competitive advantages of helping employees get and stay healthy. IBI is supported by more than 1,100 member companies representing over 20 million workers.

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Executive Summary

Chief financial officers (CFOs) are responsible for ensuring that a company's financial resources further its business strategy. Three times over the past decade and a half, the Integrated Benefits Institute (IBI) has surveyed CFOs and other senior finance executives about how employers invest in the health of their workers—and the expected returns from their portfolio of health benefits.

This fourth CFO survey investigates changes in health benefits since the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and explores the links among employers' benefits decisions, their corporate culture and their stated benefits goals. We asked CFOs to think broadly about "health-related" benefits—including health insurance but also other employer-sponsored policies and programs designed to improve enrollees' health; reduce illness-related absences, underperformance and lost productivity; or otherwise reduce the financial burden of illness on the company—to answer the overarching question: ***Do benefits strategies such as cost-sharing with employees, investment in health promotion efforts, value-based benefits, specialty pharmaceutical coverage and private healthcare exchanges reflect priorities other than simply managing costs?*** Their responses can help human resource (HR) and benefits professionals emphasize critical issues when they engage senior executives about the strategic value of workforce health. At the same time, identifying consistent patterns among corporate goals, values and benefits decisions helps point out gaps that might disadvantage a company compared with its peers (and competitors).

The survey was completed by 345 CFOs and other senior finance executives—40% of whom reported their company's revenues at more than $2 billion, placing them among the Fortune 1000. The results clearly show that while CFOs are strongly cost conscious about benefits, helping employees manage their health and developing high-performing human capital are also important benefits goals. The salience of these goals—and the strength of an employer's culture of health—sheds light on the benefits decisions that employers have made since the passage of the ACA and the changes they intend to make in the near future.

IBI and CFO Research Services (the research arm of CFO Publishing LLC) collaborated to develop and field the survey via e-mail. IBI performed the analyses and drafted this report.

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Survey Highlights

As partners in making benefits decisions, CFOs do not focus single-mindedly on costs. They also consider their company's business strategy and corporate value system.

- **CFOs are deeply involved in decisions about their company's health benefits.** Only 15% of CFOs surveyed said that the finance function played no role in their company's benefits decisions. A majority share benefits decision-making as equal partners with other departments or make all or most benefits decisions; 24% of CFOs said that the finance function's role in benefits decision-making has expanded since the passage of the ACA, compared with 5% who said the finance function's role in benefits decision-making has shrunk.

- **Cost-sharing with enrollees is on the rise since the passage of the ACA.** About half of all CFOs surveyed said that their company is increasing its offerings of high-deductible plans for employees and dependents and raising enrollees' premium shares and out-of-pocket expenses.

- **Employers remain committed to programs that promote workforce health.** More than half of CFOs surveyed said that their company had enhanced their health and well-being programs since the passage of the ACA, while over one-third enhanced incentives for employees to adopt healthy lifestyles or participate in wellness programs. Few CFOs said that their company made changes to the structure of benefits programs such as integrated healthcare and disability, coverage of specialty pharmaceuticals and disability leave benefits.

- **Few CFOs foresee changing their health benefits strategy in the next three years.** CFOs who said their company would likely provide benefits to full-time employees through private health insurance exchanges (27%) were outnumbered two to one by CFOs who said that their company was unlikely to do so. For every CFO who said that his or her company would likely eliminate health insurance for part-timers in the next three years, 15 CFOs said that their company was unlikely to do so. Virtually no CFOs said that their company would likely eliminate health insurance for full-time employees in the next three years. Likewise, few CFOs indicated that their company would convert some full-time employees to part-time to reduce ACA obligations or would incur financial penalties under the ACA.

- **Controlling costs is only one of several goals for employers' health benefits.** Not surprisingly, CFOs are strongly cost conscious about benefits. Almost half cited "reducing and controlling healthcare costs" as the most important benefits goal since the passage of the ACA, while 87% cited cost control as one of their five most important goals. Other important goals included helping employees manage their health and become better consumers of care, complying with government regulations, and attracting/retaining or satisfying talent in the labor market.

- **Employers' benefits goals shed light on actions taken since the passage of the ACA.** CFOs who said that their company's health benefits had important human capital goals—such as competing for talent in the labor market—cited less cost sharing with employees and a lower likelihood of eliminating coverage for full-time employees in the next three years. Employers with benefits that had important business performance goals—such as improving customer service—were less likely to increase cost sharing for employees and more likely to enhance coverage of specialty pharmaceuticals and disability leave. Finally, the importance of improving enrollees' health was linked to enhancements in health promotion efforts and the provision of high-deductible plans in concert with value-based benefits and specialty pharmaceutical coverage.

- **Employers with a stronger culture of health show a greater commitment to health promotion efforts and less willingness to change their health benefits strategy.** CFOs who described their company as having a stronger culture of health were more likely to say that their company enhanced its efforts to improve workforce health—such as incentivizing healthy lifestyles and wellness participation and providing value-based benefits and specialty pharmaceutical coverage. Employers with stronger cultures of health were also less likely to say they would eliminate health insurance benefits for employees or dependents.

- **Employers that recognize how illness impacts productivity appear less likely to change their health benefits strategy.** CFOs who agreed that illness impacts employee absences and who disagreed that illness-related underperformance was unquantifiable were less likely to say that their company would eliminate health insurance benefits for full-time employees in the next three years, would provide benefits through private health insurance exchanges or would incur penalties under the ACA.

- **Improving measurement of benefits outcomes could strengthen the business case for workforce health.** Overall, only 23% of CFOs reported that their company made any assessment of whether its benefits are producing positive results. The most common assessment method was whether employees participated in programs (14% of all employers and about 60% of employers that make any assessment), followed by employee satisfaction with programs. Only 6% of employers calculated the return on investment (ROI) of their health benefits.

Introduction

The research literature provides strong evidence that workers' illnesses take a toll on their productivity and that a healthy workforce offers competitive business advantages.[1] The large percentage of firms that invest in workplace wellness and health promotion programs[2] indicates clearly that human resource (HR) and benefits professionals have gotten the message.

Like any portfolio of investments, health benefits—including health insurance but also other employer-sponsored policies or programs designed to improve enrollees' health or otherwise reduce the financial burden of illness on the company—must be managed with attention to both costs and returns. Nonetheless, many employers still base their decisions about workforce health primarily on the costs of healthcare benefits without considering fully the strategic value of healthy employees.[3] This disconnect between the amount employers pay for healthcare benefits and what they get in return—high-performing workers who can contribute to the value of the firm—jeopardizes the momentum for workplace health, well-being and productivity initiatives. Shifting more of healthcare's rising costs to employees might look good on this year's financial statements but will do little to improve the quality of companies' goods and services in the long run. For that, employers need workers who are on the job consistently and feeling healthy, engaged and mentally alert enough to perform at a high level—all of which is compromised when employees engage in unhealthy behaviors or forgo necessary and beneficial care they feel they cannot afford.[4]

The chief financial officer (CFO) is responsible for ensuring that a company's financial resources further its business strategy. This responsibility places the CFO at the intersection of the costs and value of a healthy workforce. Previous Integrated Benefits Institute (IBI) surveys of CFOs[5] investigated such topics as the information financial executives find helpful in making decisions about health benefits and their assessments of illness-related business costs, such as healthcare spending,

[1] For a list of the most cited health and productivity studies of the past two decades, see the Integrated Benefits Institute's *The Health and Productivity Hall of Fame, 1993-2013.* ibiweb.org.

[2] See for example Gifford B, Molmen W, Parry T. *More Than Health Promotion: How Employers Manage Health and Productivity.* Integrated Benefits Institute, 2010. ibiweb.org; Mattke S, Liu H, Caloyeras JP, et al. "Workplace Wellness Programs Study: Final Report," RAND, 2013, rand.org; Fidelity Investments/NBGH. fidelity.com. "Companies Are Spending More on Corporate Wellness Programs but Employees Are Leaving Millions on the Table," 2015; PriceWaterhouseCoopers. "2015 Health and Well-Being Touchstone Survey," 2015. pwc.com

[3] Gifford, B. *Linking Workforce Health to Business Performance Metrics: Strategies, Challenges and Opportunities.* Integrated Benefits Institute, 2015. ibiweb.org

[4] Gifford, B. "Consumer-Directed Health Plans: The Challenge to Managing Workforce Health, Performance and Productivity." *Health Insurance Underwriter.* June 2015: 30–37.

