CHAPTER 11

LEADING CHANGE

Those who have had the most success transforming benefits for their organizations have realized that great plan design alone is not enough. That is, they understand that even improvements require leadership to bring everyone along, whether they are rank and file or senior executives. In this chapter, we outlined 10 steps that ensure success.

Step 1: Help Employers Treat Employees Like Their Most Valuable Asset

Even if they think they do, most employers do not truly act on the phrase "employees are our most valuable asset" because they aren't actually aware of what their employees want most. For example, some CEOs assume they need to offer higher salaries and more vacation days to make workers feel valuable, when employees care more about something that's not quite as glamorous.

What employees often want is better health benefits.[106] And no, giving them that is not as simple as tacking on an expensive and ineffective workplace wellness program.[107]

One irony is that despite being in an organization of fewer than 10 people, my benefits package is better than when I was at Microsoft during their heyday, when I did not pay a dime for

anything. Why? Back then, Microsoft did not guide me to high-value, unconflicted primary care; I was left to figure it out on my own. Like most people, I was not aware of how the big health system in town was – and is – a haven for overtreatment[108] that puts people in harm's way. Now I have a primary care doctor who will guide me to a high-value medical center that won't perform unnecessary, inefficient procedures; one example is the well-regarded Virginia Mason Medical Center in Seattle,[109] which realized that 90% of its spinal procedures didn't help and that physical therapy would have been more beneficial–and changed accordingly.

Designing health plans that cover providers like these comes with challenges, but the rewards are immense. It starts with employers switching from a carrier-controlled, fully-insured plan purchased from a mainstream insurance carrier to a self-insured plan[110] where they pay directly for their employees' medical expenses. (The fact is they were already pre-paying for care but also for a boatload of bureaucracy). Being self-insured, however, will not generate maximum value if employers continue to use the same carrier-provided tools that have created some of the lowest Net Promoter Scores[111] – measures of customer satisfaction – in any industry. These status quo approaches have put employees in harm's way medically and financially, and they persist today.[112]

When employers shed old-line approaches and their benefits advisors craft plans centered around value-based primary care – where physicians are paid for positive outcomes as opposed to being paid for every service or test they administer (fee-for-service care) – they can see tremendous improvements in employee satisfaction and a 20% or more reduction in health care costs. Forward-looking employers are reinvesting those previously squandered dollars, what we call the Health Rosetta Dividend, into what truly drives health outcomes.

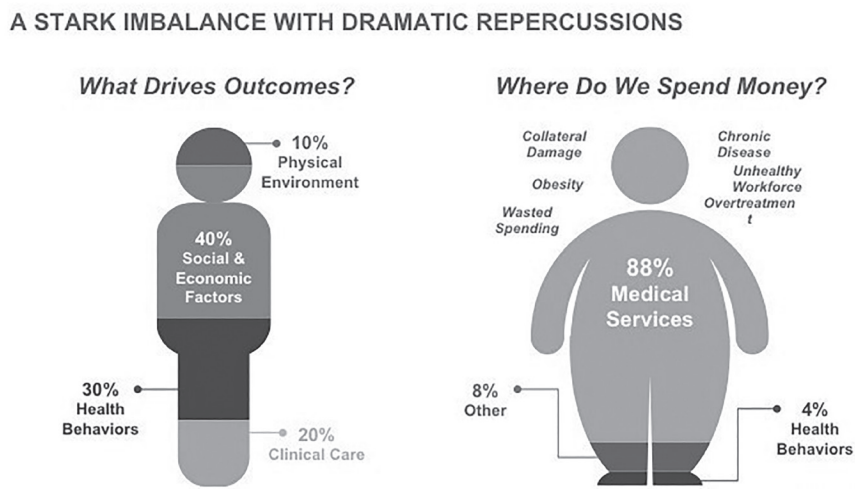

Figure 12: Image Credit: Cascadia Capital LLC[113]

This approach keeps employees happy and healthy; allows employers to invest in the local community or grow their business; and also helps solves a multitude of other public health issues like the opioid crisis.[114] And yet, despite these many benefits, there's still an abundance of employers who haven't made the switch.

I understand that there's comfort in the status quo, even if we know deep down that it is not the best. It is basic human nature to be fearful of the great unknown and not want to take on the work that usually accompanies change. Still, this is not a good enough justification for avoiding it. Change is necessary for any organization to thrive, and we should never settle for something that's "just OK," especially when lives are concerned.

The good news is that I have seen the light at the end of the tunnel. I know that change can happen because I have worked with employers who have chosen the road less traveled and truly demonstrated that their employees are their most valuable asset. (It also does not hurt that their businesses are excelling as a result.)[115] Even better, I am confident other employers can get there too, provided they have the right benefits advisor, take the right approach to leading change, and create a sense of urgency early.

Step 2: Create a Sense of Urgency – Why Change Now?

An unfortunate example of status quo health care was brought to light recently by *LA Times* reporter Noam Levey.[116] Levey helped tell the story of middle-class families who are being crushed by ever-increasing out-of-pocket costs – costs their employers are passing along in a desperate attempt to keep down monthly premiums.

And yet, for every story like this that emerges, there are still millions of people who perceive their current circumstances to be good enough, often because they haven't had a recent medical event and thus haven't experienced how their health plan lets the health care industry extract as much money as possible out of their pockets. They don't want to see changes in their employer-sponsored insurance plans because they've been conditioned to understand that any change will likely make things worse; legacy insurance carriers are good at using FUD tactics[117] to keep their accounts.

