Employee Health Benefit Redesign at the Academic Health Center: A Case Study

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Abstract

The rapidly escalating cost of health care, including the cost of providing health care benefits, is a significant concern for many employers. In this article, the authors examine a case study of an academic health center that undertook a complete redesign of its health benefit structure to control rising costs, encourage use of its own provider network, and support employee wellness. With the implementation in 2006 of a high-deductible health plan combined with health reimbursement arrangements and wellness incentives, the Penn State Hershey Medical Center (PSHMC) was able to realize significant cost savings and increase use of its own network while maintaining a high level of employee satisfaction. By contracting with a single third-party administrator for its self-insured plan, PSHMC reduced its administrative costs and simplified benefit choices for employees. In addition, indexing employee costs to salary ensured that this change was equitable for all employees, and the shift to a consumer-driven health plan led to greater employee awareness of health care costs. The new health benefit plan's strong focus on employee wellness and preventive health has led to significant increases in the use of preventive health services, including health risk assessments, cancer screenings, and flu shots. PSHMC's experience demonstrates the importance of clear and ongoing communication with employees throughout—before, during, and even after—the process of health benefit redesign.

Rising health care costs are a common problem facing companies and individuals alike. Health care cost growth in the United States is in excess of both the overall inflation rate and the rate of growth of the gross domestic product; this excessive growth adversely affects the financial performance of U.S. companies.[1] Increasingly, employers that provide health benefits to their employees are redesigning health plans in ways that seek to control rising costs, shift more of the cost burden to employees, and increase employees' awareness of the true cost of health care.[2–4] Often referred to as consumer-driven plans, high-deductible health plans (HDHPs) are frequently coupled with health savings accounts (HSAs) or health reimbursement arrangements (HRAs) that give the employees who are covered under the plan more control over and responsibility for their health care expenditures. With consumer-driven plans, employees can use either an HSA, a tax-advantaged medical savings account to which both the employer and employee can contribute, or an HRA, which is similar but solely employer-funded, to pay for qualified medical expenses. The trend toward adopting HDHPs and HRAs or HSAs—driven, at least in part, by the economic downturn—has been dramatic: Enrollment in HDHPs has increased from 8% in 2009 to 13% in 2010.[2] Adopting such plans is one option that may potentially offer substantial relief from the escalating cost of providing health care benefits. In a related trend, many employers are beginning to place an increased emphasis on employee wellness by creating incentives for healthy behaviors and preventive care in an effort to reduce health care costs and enhance employee morale and productivity.

Academic health centers (AHCs) are not immune to these trends. Penn State Hershey Medical Center (PSHMC) has dramatically restructured its employee health care benefits to control costs, encourage the use of PSHMC providers and services, and promote wellness. PSHMC is an AHC in south central Pennsylvania encompassing a medical school, teaching hospitals, health system, a faculty medical group practice, and outpatient clinics with more than 9,000 full-time and part-time employees and over $1.5 billion in annual revenue. Between the years 2000 and 2005, PSHMC leaders observed that the vast organization's health care costs were rising at double-digit rates that were not tenable over the long term. This rate of increase was especially problematic because PSHMC was a self-insured entity (barring stop-loss coverage, which is purchased by self-insured employers to cover losses if claims exceed a predefined threshold) and was therefore paying higher-than-anticipated rates for medical and prescription coverage. This increase in costs also meant annually rising employee contribution rates.

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Knowing that the continually rising cost of coverage was not sustainable, in 2005 PSHMC leadership began planning a transformational change to control escalating health care costs for both the employer and employees, to promote long-term wellness in the employees and their dependents, and to create a culture of consumer accountability for health care decisions. The new plan centered around five main principles:

- Reducing the cost of providing health care benefits,
- Creating incentives to use the home network (PSHMC providers and clinical services),
- Encouraging preventive care and employee wellness,
- Beginning a long-term employee reeducation process around health risks and the social determinants of health, and
- Saving for future individual health care spending.