[5] See Gifford B, Molmen W, Moore J, Parry S. *Making Health the CFO's Business.* Integrated Benefits Institute, 2012. ibiweb.org; Parry T, Jinnett K, Molmen W, Lu Y. *The Business Value of Health: Linking CFOs to Health and Productivity.* Integrated Benefits Institute, 2006. ibiweb.org; Parry T, Molmen W, Newman A. *On the Brink of Change: How CFOs View Investments in Health and Productivity.* Integrated Benefits Institute, 2002. ibiweb.org

sick-day and disability wage replacements, and the costs of replacing the absent and underperforming employees' lost output.

Nonetheless, while those studies provided valuable insights about making the business case for a healthy workforce, they were focused squarely on costs. Now that most of the employer provisions of the Patient Protection and Affordable Care Act (ACA) are in place—with significant uncertainty remaining about the excise tax on insurers of high-cost employer-sponsored health plans—the focus on costs without regard to the strategic intent of benefits increasingly seems misplaced.

For one thing, though the ACA's financial penalties for not covering employees are far lower than most health insurance premiums, survey after survey shows that employers remain committed to offering health benefits rather than paying fines and subsidizing their employees' enrollment in public healthcare exchanges.[6] For another, while cost-sharing is becoming more common, so are workplace efforts to help employees get and stay healthy.[7] The finding that employers are largely covering their part-time workers as required by law rather than reducing hours[8] is another reminder that human capital considerations remain part of the benefits cost equation.

Clearly, CFOs pay attention to costs as they oversee the performance of their firm's portfolio of health benefits. But is managing costs their only concern? What other returns do CFOs anticipate from their firm's benefits portfolio? And how might that portfolio change as new benefits options, such as private exchanges and specialty pharmaceutical tiers, gain traction?

[6] See for example Mercer LLC. "Health Reform Five Years In," 2015. mercer.com; Kaiser Family Foundation. "Employer Health Benefits, 2014 Annual Survey, 2014. kff.org

[7] Society for Human Resource Management. "2015 Employee Benefits: An Overview of Employee Benefits Offerings in the U.S.," 2015. shrm.org

[8] Mercer, "Health Reform Five Years In."

Detailed Survey Findings

IBI partnered with CFO Research Services, a unit of CFO Publishing LLC, to survey 345 CFOs, controllers, directors, VPs of finance, treasurers and other senior finance executives at firms of a variety of sizes across a range of industries.[9] Forty percent of respondents represented firms with at least $2 billion in annual revenues, placing them among the Fortune 1000 in 2015.[10]

The major goal of this study was to better understand employers' financial and strategic goals for their health benefits[11] from the CFO's perspective. We asked CFOs a battery of questions about how their company approaches workforce health as a business strategy. Topics covered included the following:

- The top goals for their health benefits since the passage of the ACA
- The overall culture of health at their company
- Their impressions of how employees' health impacts their job performance and the performance of the business
- Their standards for a credible business case linking health to job performance

We also asked CFOs about changes their company has made to its benefits since the passage of the ACA. Topics covered included the following:

- Cost-sharing (high-deductible plans, out-of-pocket amounts and premium amounts) for employees, dependents and retirees
- Health and well-being programs and financial incentives for enrollees to make healthy choices
- Enhanced benefits, such as disability and value-based arrangements and specialty pharmaceutical coverage

Finally, we asked CFOs about their company's likelihood of changing its health benefits strategy by taking actions traceable to the ACA's policies and regulations. Topics covered included the following:

- Providing healthcare benefits to full-time or part-time employees or retirees through private health insurance exchanges
- Eliminating healthcare benefits for full-time employees, part-time employees, dependents or retirees
- Converting some full-time employees to part-time to avoid some ACA regulations
- Incurring financial penalties under the ACA

To establish that CFOs can respond knowledgeably about their company's health benefits in relation to productivity, we also asked about the finance function's role in benefits decision-making and how their company assesses whether their health benefits are achieving positive outcomes.

[9] See the appendix for a summary description of the sample respondents. For convenience, throughout this report we refer to all respondents as "CFOs" to indicate senior-level financial executives and officers.

[10] http://fortune.com/fortune500/, accessed July 22, 2015.

[11] The survey questions asked about "health-related benefits" and instructed respondents that this term refers not just to health insurance but to any company-sponsored policy or program designed to improve enrollees' (employees, dependents or retirees) health or otherwise reduce the financial burden of illness on the company. For simplicity, we use the more general terminology of "health benefits" throughout the report.

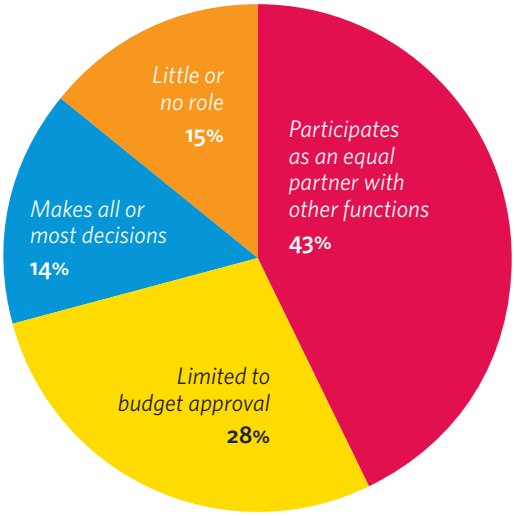
CFOs are deeply involved in decisions about their company's health benefits.

More than half of all CFOs play an important role in making decisions about health benefits. Over 40% of CFOs participated more or less as equals with other departments, while 14% made all or most benefits decisions. Only 15% said that the finance function played no role in benefits decisions. The remaining CFOs stated that they primarily approved benefits budgets while other departments set priorities and made decisions about benefits and policies.

Importantly for the focus of this report, CFOs' roles making decisions about health benefits have expanded since the passage of the ACA: 24% of respondents said that the finance function's role in decision-making has expanded, compared with 5% who said the role has shrunk.

FIGURE 1

IN YOUR COMPANY, HOW WOULD YOU DESCRIBE THE FINANCE FUNCTION'S ROLE IN MAKING DECISIONS ABOUT YOUR COMPANY'S HEALTH-RELATED BENEFITS?

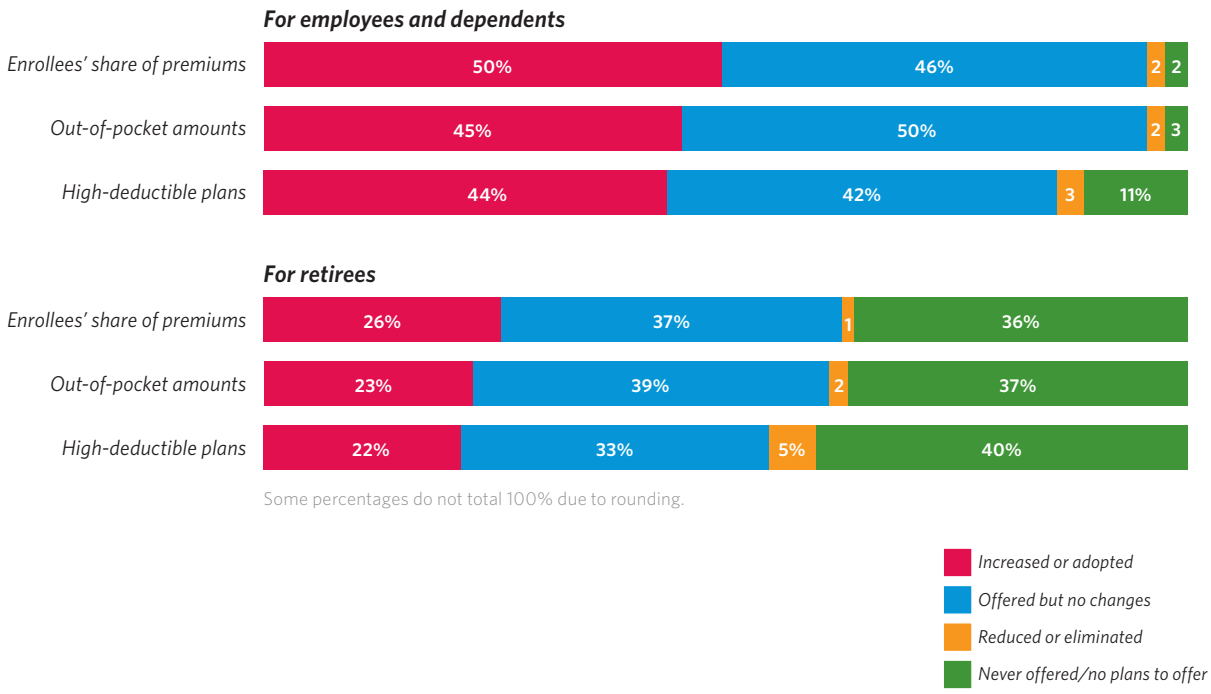


Cost-sharing with enrollees is on the rise since the passage of the ACA.