The COVID-19 pandemic has also highlighted the failings of and collateral damage from status quo approaches to health plans. As outlined earlier in the book, the pandemic was made worse by a hospital-centric system that devastated the most effective methods of slowing pandemics – strong public health departments and proper primary care. Since most Americans don't have ongoing relationships with a primary care physician anymore, they end up in the hospital where there is already infection and potentially an overburdened facility.

That is why it's crucial for benefits advisors to help employers take employees through the following stages:

Request Suspension of Disbelief

First, employers must ask that individuals suspend their current beliefs about health care finance and delivery as simply

not true, backing this up with a data-driven explanation of how health care actually works and its impact on their well-being, and, critically, assuring them that there's already a broadly proven solution – one that will reward their patience and cooperation.

Outline Dysfunction

People will be most moved when they stop thinking of health care as the medium through which their ailments are (hopefully) cured and start viewing it as a poorly run business instead. In effect, it is by far the worst-performing supply chain partner for most organizations. After all, in what other sector would we accept paying more and getting less every year? Learning that their hard-earned, high-deductible dollars feed into a system that's one-third[118] to one-half[119] waste – that adds no value and is often harmful – will get their interest, believe me. Showing them how the current fee-for-service system is rigged against them[120] and is unsustainable in the long-term will light a fire.

Employers should remind workers that the U.S. is the undisputed world leader in medical-bill-driven bankruptcy – the No. 1 cause of bankruptcy for Americans. What is worse, 70% of those people had health insurance. This is because status quo health plans have used a blame-the-victim approach to health plan design.

Soon, employees will start to connect the dots. That time they got a surprise bill in the mail and weren't sure why a visit to an in-network hospital left them with a thousand-dollar balance? How difficult it always seems to be to make a primary care appointment? And how once they get in, tests are done but they are not cured and must go back later? When the inefficiencies and lack of transparency add up, everything will start making sense.

While those wheels are turning, benefits advisors can help employers really drive home their argument by reiterating the fact that they are all paying dearly for this very low-quality, high-cost care. Even worse, the money being spent is money coming out of wages; since 2008, employee family premiums have increased

by 55%, two times faster than wages and three times faster than inflation, but doctors and nurses aren't seeing the increase in their own compensation.[121] The median household spends more on hospitals – not health care overall, just hospitals – than on federal taxes. You might call this taxation without representation.

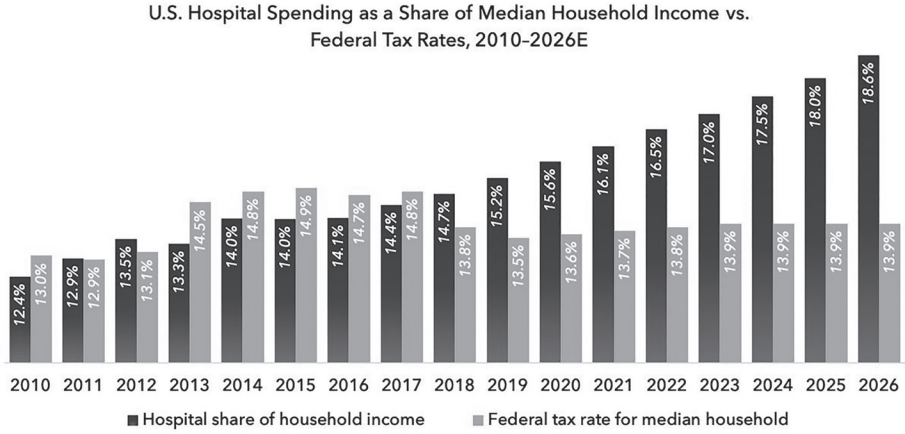

Figure 13: "In 2018, the Average Family Paid More to Hospitals than to the Federal Government in Taxes."[122]

Figure 14: Stock price history for publicly traded health insurance companies and S&P index, March 6, 2009 to April 14, 2015

Where have those hard-earned dollars gone then? The graphic above will give you a clue. That's stock growth that Jeff Bezos would be proud of.

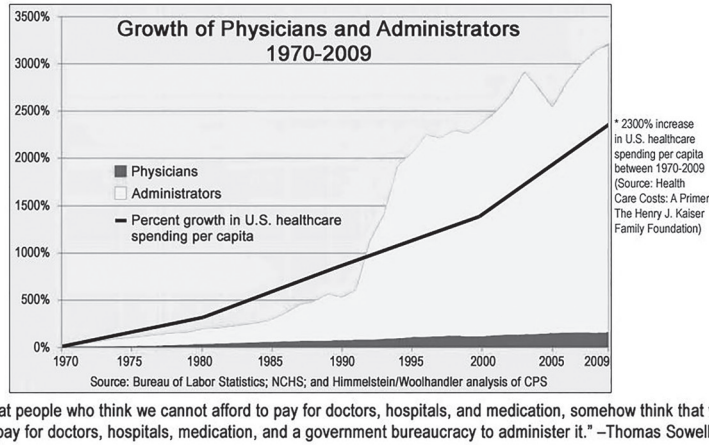

Figure 15: "Senator Sanders: No, Saving Hospitals Actually Isn't a Solution to Our Broken Healthcare System."[123]

Employees need to understand the wealth transfer from the working and middle class to a wildly underperforming health care system. We spend twice what most developed countries spend and have the worst health outcomes, so once again, where has all that money gone? The following two graphics start to explain it.