From the employer standpoint, the top priority was to reduce the cost of health care benefits through a combination of medical cost savings and reduction of administrative fees. Additionally, the organization viewed this change as transformational rather than incremental, and the leadership recognized the importance of communication and employee education throughout the process.

Designing a New Health Benefits Plan

As mentioned, in 2005, PSHMC began a redesign of its employee health benefits plan; leadership planned for full implementation to occur at the beginning of 2007. The health benefits plan in place through 2005 was a preferred provider organization (PPO) plan, available in two options (basic and premium). PSHMC offered both plans through three different carriers (Health America, Capital Blue Cross, and Highmark), and the cost to employees was similar across carriers. The premium PPO option charged higher premiums than the basic option, but it limited employees' out-of-pocket costs more. For in-network care, the premium PPO option covered most services in full, requiring co-pays for just some services, such as office visits; the basic PPO covered preventive services in full but imposed a 20% coinsurance penalty for other inpatient and outpatient services, up to an out-of-pocket maximum of $1,500 (for an individual) or $4,500 (for a family). Both options charged higher rates of coinsurance (30% with the premium and 40% with the basic option) for covered, out-of-network services. The premium option charged no deductible for in-network care, and the individual deductible for out-of-network care was $1,000 ($3,000 for families); the basic option included a $300 deductible for individuals ($900 for families) for in-network care and a $1,500 deductible ($4,000 for families) for out-of-network care. In the cases of both the basic and premium options, as long as employees received care within the carrier's network, out-of-pocket costs were quite low.

The first major change in the new health benefits program was a reduction from two plan options to only one, a change implemented at the beginning of 2006. A second major change, which took effect at the beginning of 2007, was to offer the plan through only one insurance carrier as a result of a 10-year partnership agreement with Highmark. Offering only one plan and doing so through a single carrier created the opportunity to negotiate drastically lower long-term administrative fees with a third-party administrator.

The new coverage offered was an HDHP with an HRA. As shown in Table 1, the deductible for employee-only coverage is $1,000, and, for employee-plus-family coverage, the deductible is $3,000. To cover a portion of the deductible, PSHMC annually contributes up to 75% of the deductible cost into the employee's HRA. (Originally, premium contributions were indexed by income such that higher-earning employees contributed a larger amount to the cost of health benefits.) For employee-only coverage, the organization contributes a base of $550 to the HRA, and for employee-plus-family coverage, PSHMC contributes $2,050. Employees also have the opportunity to earn an additional $200 toward their HRAs for completing the three-step Lifestyle Returns program, which includes a health risk assessment (i.e., a questionnaire designed to assess each patient's health risk and provide individualized feedback to support health and well-being). During the first year of the plan, employees could receive $100 for their HRAs by reading about blood donation, organ donation, advance directives, and medical liability reform. After five years of service, the account is vested to the employee for use during retirement or while covered under another employer's health benefits. Employees with five or more years of service were grandfathered in and vested at the inception of the HRA program. Currently, the maximum amount employees can retain in their HRAs is $25,000. The redesigned benefit plan includes several incentives for employees. The first incentive is to encourage regular preventive care; therefore, employees do not pay co-payments on preventive services. Another incentive—prorating coinsurance at higher rates for out-of-network care—encourages use of the home network. Employees pay the lowest amount of coinsurance and co-payments when seeing Penn State Hershey Medical Group providers, which together constitute the home network. They pay slightly higher coinsurance rates when receiving in-network care through the Highmark network, and they incur the highest coinsurance rates when receiving out-of-network care.