CFOs report that cost-sharing for employees, dependents and retirees is on the rise since the passage of the ACA. Between 44% and 50% of all CFOs said that their company increased[12] its offerings of high-deductible plans for employees and dependents and raised enrollees' premium shares and out-of-pocket expenses. The responses for retirees' cost-sharing are between 22% and 26% but are similar in impact when taking into account the number of CFOs stating that their companies did not offer retiree benefits.

FIGURE 2

SINCE THE PASSAGE OF THE ACA, WHAT CHANGES HAS YOUR COMPANY MADE, OR DOES IT PLAN TO MAKE, TO THE FOLLOWING HEALTHCARE BENEFITS?



Some percentages do not total 100% due to rounding.

[12] Respondents were asked about changes their company has made or plans to make. Except for the sections that deal with actions a company likely will take in the next three years, we refer to changes in the past tense throughout this document.

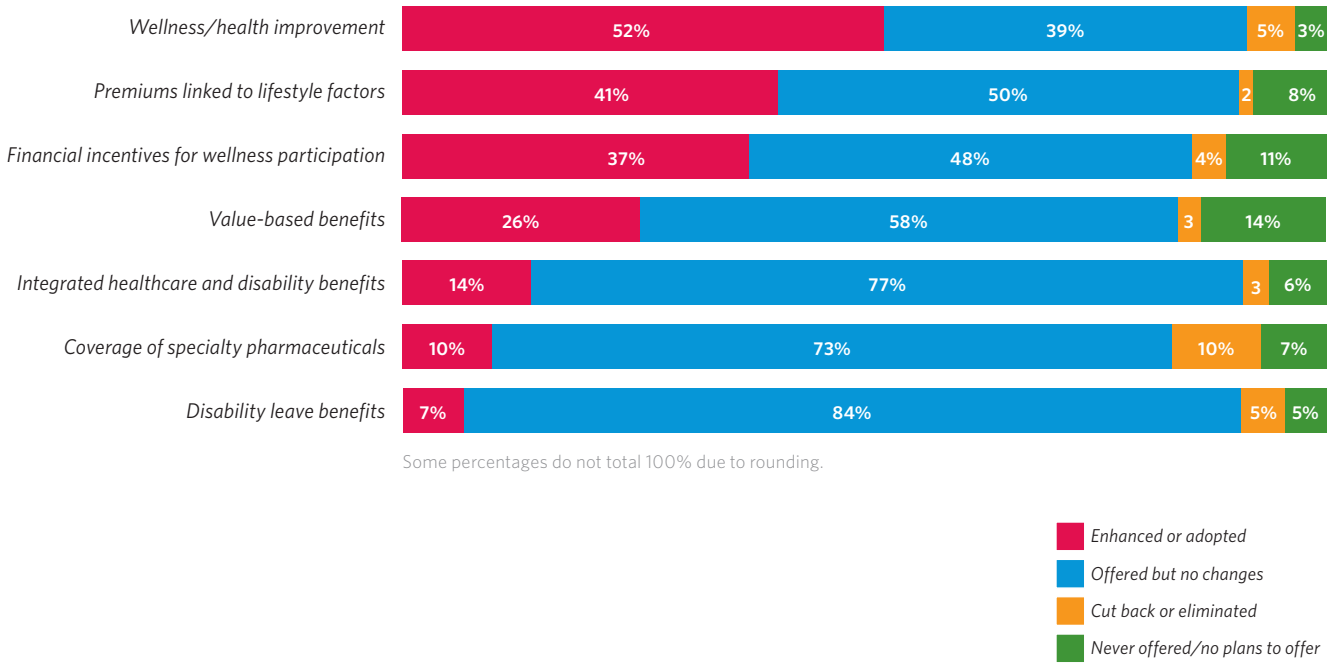
Employers remain committed to programs that promote workforce health.

CFOs stated that their company enhanced some benefits that can support workforce health but left more-established benefits largely intact. More than half said their company adopted or enhanced its wellness and health improvement offerings. Between 37% and 41% enhanced or adopted financial levers to encourage enrollees' healthy choices, such as linking premiums to lifestyle factors and offering incentives for participation to encourage enrollees' efforts to engage in their health. About one-quarter of CFOs said that their company adopted or enhanced value-based benefit designs. Few CFOs said that their company made changes to benefits such as integrated healthcare and disability, coverage of specialty pharmaceuticals or disability leave.

Nonetheless, the proportion of CFOs who said that their company reduced or eliminated coverage of specialty pharmaceuticals—10% of the total—equaled the proportion who said that they enhanced or adopted such benefits.

FIGURE 3

SINCE THE PASSAGE OF THE ACA, WHAT CHANGES HAS YOUR COMPANY MADE, OR DOES IT PLAN TO MAKE, TO THE FOLLOWING HEALTH-RELATED BENEFITS IN GENERAL?



Some percentages do not total 100% due to rounding.

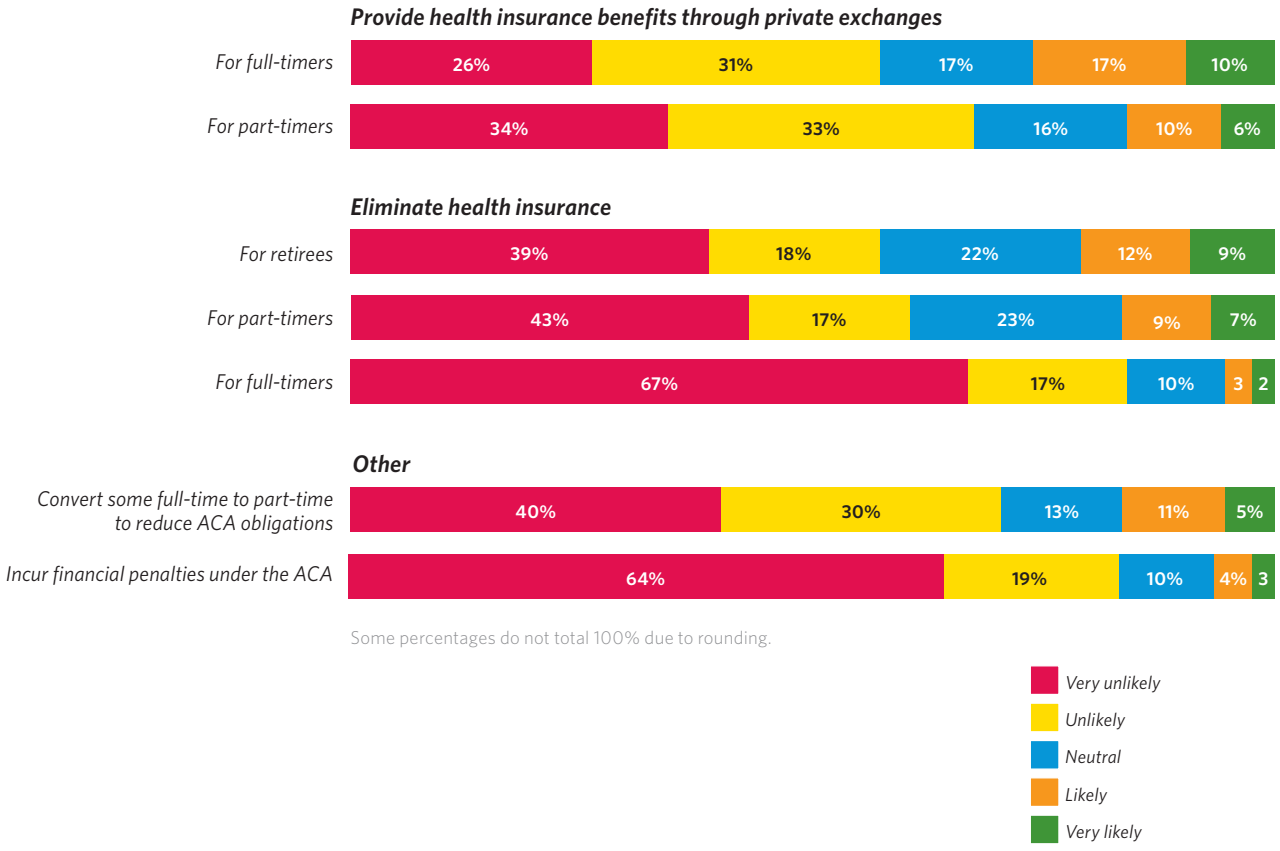
Few CFOs foresee changing their health benefits strategy in the next three years.