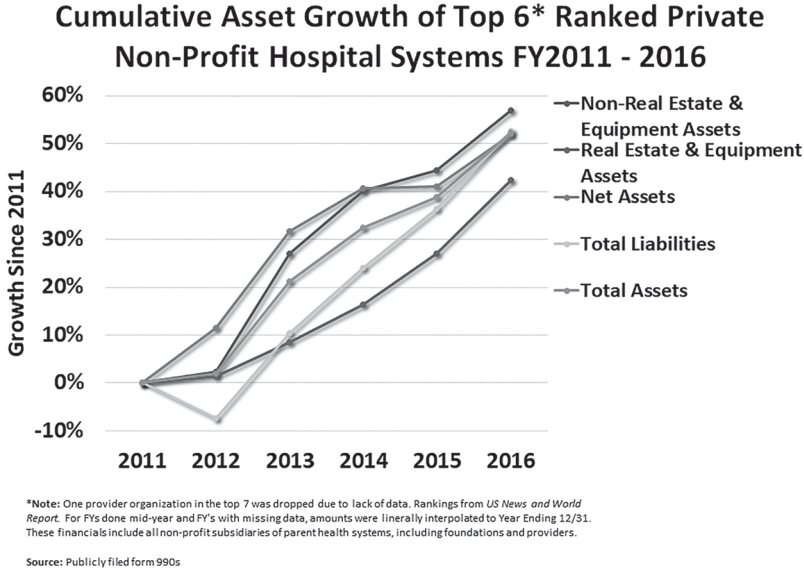

Figure 16: "Senator Sanders: No, Saving Hospitals Actually Isn't a Solution to Our Broken Healthcare System."

Note that the tax-exempt health systems not only charge an arm and a leg, they do not pay local or federal taxes: 7 of the 10 most profitable hospitals are so-called "nonprofits." Often profits are buried in more real estate to fuel their edifice complex, taking even more valuable real estate off local tax rolls. Meanwhile, the CEOs of these tax-exempt health systems are among the most highly compensated, demonstrating a complete disconnect between high pay and strong health outcomes.

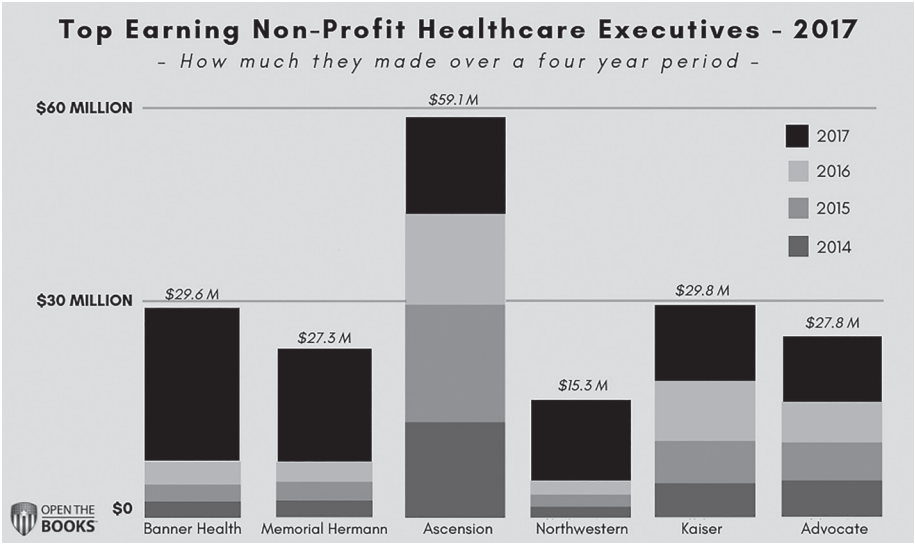

Figure 17: "Top U.S. 'Non-Profit' Hospitals & CEOs Are Racking Up Huge Profits."[124]

The other destination of 20 years' worth of lost wage increases for the working and middle class is in the pharmaceutical arena. Not to let the drug companies off the hook, but do employees know that eight of the Fortune 50 companies primary or most profitable business isn't from making drugs, but administering drug plans (e.g., distributors and PBMs)?

Make It Meaningful

Employees also need to understand the long-term effects of a standard health plan. That explanation starts with a description

of what care delivery looks like in the status quo fee-for-service care setting, where providers aren't held accountable for outcomes and where their health system often pushes them to order unnecessary and even harmful tests and procedures. To show them just how devastating this can be when replicated across the entire country, employers should make crystal clear the connection to today's opioid crisis – a self-inflicted wound by a wildly dysfunctional health care system paid for by dollars that should be in the employees' pocketbooks.

Especially if employees have children of their own, this example will really resonate. So many people have been personally touched by the opioid crisis, whether through a family member or friend. And now, history is repeating itself in the form of a dependence on and addiction to benzos like Xanax and Valium, with similarly deadly consequences being funded by your health plan dollars.

No one wants to be viewed as the generation that allowed the creation of another public health disaster, and when they understand that their company's old health plan is a key enabler of the opioid crisis, employees will find it easier to part ways with it. And that's how would-be change-makers get others on board. Knowledge is power and sharing knowledge is all it takes to get employees to realize that health care is expensive and inefficient – but that it does not have to be. Once that registers, benefits advisors and employers will be ready to move forward in their drive for better health benefits.

Step 3: Develop a Vision of Better Benefits

Every organization is unique, which means that the how and why of an employer's vision should be tailored to that organization's culture and circumstances.

However, it is not necessary to reinvent the wheel each time. Here are some visions that have been embraced by forward-looking organizations committed to turning the tide against health benefits that feel like health *detriments* due to mediocre outcomes,

poor consumer experience, and the crushing financial burden put on the working and middle class by status quo health plans.