Relatively few CFOs said that their company was likely or very likely to change its health benefits strategy by taking actions over the next three years that correspond to new opportunities or requirements traceable to the ACA.

For example, about 27% of CFOs said that their company would likely provide benefits to full-time employees through private exchanges, but they were outnumbered two to one by CFOs who said that their company was unlikely to do so. Virtually none of the CFOs said that their company would likely eliminate health insurance for full-time employees. For every CFO who said that his or her company would likely eliminate health insurance for part-time workers, 15 CFOs said that their company was unlikely to do so. Likewise, few CFOs indicated that their company would convert some full-time employees to part-time to reduce ACA obligations or would incur financial penalties under the ACA.

FIGURE 4

OVER THE NEXT THREE YEARS, HOW LIKELY IS IT THAT YOUR COMPANY WILL DO ANY OF THE FOLLOWING?



Some percentages do not total 100% due to rounding.

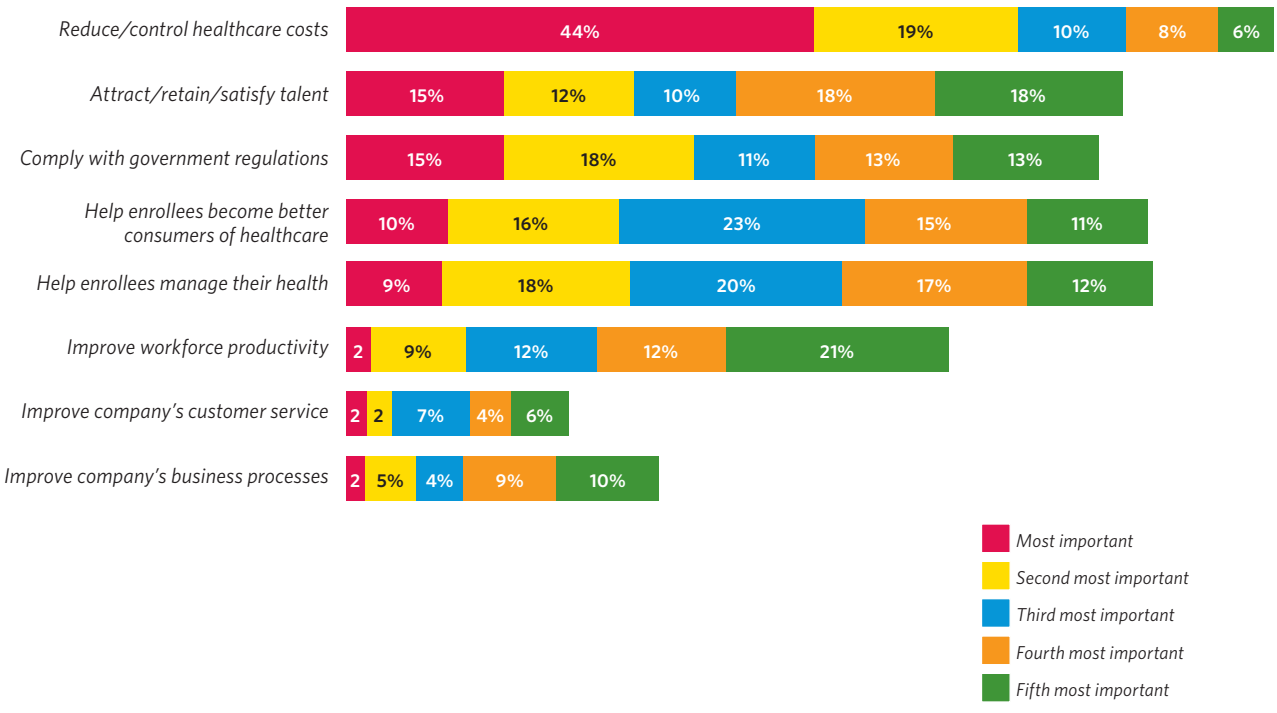
Controlling costs is only one of several goals for employers' health benefits.

We asked CFOs to rank the top goals for their company's health benefits since the passage of the ACA. Not surprisingly, CFOs are strongly cost conscious about benefits. Almost half cited reducing and controlling healthcare costs as the most important benefits goal since the passage of the ACA, while 87% cited cost control as one of their five most important goals.

However, CFOs also assign high levels of importance to such goals as helping employees manage their health and become better consumers of care, complying with government regulations, and attracting/retaining or satisfying talent in the labor market.

FIGURE 5

SINCE PASSAGE OF THE ACA, WHAT HAVE BEEN THE TOP FIVE MOST IMPORTANT GOALS FOR YOUR COMPANY'S HEALTH-RELATED BENEFITS?



A factor analysis revealed that the importance CFOs assigned to some goals corresponded in predictable ways to the importance of other goals.[13] The correspondence patterns indicated three distinct categories of goals, described in the table below.

TABLE 1

GOALS FOR EMPLOYERS' HEALTH BENEFITS FALL INTO THREE DISTINCT CATEGORIES

Benefits goals	*Places greater importance on:*	*Places less importance on:*
Human capital goals	■ Improving workforce productivity ■ Attracting/retaining/satisfying talent in the labor market	■ Complying with government regulations
Business performance goals	■ Improving the company's customer service ■ Improving the company's business processes	■ Reducing/controlling healthcare costs
Enrollee health goals	■ Helping enrollees become better consumers of care ■ Helping enrollees manage their health	

The items that characterize each category can be combined into scales indicating that the overall goal is less important or more important for a particular employer.

- Employers with more-important **human capital goals** for their health benefits emphasize improving workforce productivity and recruiting and retaining talent in the labor market and de-emphasize complying with government regulations.
- Employers with more-important **business performance goals** for their benefits emphasize improving the company's customer service and business processes and de-emphasize reducing/controlling healthcare costs.
- Employers with more-important **enrollee health goals** for their benefits emphasize helping enrollees manage their health and become better consumers of care.

[13] Factor analysis is a statistical approach to grouping survey items based on how responses correspond to one another. See the appendix for a more detailed description.

Employers' benefits goals shed light on actions taken since the passage of the ACA.

Establishing the links between benefits goals and actions offers two important insights. First, it provides a context for understanding what gets considered when employers make decisions about their benefits. This can help HR and benefits professionals emphasize critical issues when they engage senior executives about the strategic value of workforce health.

Second, identifying consistent patterns between senior leaders' intentions and actions can help point out where benefits gaps might occur. For example, employers with the declared goal of helping employees manage their health may find that they are out of step with their peers (and competitors) if they do not provide incentives for participation in wellness programs.

We use multivariate regression analysis[14] to assess whether employers' overall benefits goals have any bearing on their commitment to different policies since the passage of the ACA and on whether they will likely change their health benefits strategy in the next three years.

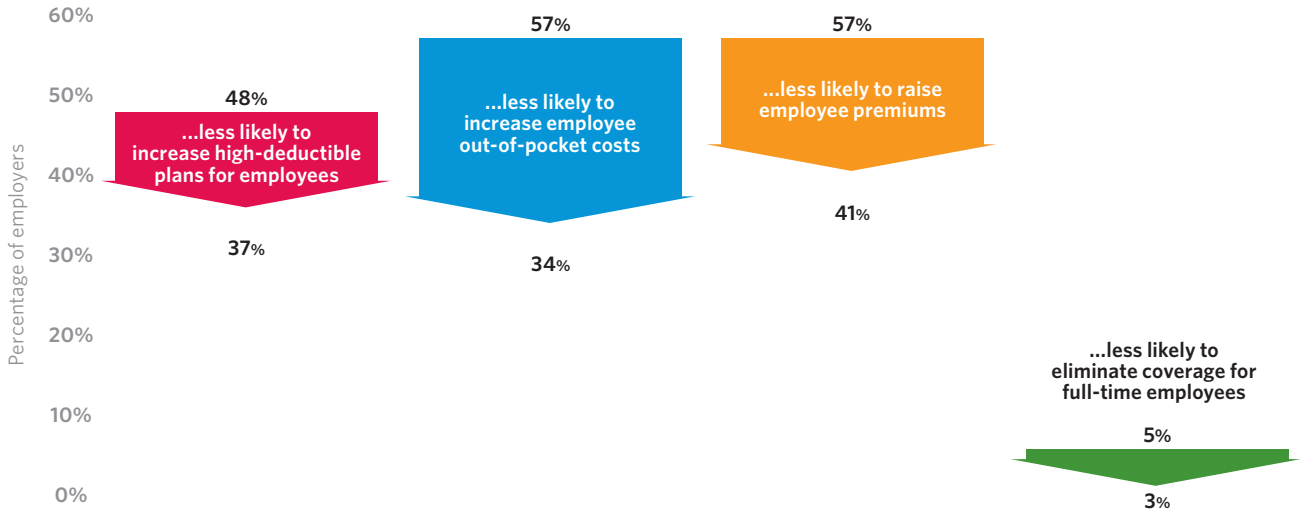
The results indicate that benefits goals provide some consistent guides to the types of actions employers have taken since the passage of the ACA. Employers with important human capital goals for their benefits (such as becoming more competitive for talent in the labor market and improving productivity) were less likely to increase employees' high-deductible plans, premium shares and out-of-pocket costs. They were also less likely to eliminate coverage for full-time employees in the next three years.

For example, as Figure 6 illustrates, we would expect about 37% of employers with above-average scores on the "human capital goals" scale to increase high-deductible plans for employees, compared with about 48% of employers with below-average scores. (See note for explanations of *above-* and *below-average*.)

[14] See the appendix for a description of the regression method and a full list of the organizational characteristics used as control variables.

FIGURE 6

AS IMPROVING HUMAN CAPITAL BECOMES A MORE IMPORTANT BENEFITS GOAL, EMPLOYERS ARE...



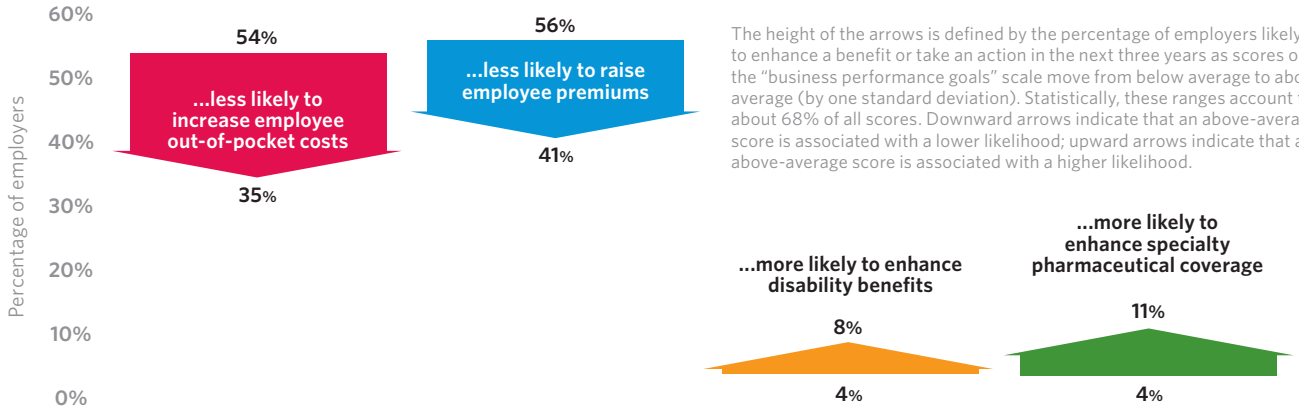
The height of the arrows is defined by the percentage of employers likely to enhance a benefit or take an action in the next three years as scores on the "human capital goals" scale move from below average to above average (by one standard deviation). Statistically, these ranges account for about 68% of all scores. Downward arrows indicate that an above-average score is associated with a lower likelihood; upward arrows indicate that an above-average score is associated with a higher likelihood.

Employers with important business performance goals for their benefits (such as improving customer service or business processes) were less likely to increase employees' premium shares and out-of-pocket costs. They were also more likely to enhance coverage of specialty pharmaceutical and disability leave.

For example, as Figure 7 illustrates, we would expect about 35% of employers with above-average scores on the "business performance goals" scale to increase employee out-of-pocket costs, compared with about 54% of employers with below-average scores. (See note for explanations of *above-* and *below-average*.)

FIGURE 7

AS IMPROVING BUSINESS PERFORMANCE BECOMES A MORE IMPORTANT BENEFITS GOAL, EMPLOYERS ARE...



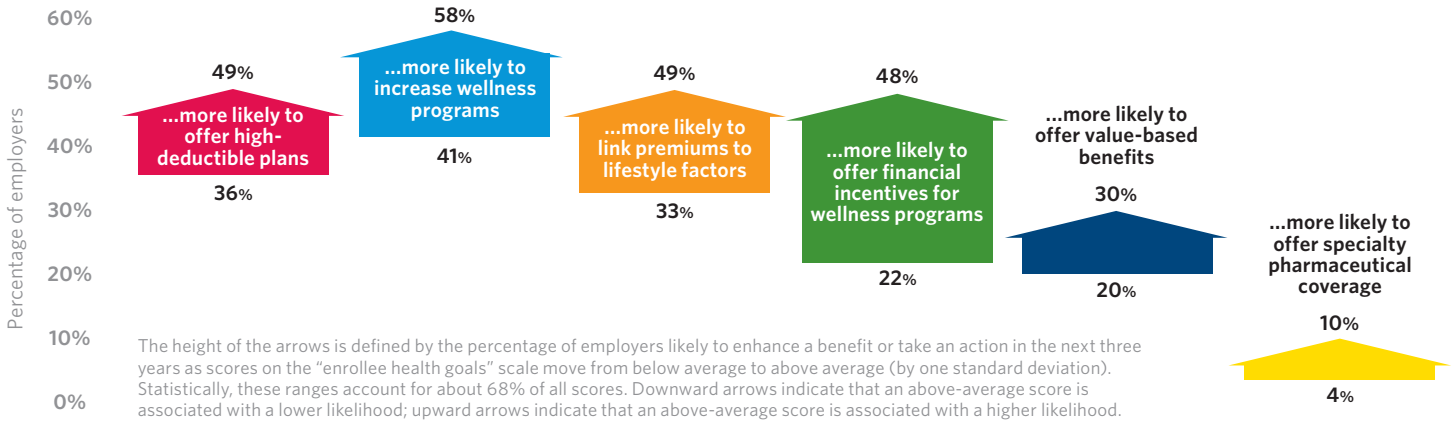
The height of the arrows is defined by the percentage of employers likely to enhance a benefit or take an action in the next three years as scores on the "business performance goals" scale move from below average to above average (by one standard deviation). Statistically, these ranges account for about 68% of all scores. Downward arrows indicate that an above-average score is associated with a lower likelihood; upward arrows indicate that an above-average score is associated with a higher likelihood.

Finally, employers with important enrollee health goals for their benefits (such as helping enrollees manage their health and become better consumers of care) were more likely to enhance health promotion efforts (such as financial incentives for adopting healthy lifestyles and participating in wellness programs). Yet they also paid attention to the value considerations of high-quality care by increasing their use of high-deductible plans for employees in concert with value-based benefits and coverage of specialty pharmaceuticals.

For example, as Figure 8 illustrates, we would expect about 49% of employers with above-average scores on the "enrollee health goals" scale to increase high-deductible plans for employees compared with about 36% of employers with below average scores. (See note for explanations of *above-* and *below-average*.)

FIGURE 8

AS IMPROVING ENROLLEE HEALTH BECOMES A MORE IMPORTANT BENEFITS GOAL, EMPLOYERS ARE...



The height of the arrows is defined by the percentage of employers likely to enhance a benefit or take an action in the next three years as scores on the "enrollee health goals" scale move from below average to above average (by one standard deviation). Statistically, these ranges account for about 68% of all scores. Downward arrows indicate that an above-average score is associated with a lower likelihood; upward arrows indicate that an above-average score is associated with a higher likelihood.