The "Nuts and Bolts" Vision

The most common approach is to focus on the basics:

- Establish a vision for profitability and sustainability. Employers should stress that without change, the company will struggle – and that when the company struggles, so do its employees via reduced benefits, increased cost sharing, and flat wages.
- Focus on the fear of missing out (FOMO). Employers should tell a story, like the one in which a competing organization drives change, gains a market advantage, and puts their company in the hot seat. More and more organizations are realizing the benefit of the Health Rosetta Dividend, where money previously squandered on waste (e.g., overpricing, overtreatment, low-value care) can go to improved take-home pay, better benefits (e.g., paying for a college education), greatly improved retirement benefits, and company competitiveness.
- Focus on how being a smart consumer will help employees. Benefits advisors should help employers leverage tools like bundled surgery payments, affordable/transparent pharmacy benefits, and patient navigation/concierge services – and then incentivize employees to use these services by covering out-of-pocket expenses.
- Create a three-to-five year goal of having better, cheaper coverage. The first-year goal could be to reduce costs by 10% while implementing new, non-carrier programs for employees to use. Many such opportunities for improvement do not take a long time to implement, but it's critical to think in terms of three to five years. This helps filter out the onslaught of short-term oriented, not to mention ineffective solutions that traditional carriers propose.

- Employers should let everyone know that if the organization does nothing, there will be cuts, painting a picture that everyone will want to avoid.

The 11-Star Vision

Another approach comes from LinkedIn founder Reid Hoffman's interview[125] with Airbnb co-founder Brian Chesky about how they overcame conventional thinking with an 11-star system. It's a process in which individuals rate their experience beyond the conventional 5-star system.

Chesky describes the difference:

"A 5-star experience is: You knock on the door, they open the door, they let you in. Great. That's not a big deal. You're not going to tell every friend about it. You might say, 'I used Airbnb. It worked.' So we thought, 'What would a 6-star experience be?'

A 6-star experience: You knock on the door; the host opens and shows you around. On the table would be a welcome gift. It would be a bottle of wine, maybe some candy. You'd open the fridge. There's water. You go to the bathroom, there's toiletries. The whole thing is great. That's a 6-star experience. You'd say, 'Wow, I love this more than a hotel. I'm definitely going to use Airbnb again. It worked. Better than I expected.'"

Maybe employers don't need to go up to 9, 10, or 11, but if they go through the exercise, there will be some sweet spot that's compelling. When the goal is compelling enough, there can be broad-based employee support and "out there" ideas can become feasible.

Even though the organization I co-founded has fewer than 10 employees, we already have a benefits plan better than virtually any employer in the country – large or small. However, we believe we must walk the talk and are striving for more.

For example, we hope all Health Rosetta-type plans can deliver an "11-star" experience in the future that includes these benefits:

- Employer provides health benefits with value-based primary care in a self-funded plan.
- No copays or deductibles for wise decisions.
- All savings go into enhanced pay and profit-sharing.
- Funded college and continuing education for employees and their children.
- 26 weeks of family leave for every seven years of service (can be used for maternity, paternity, family leave/bereavement and sabbatical).
- Free (or discounted) healthy meals provided seven days/week (e.g., the Acme Box).

Knowing that we are striving toward these goals creates a shared vision that guides our efforts. It may take a while to achieve our 11-star vision, but it will help us overcome the inevitable speed bumps along the way.

The Community-Owned Health Plan Vision

Community-minded employers, often referred to as those that adhere to Conscious Capitalism principles,[126] recognize that their community is a key stakeholder in their business and that most health outcomes are determined by what happens in their community – not in hospitals or even the workplace. IBM[127] and Rosen Hotels & Resorts are two exemplary organizations that have acted on this connection. (See case studies.)

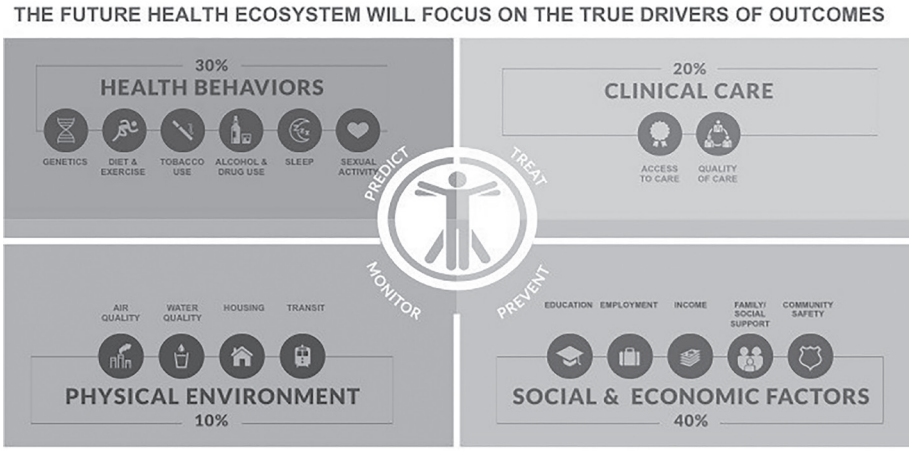

Figure 18: Image Credit: Cascadia Capital, LLC

Not unlike what happened with electrification and telecommunications cooperatives, health plan choices are limited throughout rural America, and the big incumbents either do not serve them at all or serve them very poorly. The good news is that political leaders are eager for solutions and because incumbents do not pay much attention to those markets, innovation can be more unfettered. A great example of this is in Alaska, where the Southcentral Foundation turned a once-failing health care system 90% funded by government programs into a two-time Malcolm Baldrige Award winner owned by the community. They call their model of care the Nuka model.[128] "Nuka" is an Alaska Native word that means "strong, giant structures and living things."