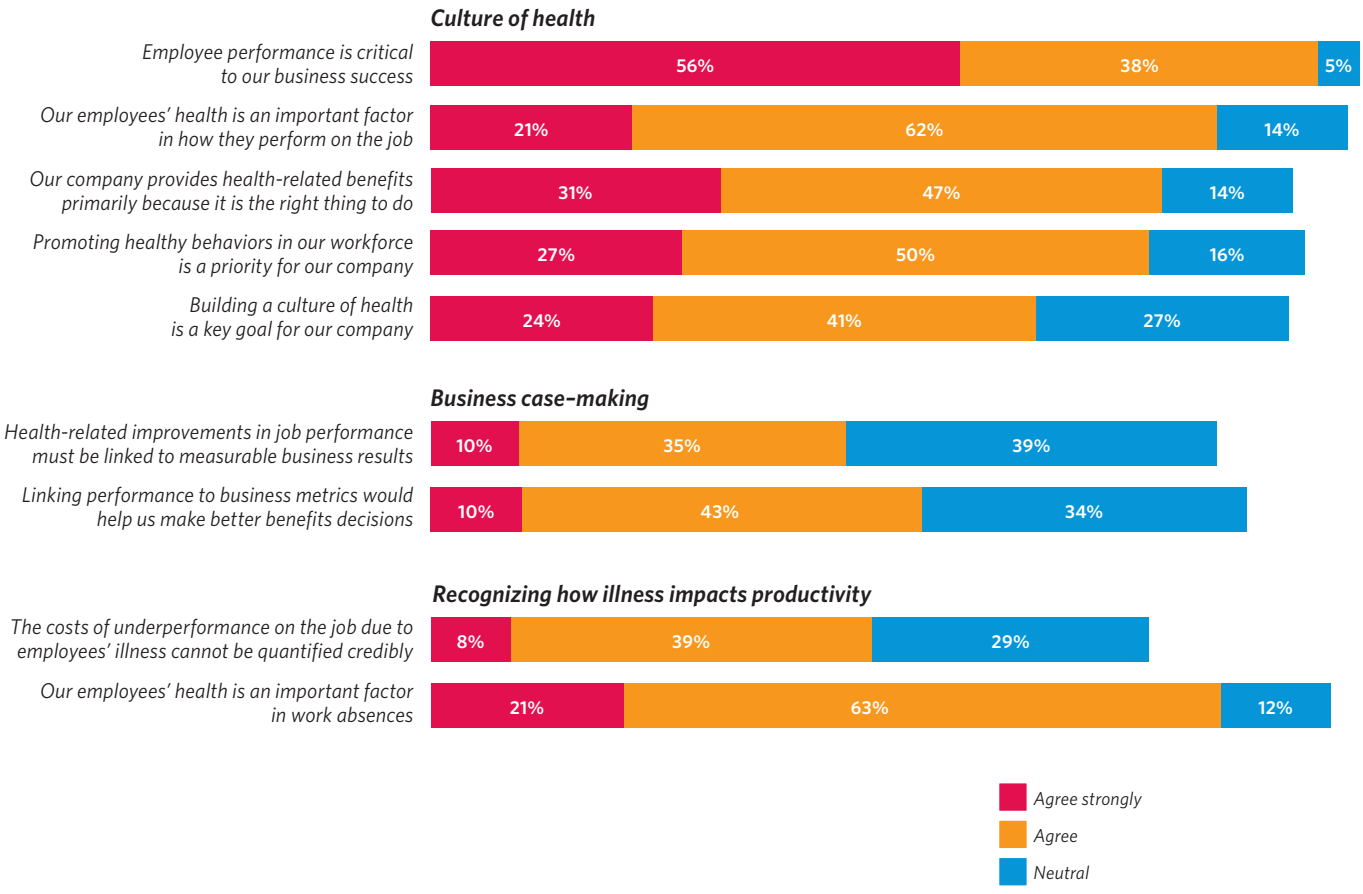
Employers with a stronger culture of health show a greater commitment to health promotion efforts and less willingness to change their health benefits strategy.

What can be said of benefits goals may also hold for employers' strategic views of workforce health and performance more generally. We asked CFOs several questions regarding their company's culture of health, their recognition of how illness impacts employees' abilities to contribute productively on the job and the type of information employers need (or could utilize) to make a business case for helping employees improve their health.

A factor analysis indicated that CFOs' perspectives corresponded to three separate themes, as shown below.

FIGURE 9

CFOs' PERSPECTIVES ON WORKFORCE HEALTH AND PERFORMANCE CORRESPONDED TO THREE THEMES: CULTURE OF HEALTH, BUSINESS CASE-MAKING, AND RECOGNIZING HOW ILLNESS IMPACTS EMPLOYEES' ABILITIES TO CONTRIBUTE PRODUCTIVELY ON THE JOB.



A majority of CFOs agreed or strongly agreed with statements describing a strong culture of health (such as "*Promoting healthy behaviors in our workforce is a priority for our company*"). Fewer CFOs agreed with statements indicating the need for a strong business case for workforce health (for example, "*Health-related improvements in job performance must be linked to measurable business results*"). Finally, responses to questions about health as a factor in absences and the ability to quantify the costs of underperformance due to illness fall under the theme of "recognizing how illness impacts productivity." Note, however, that CFOs who strongly agreed that *"Employee health is an important factor in work absences"* were less likely to agree that illness-related underperformance cannot be quantified.

Importantly, company demographics such as size, revenues and industry were not significant predictors of the strength of a culture of health, the need for a strong business case for workforce health or recognition of how illness impacts productivity.

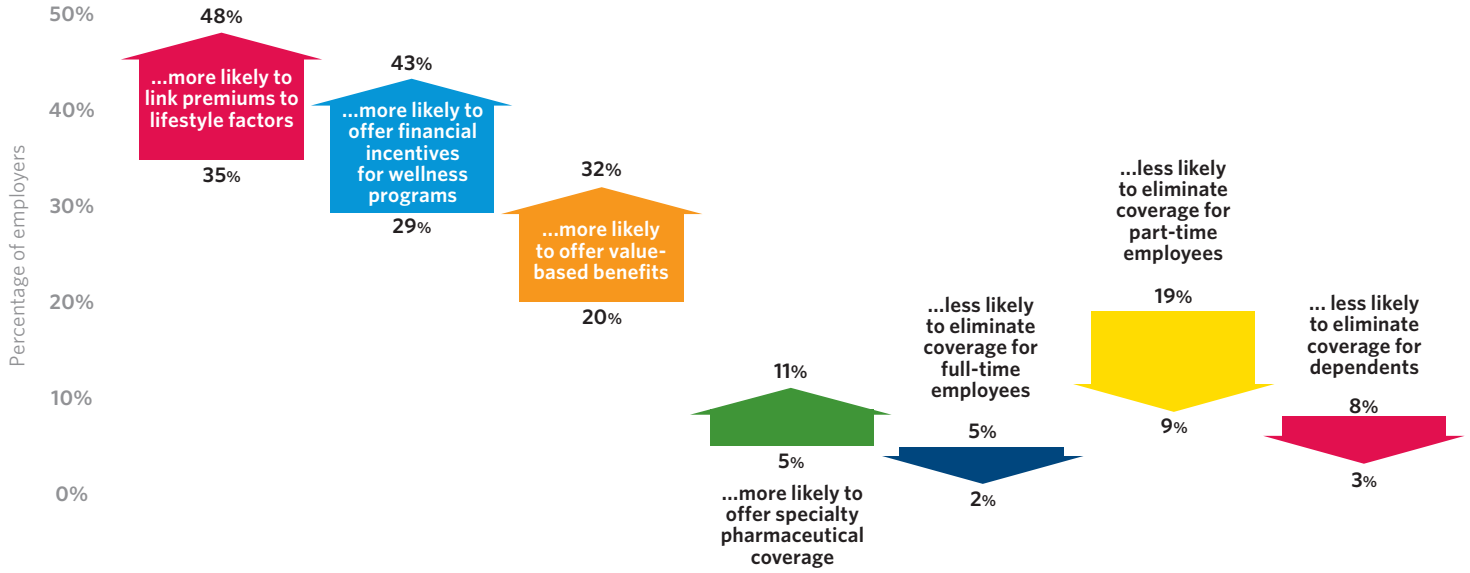
These themes were distributed across companies of all shapes, sizes and revenue levels.

"Culture of health" had the most consistent association with actions employers have taken since the passage of the ACA and with steps they likely will (or will not) take over the next three years. In particular, employers with a stronger culture of health were more likely to enhance efforts to improve workforce health, such as incentivizing healthy lifestyles and wellness participation and providing value-based benefits and specialty pharmaceutical coverage. Employers with a stronger culture of health were also less likely to say they would eliminate health insurance benefits for employees or dependents.

For example, as Figure 10 illustrates, we would expect about 48% of employers with above-average scores on the "culture of health" scale to link premiums to lifestyle factors compared with about 36% of employers with below-average scores. (See note for explanations of *above-* and *below-average*.)

FIGURE 10

EMPLOYERS WITH A STRONGER CULTURE OF HEALTH WERE...



The height of the arrows is defined by the percentage of employers likely to enhance a benefit or take an action in the next three years as scores on the "culture of health" scale move from below average to above average (by one standard deviation). Statistically, these ranges account for about 68% of all scores. Downward arrows indicate that an above-average score is associated with a lower likelihood; upward arrows indicate that an above-average score is associated with a higher likelihood.

Employers that recognize how illness impacts productivity appear less likely to change their health benefits strategy.