A core tenet of the Nuka model is that individuals formerly known as patients are referred to as "customer-owners" as they have a role in health care's governance and direction. From a clinical vantage point, despite a vast coverage area and significant disease burden, they have seen a 40% reduction in ER visits and a 36% drop in hospital stays while achieving 97% customer-owner satisfaction and 95% employee satisfaction. They're also in the 75th to 90th percentile on many health quality measures. No flash-in-the-pan, this has been consistently achieved for over a decade. The message here: One-size-fits-all approaches from

remote, out-of-town headquarters rarely reflect the unique needs and priorities of a community. Instead, when health care dollars are spent locally, all parties can benefit.

Models such as the Nuka model or what's happening in Jönköping, Sweden,[129] are helping us develop our own 11-star vision, which includes health and well-being initiatives that recognize that at least 80% of health outcomes are driven by nonclinical factors. When people see a benefit plan change as a key building block for something much bigger, they are inspired to move further, faster.

Increasingly, companies are driving social change.[130] It's remarkable when one company's benefits plan can catalyze a 62% reduction in crime and a doubling of high school graduation rates.[131] Imagine the impact of several companies in the same community teaming up to solve other challenging, but solvable, problems.

Developing a vision for better health care is a critical step in benefits advisors' and employers' pursuit of change, and fortunately, they have great options. Only with a clear idea of what is ahead will employees see that hard work has a purpose and stay on the path.

Step 4: Secure Grassroots Support

Given the previous three steps, most employees will agree that a major benefits change is critical. Less obvious to employers, though, is how important it is to generate support from the lower levels of the organization. Often, it is people without any traditional, org-chart-based status who can set the tone for how a benefits program is received.

These are some things organization leaders, together with their benefits advisors, should consider when building an alliance for change:

Start Quietly to Build Success

In the words of one benefits consultant, "I prefer to fight my battles as a ninja in the night rather than a soldier on the field."

Providing proper primary care is a great place to start helping employees "see and believe" in the health plan transformation. Even though primary care itself is not a high-cost area, it is the linchpin for success with the other key areas of a plan – transparent open networks, procedures to treat complex medical conditions, and pharmacy benefits.

People who have one trust their primary care physician (PCP), especially if that person is employed by a health system that allows them to practice in the best interests of patients. Trust in PCPs far exceeds trust in health insurance carriers or company leaders.

Build from the "Bottom"

A good place for benefits advisors and employers to start gathering input is in focus groups and wellness committees that include people from all areas of the company – especially some of the complainers, high-health plan utilizers, and people who have been very unhappy with the current health plan. These individuals can also be the beta testers for any new plan.

When such individuals are given access to a value-based, direct primary care physician, it may turn out that lack of adherence to care plans or hypochondria has been part of the problem. Because status quo health plans do not serve these individuals well, they quickly see the great opportunity for improvement. In the beta test, these previously "out of control" patients get the guidance and care they need, and it takes extraordinarily little time to see costs go down along with ER visits and hospitalizations.

An example: One organization had an individual who was having post-bariatric surgery complications that were costing the organization $16,000 every month. By enrolling them with a value-based primary care doctor, the costs (other than the less than $100/month fee for VBPC) immediately dropped to zero. While examples aren't always this dramatic in terms of cost, it is relatively easy to get these types of wins that set the stage for broader rollout success.

If a benefits advisor or employer can show the lowest-paid part of the workforce how to use the plan in a way that saves them and the company money, other excuses about not being able or willing to change seem to diminish. Millennials are especially important to include because their focus on convenience, transparency, and safety – all items the status quo health care system has failed to achieve – often makes them early adopters of new products/ventures.

The initial rollout also sets the stage for a broader rollout where the primary care physician(s) goes onsite during open enrollment. The initial intake should be an hour long and positioned as an executive wellness visit – the same program executives have already received. Having members feel they are getting white-glove treatment goes a long way toward getting broad-based buy-in.

During these initial encounters, the physician(s) should also set up a mobile app that allows members to text them securely and easily. People will be blown away by how accessible their doctor is compared to the past, particularly people who have chronic health problems and think of a doctor visit as the equivalent of going to the principal's office. Fingerwagging doesn't work, as the *New York Times* pointed out recently.[132]

Educate Change Agents.

Once employers have demonstrated to a diverse subset of employees the positive impact of their proposed health plan changes, the next step is to deepen that education. They should communicate the most important information first, including the profits of the hospitals in their market, the hospitals' CEO pay (especially those of tax-exempt organizations who've transferred tax burden onto others in the community), and the value of the real estate owned by the hospital within the community. This can be done by pulling the numbers from county auditor websites in communities where hospitals have a significant presence. Each parcel listing shows taxable value – usually lower than market

rate. In some communities, those organizations would be paying more than $20 million per year if they were not tax exempt.

Once they make the connections, employees can begin to see that the choice is between continuing to fuel the massive salaries of tax-exempt executives or finally getting those long-overdue raises.

Next, employers should walk employees through what three to five years down the road will look like if things do not change – the vision to be avoided.

By giving employees – especially lower-level ones that are often overlooked and perhaps most disgruntled by the current health plan – the opportunity to see what positive change will look like, an organization can better position itself to move forward. How, exactly? By using short-term wins to create momentum.

Step 5: Sustain Change and Encourage Progress Using Short-Term Wins

At this point, benefits advisors and employers will already have gotten an alliance of employees on board and be ready to roll out their vision for an improved health benefits transformation. Here, it is important to keep the momentum going, fueling the fire for change and propelling people forward.

The best way to do that is by identifying, sharing, and celebrating short-term wins, which, as Dr. John Kotter points out, should be visible and tangible, unambiguous, and clearly related to the change effort.