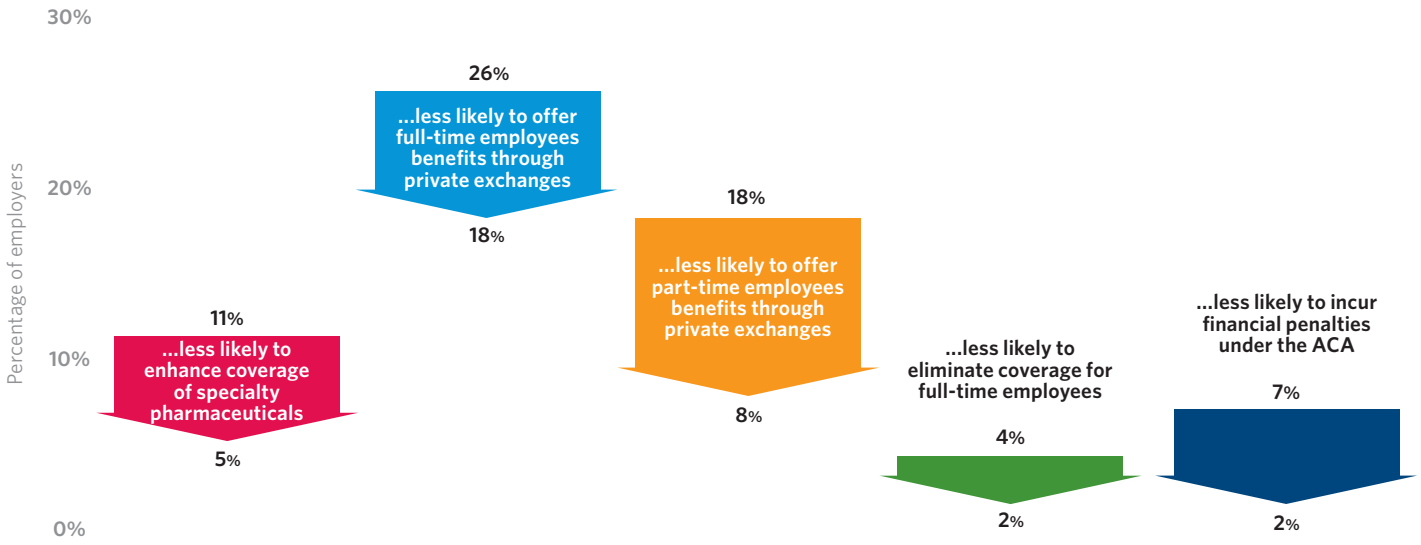
CFOs with greater recognition of how illness impacts productivity generally did not report levels of commitment to benefits that were any different from other employers. The single exception was that they were less likely to enhance their coverage of specialty pharmaceuticals. On the other hand, CFOs with greater recognition of how illness impacts productivity appear less likely to change their health benefits strategy by providing health insurance through private exchanges, eliminating coverage for full-time employees or incurring penalties under the ACA.

Employers that required a stronger business case for health and productivity showed no greater commitment to benefits or greater likelihood of changing their health benefits strategy. The single exception to this pattern was that employers with a need for a stronger business case for health and performance were more likely to say that they would convert some full-time employees to part-time to reduce benefits requirements of the ACA.

For example, as Figure 11 illustrates, we would expect about 5% of employers with above-average scores on the "recognizing how illness impacts productivity" scale to enhance coverage of specialty pharmaceuticals compared with about 11% of employers with below-average scores. (See note for explanations of *above-* and *below-average*.)

FIGURE 11

EMPLOYERS WITH GREATER RECOGNITION OF HOW ILLNESS IMPACTS PRODUCTIVITY ARE...



The height of the arrows is defined by the percentage of employers likely to enhance a benefit or take an action in the next three years as scores on the "recognizing how illness impacts productivity" scale move from below average to above average (by one standard deviation). Statistically, these ranges account for about 68% of all scores. Downward arrows indicate that an above-average score is associated with a lower likelihood; upward arrows indicate that an above-average score is associated with a higher likelihood.

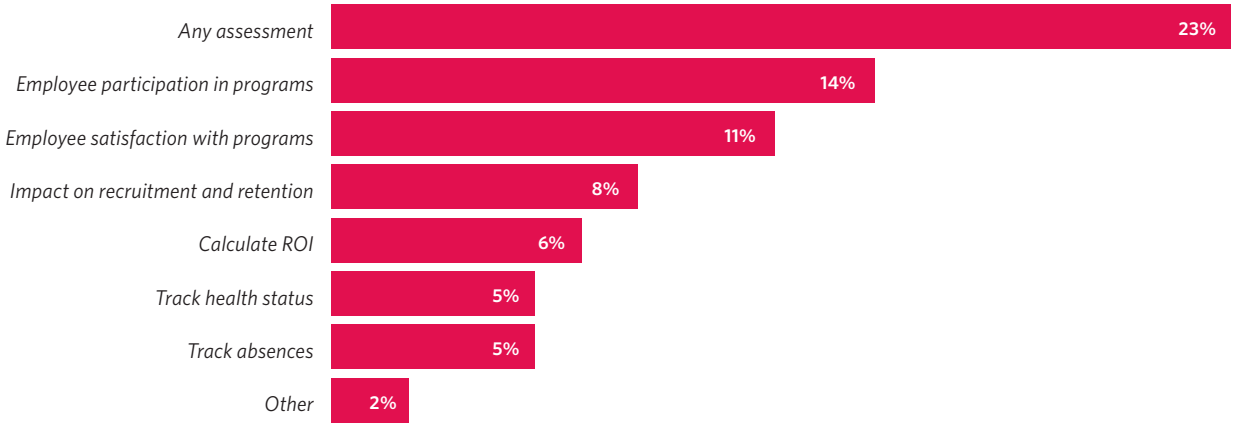
Improving measurement of benefits outcomes could strengthen the business case for workforce health.

A lack of information about the performance of health benefits may provide one explanation for why the need for a strong business case does not seem to play a role in employers' benefits decisions. Overall, only 23% of CFOs reported that their company made any assessment of whether its benefits are producing positive results. The most common assessment method was the whether employees participated in programs (14% of all employers and about 60% of employers that make any assessment), followed by employee satisfaction with programs. Only 6% of employers calculated the return on investment (ROI) of their health benefits.

Employers with greater need for a strong health and performance business case were no more likely to assess their benefits than were other employers. However, a stronger culture of health was linked to a greater likelihood of performance assessment.

FIGURE 12

ONLY ONE IN FOUR CFOs REPORTS THAT HIS OR HER COMPANY ASSESSES THE PERFORMANCE OF ITS HEALTH BENEFITS. THE TYPICAL ASSESSMENT METHOD FOCUSES ON EMPLOYEES' EXPERIENCES WITH THE PROGRAMS.



Conclusions

Costs, goals and values shape employers' benefits decisions.

The results of this survey give important insights into how senior finance executives view the strategic business role of health-related benefits. As partners in making benefits decisions, CFOs do not focus single-mindedly on costs; they also consider their company's business strategy and corporate value system. Since the passage of the ACA, employers' strategic goals, their commitment to a culture of health and their recognition of how illness impacts workers' value to the firm have helped shaped the benefits they offer.

The findings underscore the potential for a broader discussion about workforce health investments. Employers have not responded mechanically to rising healthcare costs, a new regulatory environment and emerging healthcare financing mechanisms. Instead, they are making benefits decisions that are coherent and consistent with what they hope to achieve by offering benefits in the first place. In the words of one benefits executive, the passage of the ACA and the slow recovery from the Great Recession have led to a "parsing of employers":

"On one side you have those who put 'health culture' as a necessary imperative to their company's success versus others who do not. Those who do will invest more strategically in their benefits designs and overall member experience, and they will also be more disciplined about value measurement, including the connection to workforce productivity and talent retention."

Hence, we see that employers that use benefits to access high-performing human capital are more willing to absorb a greater share of benefits costs; those that intend to help employees become healthier are committed to offering wellness programs and incentivizing their use. Employers with a strong culture of health not only incentivize healthy choices but also maintain the strongest commitment to keeping benefits intact into the near future.

The conventional narrative about ROI falls short of employers' intentions.

These patterns may seem entirely predictable. Companies are supposed to make at least some recognizable efforts to achieve their stated goals (allowing, of course, that companies sometimes make counterproductive decisions). And no one—certainly not employees—would take seriously a company's rhetoric about its culture of health if the words were not backed up by some tangible actions.

Yet the coherence of the findings cannot explain why considerations of business strategy and corporate culture appear so rarely in conversations about employers' workforce health investments. Recent high-profile debates about the ROI of workplace wellness programs clearly demonstrate how the costs of illness have crowded out discussions of the value of health. Such a narrow focus on costs lends itself to a caricature of the CFO as little more than a bean counter. By contrast, our findings invite a more complex view of the "returns" portion of ROI and draw attention back to the CFO's responsibility to ensure that financial resources further a company's business strategy.