Dr. Kotter's work has informed a lot of my thinking in this area. His 8-Step Process for Leading Change[133] is an excellent framework. For example, as it applies here, a short-term win could be either qualitative in the form of an employee success story, or quantitative in the form of black-and-white cost savings.

The following are qualitative examples of short-term wins celebrated after implementing Health Rosetta-type plans:

- More people enrolling in, and taking advantage of, direct primary care (DPC). Despite the concept being foreign to

the average employee, we have seen multiple organizations achieve over 50% enrollment in direct primary care models that provide an immediate accessibility advantage.
- Praise for care navigators, often nurses. Typically, navigators are not well received when there is not proper primary care available. But when they help families with guidance on treatment, finding a center of excellence, or obtaining diabetes supplies in a more affordable and convenient way, word will get around.
- The city of Tyler, Texas has countless qualitative examples of short-term wins due to a wise onboarding program with a local DPC organization. Formerly at-risk patients, men particularly, were astonished to find they had a mobile app where they could easily reach their DPC doctor. And starting with small steps, these patients – many already on multiple medications – were able to turn things around on issues like blood pressure, diabetes, and back pain. They were able to get off medications that were costing them financially and physically, and they now consider the doctors their friends and allies. (Many of their health care costs also dropped.)

And here are some quantitative examples of short-term wins:

- Despite budget constraints, one municipality was able to put $500 into everyone's HRA-VEBA accounts – the public-sector equivalent of a health savings account (HSA).
- A private sector employer uncovered significant pharmacy rebates that had not been returned to the plan sponsor – until now. This turned what would have been an okay year into a great year for the employer and its employees.
- An employee who had previously walked into the CEO's office in tears because she was taking a $40,000/year medication the old plan did not cover was now able to get it for free under the new plan. Half of her income had been

going towards paying for this medication, exhausting her savings; the new plan was able to navigate the opportunities to source this medication at no cost to the member and at a fraction of the cost for the health plan.
- Many Health Rosetta-type plans remove all copays and deductibles if individuals make wise choices such as calling the concierge line to find high-value care.

Wins like these meet Dr. Kotter's three criteria. They are benefits that employees can see, cannot deny, and can easily relate back to the change effort. They validate the vision, along with everyone's patience and hard work.

When correctly leveraged, they can also be used to drive even greater change: to silence disbelievers; provide feedback to benefits advisors and employers on what's working well, what isn't, and what can be done even better; and keep everyone on track and moving forward.

However, employers cannot just hope for short-term wins to pop up. They must actively look for ways to obtain clear health improvements and reward the people involved with recognition and even money. I know of one organization that rewarded employees for finding billing errors by passing along 20% of the savings. Early on, one employee found a six-figure billing error that they prevented the employer from paying, and it boosted the employee's annual income by over 50% that year. The employer called a company meeting and presented the individual with a giant novelty check, unleashing a small army of people reviewing hospital bills, which are often riddled with errors and duplicate charges.

At the end of the day, short-term wins have a gigantic impact on long-term success.

Step 6: Be on the Lookout for Barriers to Change

Unfortunately, though organizational change will generate moments worth celebrating, it may also throw up some roadblocks

along the way. These barriers can be broadly grouped into the following categories: structural, psychological, and cultural.[134]

In the context of a health benefits transformation, here is how each of these might manifest:

Structural Barriers

One potential barrier could be a disagreement between the finance and HR departments over what happens with the savings that are achieved. To prevent this conflict, there should be upfront agreement between employer and employees on how to use what we call the Health Rosetta Dividend: previously squandered dollars that can be used for higher and better purposes. Will that dividend be allocated to profit-sharing or bonuses, R&D, or other enhanced benefits such as paying for education?

Psychological Barriers

Many people have been trained to believe that spending more on care is synonymous with receiving better care, since that is usually the case in other areas of life. If you spend more on a car, you usually get a nicer car. Not so in health care.

If that mentality does not give way before the new health plan, employees may refuse to believe that the benefits change is legitimate, assuming that since their employer is paying less, they are getting less. Employees may enter relationships with the new higher-quality, lower-cost physicians with reluctance, and may even refuse to see them, choosing to stick with their old high-cost, low-quality physicians.

Cultural Barriers

When multiple employees adopt this mindset, it can quickly become a cultural barrier. Attitudes can be contagious, and if a handful of dissenters plant seeds of negativity among their fellow employees, resistance can easily sprout up.

Overcoming a cultural barrier like this is absolutely essential because a value-based health plan only works if everyone does their fair share. If employees do not take advantage of all that the new health plan has to offer, it will not improve outcomes or reduce health care costs.

As you can see, structural, psychological, and cultural barriers often overlap, which also means they can be solved by deploying some of the same strategies. One is to reiterate some of those short-term wins described in Step 5. Step 7 spells out some others.

Step 7: Break Down Change Barriers

People say change is the only constant in life, and barriers almost always come along with it. Barriers, however, can be overcome – assuming you are able to recognize them. Employers need to know how each barrier might manifest in their organization to anticipate and forestall them. Benefits advisors can help on both fronts, specifically by doing the following:

Talking to Both Supporters and Resisters

In Step 4, we saw how resisters can actually work in employers' favor. Here, the same idea applies. Instead of fighting the people that are not for change, benefits advisors should encourage employers to embrace and engage with them.

In fact, employers should communicate with both supporters and resisters early on and often, being consistently truthful, straightforward, and timely. They should use social proof, storytelling, and "what if" scenarios in company-wide emails, intranets, and face-to-face and town hall meetings that allow employees to ask questions and stay informed. They should use a blend of formal and informal communication to ensure that all employees receive the news about the change in some way or another, always referring to their vision and reiterating why change is for the better.

If HR managers are hesitant because they do not want to upset the workforce, they should also be given the opportunity to experience the new benefits program in a beta test. HR managers usually love seeing employees being better supported in new plans via nurse navigators/patient advocates, unlike status quo plans that often leave employees adrift. Once they experience an advocate who is truly on their side, they will quickly abandon their previous resistance.

Thoroughly Engaging Everyone

Talking to employees is important, but just as important is to listen, listen, listen. When transforming their health plan, benefits advisors and employers should engage with employees by asking them probing questions like "Is the new health plan working? What can we do to make it work better? Do you have any questions or concerns?"

Then, benefits advisors and employers need to respond. If feedback is going to be collected, it needs to be read and acted on – perhaps via relevant plan changes – to show employees their ideas and concerns are being heard.

Wise employers will take things a step further by trying to genuinely understand employees' concerns. Instead of only looking at issues on the surface, they should realize that there could be many different reasons for opposition, depending on the person. This information can be especially useful in helping tailor appropriate solutions to work out these problems.

Implementing Change in Several Stages

Change does not happen instantaneously, but it does not and should not have to happen strictly in terms of annual cycles either. Moving too soon or too fast can create resistance; moving too slow and you will fail to build momentum.

Despite their sense of urgency, and along with envisioning change in terms of three to five years, they should set the founda-

tion for change 6-12 months before most employees actually feel that it's happening.

For example, focus groups where employees are asked about the current health plan (What do they like/dislike? What would they like to see?) should be held outside of the normal "benefits season." Then, when the new plan is rolled out, employees can be reminded of the feedback they gave and see how benefits advisors and employers responded to their input. From there, leaders need to develop a roadmap that includes progress checks and course corrections, and opportunities for those confidence-building short-term wins.

Keep Communicating Change

By now, it should be clear just how critical communication is in properly initiating and effectively carrying out change. Benefits advisors and employers must explicitly tell employees what is going on, using the tactics previously laid out. In this way, they can avoid information vacuums and ensure that employees – even the ones who were initially opposed – get on board with the vision, goals, and expectations for what needs to happen and why.

Step 8: Communicate More Than You Think You Need To

George Bernard Shaw once said, "The single biggest problem in communication is the illusion that it has taken place."

It's easy for employers to assume that employees are hanging on their every word – especially when they're making a monumental transition to a higher-quality, lower-cost health plan that benefits them and the organization. But the reality is that a lot can get lost in translation, especially when information is detail-heavy, as it so often is with health care coverage.

Not having a thorough understanding of the health plan, or why a new one is even necessary, can result in employees

making high-impact mistakes, ones that could put their own physical and financial well-being on the line. When employees suffer, employers suffer, and this is just one of the reasons why regular communication is critical.

This can be a challenge for HR and benefits advisors. Odds are, they have invested substantial time on the rollout of the new health plan, much of it dealing with technical implementation matters rather than continuous communication. If that is the case, if employees don't know how or why they have to use the new health plan, all that effort could be for naught.

To avoid this, it is critical that benefits advisors and employers revisit their initial message. They should frequently check in with employees to see how things are going. If employees are not able to reiterate why the shift is happening, or if the reasons vary from employee to employee, this could be an indicator that early communication attempts were either ineffective or forgotten.

At this point, benefits advisors and employers should set aside time to recirculate their core messages: why the change is happening, who will benefit from it, when it will happen, what those involved have to do and how they have to do it. It is best to keep these messages short and to the point. Brevity will help ensure they are stored in the memory bank, so when employers ask employees the same questions a few weeks later, the answers should be on point and consistent from one person to the next.

These messages should also be relayed in multiple ways. A face-to-face meeting is a good start, made better when it is followed up with a handout displaying each point and/or an email for individuals to reference later.

Everyone in and connected to the organization – including spouses and other co-beneficiaries – should participate in these discussions and have a clear understanding of the information. Among other things, this will remind employees that this is a group effort, which will only strengthen the alliance for change.

Here is a useful checklist that covers these points:

- Provide a summary of the health plan and vision that is compelling and impossible to misunderstand.
- Include spouses and significant others in communication outreach plans.
- Curate the first patient experience through value-based primary care to bring the communication of the vision to life.
- Create a 12-month editorial calendar of communication that outlines what will be communicated across various channels (email, in-person meetings, posters, etc.).
- Ensure all employee segments, at all levels of the organization, are part of initial and ongoing communications.
- Incorporate feedback loops from employees and spouses as part of the regular cadence of implementation.
- Include primary care partners in member communication.

Step 9: Consolidate Improvements and Build on Gains

Until the new health plan is fully embedded into the organization, the risk of regression remains. Benefits advisors and employers know what kind of barriers to look out for and how to overcome them – especially through communication – but the next step is to really cement progress by consolidating gains and implementing further transformation.

A good indicator that this has happened is when stakeholders, like employees, begin to share the passion. When Jane in IT has a surgery with no copays or deductibles, or when John in Operations can access his care team 24/7, word-of-mouth buzz begins.

Of course, achieving this is easier said than done, and there will inevitably be setbacks along the way. However, there are ways to make sure progress is not undone by complacency.

The first is to always be on the lookout for naysayers. It is quite possible that someone is not thrilled by the health benefits

transformation, but – at least for the time being – has decided to go along with it. If their doubts or negative thoughts go on unaddressed, they could quickly fester and spread, waiting to pop up in full vengeance mode when opportunity strikes, as when someone who shares their sentiments finally speaks up.

A small spat of resistance is easier to overcome than an explosion. So, even when things seem to be going well, employers should be watchful. They should never stop asking for feedback, and never stop reiterating important information.