HR and benefits professionals will make a more compelling case for the strategic value of workforce health investments if they can link their health and productivity efforts to business outcomes that address senior leaders' larger strategic priorities. As a benefits expert advised, this includes protecting the company's human capital investments:

"HR and benefits managers need to graphically illustrate the issue of financial well-being alongside physical and mental well-being to engage the CFOs. When CFOs see the true financial impact of a medical event on the employee's out-of-pocket medical costs and living expenses while on disability, many are immediately willing to discuss financial protection alternatives," such as voluntary income-protection benefits.

Better evidence can help CFOs find the value in health—if they demand it.

That said, the survey findings also reveal the challenges of linking benefits and workforce health to business outcomes more generally. Despite that nearly half of CFOs said that linking performance to business metrics could help their company make better decisions about benefits, very few respondents measure the results of their health-related benefits. This finding shows how far the health and productivity field needs to go toward making a durable business case.

According to one benefits executive with experience measuring ROI, efforts to help employees understand their benefits and find the best treatment options at the best price can more than pay for themselves by avoiding unnecessary surgeries. To help business leaders understand what they get in return for their workforce health investments, stakeholders in the health and productivity field—researchers and practitioners alike—must redouble their efforts to define relevant program outcomes, develop strategies for linking program outcomes to more-general business processes and assist employers in implementing measurement strategies.

CFOs will be indispensable in driving demand for evidence on which to base informed decisions about workforce health investments—if they recognize their critical role in the process and act as their own investor advocates. One benefits consultant put it plainly:

"CFOs have not pushed hard enough on the cost of delivering health services. We still don't have national cost and transparency tools that every employer and employee can access to make informed health purchasing decisions. Until these tools are mainstream, strategies like high-deductible health plans will have minimal impact and be nothing more than cost-shifting."

The results of this survey show that CFOs want something better for their business and their employees. They want ***value*** from their benefits as well as cost savings. The task of benefits professionals is to help CFOs find that value and capitalize on it.

Survey Method

IBI and CFO Research Services (the research arm of CFO Publishing LLC) collaborated to develop and field a survey among senior finance executives in April and May 2015.

The survey instrument was distributed by e-mail to more than 10,000 finance executives from U.S. companies. Responses were solicited from members of the CFO Publishing community, including subscribers to *CFO* magazine, registrants on CFO.com and members of CFO's Research Panel. Responses from 308 senior finance executives from companies with more than $100 million in annual revenues were accepted in May 2015. The response rate is appropriate for surveys distributed by e-mail and is typical for surveys conducted by CFO Research Services. An additional 37 responses were obtained from CFOs representing organizational members of IBI and its partner coalitions.

Respondent Characteristics

Job Title	
Chief financial officer	26.7%
Director of finance	20.0%
Controller	19.1%
VP of finance	12.5%
Treasurer	3.8%
EVP or SVP of finance	2.9%
Other	16.0%

Industry	
Manufacturing	21.2%
Finance, insurance and real estate	21.2%
Healthcare services	9.0%
Other services	5.8%
Wholesale trade	5.2%
Construction	4.4%
Retail trade	4.1%
Transportation	3.8%
Educational services	3.8%
Mining/ resource extraction	3.2%
Communications	3.2%
Public administration	2.9%
Utilities	2.3%
Agriculture, forestry and fishing	0.6%
Other	9.6%

Ownership Type	
For profit, public	44.6%
For profit, private	37.1%
Nonprofit	11.3%
State/local government	6.4%
Other	0.6%

Organization Revenues	
Less than $100M	3.5%
$100M to <$250M	19.5%
$250M to <$1B	23.3%
$1B to <$2B	10.8%
$2B to <$5B	12.8%
$5B to <$10B	9.3%
$10B or more	20.7%

Organization Size (Headcount)	
Fewer than 100	5.0%
100–500	14.9%
501–1,000	13.2%
1,001–2,500	14.0%
2,501–5,000	14.0%
More than 5,000	38.9%

Percentage of Full-Timers	
0%–25%	2.2%
26%–50%	4.0%
51%–75%	13.5%
76%–100%	80.4%

Percentage Unionized	
None	57%
1%–25%	21.0%
26%–50%	8.5%
51%–75%	8.5%
76%–100%	4.9%

Annual Separation Rate	
0%–5%	22.6%
6%–10%	37.6%
11%–15%	23.5%
16%–25%	6.9%
26%–35%	4.9%
36%–50%	2.3%
Higher than 50%	2.3%

Compensation Relative to Industry Average	
Well below average	1.2%
Below average	7.3%
Average	57.3%
Above average	30.1%
Well above average	4.1%

Some percentages do not total 100% due to rounding.

Factor Analysis

In general, factor analysis takes into account how answers to particular survey questions correspond to one another, on the assumption that the patterns reflect some underlying—but not easily observable—beliefs or points of view. It is frequently used in survey research because it allows questions with high correspondence to be combined meaningfully into a single-scale variable. This is useful because it reduces the amount of information to be analyzed without sacrificing the richness of the data. It also increases confidence in the measured construct because responses to multiple questions are often a better gauge of an overall viewpoint than the response to a single question. For a deeper introduction to factor analysis, see Jae-On Kim and Charles W. Mueller, *Introduction to Factor Analysis: What Is It and How to Do It*, London: SAGE Publications, 1978.

We employ factor analysis to create scales from corresponding questions throughout this study and report responses for scales and individual questions where appropriate. We scored responses to opinion items using standard Likert scale values (e.g., "strongly agree" = 5, "strongly disagree" = 1). We scored goal importance by assigning 5 to "most important," 4 to "second most important" on down to 0 if a goal was not selected as among the top five. In creating scales, we use the factor loadings as standardized regression coefficients. Each scale has an approximate average of 0. Respondents with greater values for the underlying questions (e.g., stronger agreement with opinion questions, a higher ranking of an item as a goal and so on) will tend toward positive scale scores, whereas respondents with lower underlying values will tend toward negative scores.

Ordinal Logic Regression

To enable regression modeling, we code a company's changes since the passage of the ACA in terms of its commitment to a specific policy, where increasing or enhancing a policy represents the highest level of commitment (and assigned a value of 4 out of 4), having a policy but leaving it unchanged since the passage of the ACA represents the next-highest level (3 out of 4) and reducing or eliminating a policy represents the second-lowest level of commitment (2 out of 4). The lowest level of commitment is never having a policy and having no plans to adopt one.

We code companies' plans over the next three years as conventional 5-point Likert scales, where "very unlikely" is coded as 1 and "very likely" is coded as 5.

We use ordinal logistic regression to model levels of commitment to specific policies or the likelihood of taking an action over the next three years. For a dependent variable with sequential categories (i.e., the magnitude of the scores assigned to each category are irrelevant, but the higher-value scores correspond to logically "higher" outcomes), ordinal logistic regression estimates the log of the odds that a response fell into a higher category relative to a lower category. The odds are then converted to calculate the proportions of respondents in each category on average of all the control variables. For more detail, refer to J. Scott Long and Jeremy Freese, *Regression Models for Categorical Dependent Variables Using Stata*, 3rd ed., College Station, TX: Stata Press.

Our regression models control for the following company characteristics:

- Revenues*
- Number of employees*
- Percentage of full-time employees*
- Percentage unionized*
- Annual employee separation*
- Compensation relative to industry average*
- Industry: manufacturing; finance, insurance and real estate; healthcare; services; all others combined
- Ownership: for-profit, public; for-profit, private; nonprofit and all others
- Finance function's role in decision making: approves a budget, but other departments set priorities and make decisions about benefits and policies; participates in decision-making more or less as an equal partner with other functions; makes all or most of the decisions about benefits and policies; plays little or no role
- Sample source: CFO Research list and IBI member list

* For ease of computation, these variables are treated as interval scales.

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Founded in 1995, the **Integrated Benefits Institute** (IBI) is a national, not-for-profit research and educational organization focused on workforce health and productivity. IBI provides data, research, tools and engagement opportunities to help business leaders make sound investments in their employees' health.

IBI's mission, program and activities are determined by its member organizations, more than 90% of which are employers managing the health and productivity of their own workforces. IBI's membership also includes consultants, insurers, healthcare providers, third-party administrators, pharmaceutical companies, disease management firms and others having an interest in health, well-being, productivity and absence/disability management.

For more information about IBI's programs and membership, go to **IBIWEB.ORG**.