Sometimes individuals will need a little more encouragement. Leaders can offer them just that, through mid-cycle benefits improvement that add even more value to the health plan. Not all of these must be expensive. Here are some examples:

- One employer made free diapers and wipes available for two years for parents choosing the high-value birthing center in their community. Note: The plan was restricted from excluding the price-gouging behemoth health system, so they had to find a creative workaround.
- A professional services firm recognized that the best bill reviewer is the patient and their family. Any plan member who found a billing error the employer would have had to pay received a bonus equal to 20% of the savings. As described earlier, one individual found a $200,000 billing error that the organization was about to pay, and as a result, they received a check for $40,000. After that, no one could ignore how out-of-control many hospital billing practices are.
- A manufacturer added a new Transparent Open Network (TON) benefit and educated employees about how it worked. The contrast shocked them. They saw that most traditional insurers include a PPO discount that does not actually reduce prices, distribute Explanations of Benefits that are incomprehensible, and threaten to send accounts to collections. With the TON, participants started small, using it for just labs and imaging, but eventually saw

that the biggest savings came from surgeries; Before, they would have had a $2,500 out-of-pocket cost, but with the TON, they had zero.
- A large retailer rolled out a cancer-specific concierge service that helped members navigate this difficult treatment and recovery process. With reduced financial and clinical anxiety, these cancer patients had improved health outcomes and significantly lower costs.
- An auto dealer lowered costs and gave employees a month without premiums – an amazing deal that had other auto dealers clamoring for the same success after the story got out.

The lesson: It pays to be proactive and always striving to provide more and better if you want the "new way of doing things" to become the "way we do things around here."

Step 10: Anchor Change into Culture

Cementing change into the culture and preventing the organization from backsliding will require different approaches from one organization to the next, but there are some strategies that consistently work well, including these:

- Discussing the superior results produced by the new benefits approach on a regular basis, clearly explaining the improvement to all stakeholders.
- Incorporating regular updates on health plan progress and setbacks into executive meetings at the highest levels, as well as into leadership and team development meetings.
- Identifying the norms and values that must change to support the new approach.
- Modifying reward programs to align with those new norms and values.
- Counseling, reassigning, or removing employees and managers who are barriers to change and hiring those

whose values and skills match the new norms and values.
- Incorporating education on the new health plan, norms, and values into the onboarding process.
- Supplementing training and development activities to include the skills and competencies required of the new health plan.
- Modifying organizational processes and vendor agreements to align with new norms and values.

These may seem relatively easy to carry out, but they cannot be taken lightly. Culture takes time to develop, and it is only through the consistent execution of these steps that a new culture can take shape and become stronger.

"Time" is a key word here. If employers want to keep newly formed attitudes from fading away, they must accept the fact that they are in this for the long haul. Their actions today, tomorrow, and for the foreseeable future should always be in line with the new company culture, and they should always be working to reinforce it.

Here are a few examples of how employers are doing so:

- One organization publicizes all the money it saves through employee newsletters, posters around the office, monthly savings reports, etc. At the end of the year, it hosts a big party to announce how much the organization saved collectively and highlight how that is going to be reinvested in the business and employees.
- One benefits advisor stresses that all employees have an equity role in the performance of the company, and that every dollar spent on health care is a dollar not spent on their wages or pensions. This approach consistently provides validation and increases employee buy-in.
- Some employers create different contests to hammer home new processes and procedures, bringing some fun into what might otherwise be a boring and tedious information dump.

Key Takeaways and Things to Think About:

- Employers should acknowledge that employees are their most valuable asset and treat them as such. That does not mean tacking on supplemental benefits of low-value, like wellness programs, but designing a health plan that prioritizes value-based primary care.
- Once they understand that, they need to add fuel to the fire by creating a sense of urgency in doing these three things: requesting suspension of disbelief, outlining dysfunction, and making the change effort meaningful by driving home the long-lasting, negative impact of the status quo.
- After the momentum is there, it is essential to have a clear vision on which those undergoing the change can set their sights, based on the organization's own culture/ circumstances. Common vision-setting strategies include the "Nuts and Bolts" Vision, the 11-Star Vision, and the Community-Owned Health Plan Vision.
- Securing grassroots support is the next step. That means starting quietly to build success by having a select few individuals see and experience the new health plan; building from the "bottom" to ensure individuals from each level of the organization are engaged, and educating change agents.
- After the new health plan has been implemented, it is important to sustain change and encourage progress using short-term wins – being on the lookout for and celebrating both the quantitative and qualitative successes the new health plan delivers.
- There will always be pockets of negativity. Here is where leaders should search for signs of structural barriers, psychological barriers, and cultural barriers.
- Leaders must eliminate barriers they identify by talking to both supporters and resisters, thoroughly engaging everyone, implementing change in several stages, and continually communicating change.

- Leaders should always communicate more than they think they need to, checking in on comprehension by asking individuals to explain in their own words what is going on, and revisiting and redistributing the initial messages in various formats – email, posters, in-person meetings, etc.
- In the later stages of the transformation, leaders should still be on the lookout for naysayers, continue to consolidate improvements and build on existing gains, perhaps by making mid-cycle benefits improvements.
- Finally, leaders must make sure they anchor change into organizational culture, or all their efforts will be for naught. That means incorporating health plan values into company values, only hiring and retaining individuals whose skills and attitudes are in line with those new values and making health plan updates/achievements a regular part of the organization's routine.

Additional Background and Resources:

- You Run a Health Care Business Whether You Like It or Not -https://bit.ly/runhcbiz
- 7 Habits of Highly Effective Benefits Professionals -https://bit.ly/benefits7habits