In addition to coinsurance incentives for seeing home network physicians, PSHMC also offers monetary incentives to employees for making healthy living

Table 1

Health Reimbursement Arrangement (HRA) Figures for Penn State Hershey Medical Center (PSHMC) Following a 2006 Employee Benefit Redesign*

Coverage type	Deductible amount	HRA seeding	HRA + additional funds
Employee	$1,000	$550	$750
Employee + child(ren)	$2,000	$1,300	$1,500
Employee + spouse	$2,000	$1,300	$1,500
Employee + family	$3,000	$2,050	$2,250

*Source: PSHMC, Office of Human Resources, health benefits data.

choices. These incentives include reimbursements for fitness club or gym memberships, smoking cessation programs, and weight management programs (e.g., Weight Watchers).

Communicating the New Benefit Plan

PSHMC leadership gave strong consideration to communication and employee education when implementing the new health benefits plan. The change was not driven purely, or even primarily, by the human resources department; rather, the changes were driven from the senior management level. Thus, PSHMC's chief executive officer (CEO) and the dean of Penn State College of Medicine (D.G.K [2000–2006], H.L.P. [2006 to present]), along with the chief operating officer/executive director of the medical center (D.H.) and department chairs, felt that constant, transparent communication was absolutely vital. In addition to the many opportunities for in-person explanations (detailed below), PSHMC mailed benefit enrollment kits to all employees' homes and made additional resources available online.

First, prior to the new plan taking effect on January 1, 2006, senior leaders formally presented the redesign and its details to employees at over 30 meetings held June through August 2005, which were open to all employees and very well attended. The CEO (D.G.K.) and executive director of PSHMC (D.H.) personally conducted 13 town hall meetings with employees at any level to introduce the benefit redesign and explain why it was needed. Approximately 3,000 employees (50% of the total) attended at least one of these initial meetings. In September and October 2005, PSHMC held 25 benefits town meetings to present the details of the new plan; approximately 5,000 employees attended these meetings.

In addition, from August through October 2005, senior leaders held meetings with approximately 600 managers from across the organization to fully inform them of the details of the new plan and to prepare them to address additional employee questions.

Finally, during the benefits enrollment period in October and November 2005, PSHMC offered 28 consecutive days of individualized counseling sessions to employees and their spouses/partners, and over 4,000 employees received enrollment counseling. By the time the benefits were implemented in January 2006, over 5,000 employees and faculty (about 85% of those covered by the plan) had attended a benefits town meeting or had met individually with a benefits counselor in an effort to fully understand the changes in coverage and costs.

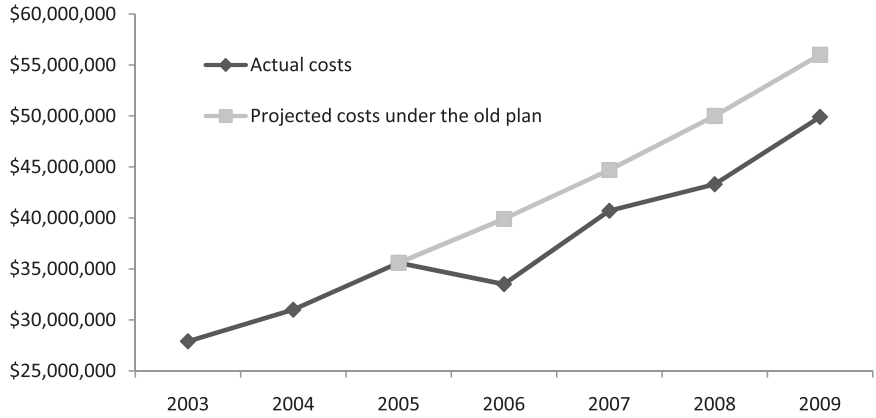

Figure 1 Actual costs versus projected costs under the former plan. This figure shows the estimated reduction in Penn State Hershey Medical Center (PSHMC) health plan costs following the 2006 health benefit redesign. Source: PSHMC, Office of Human Resources, health benefits cost data.

Impact of the New Benefits Design, 2006–2010

As a result of the interventions, PSHMC was able to control health care spending and dramatically decrease the rate at which its health care spending was growing. Over a four-year period, between 2006 and 2009, PSHMC was able to reduce its average employee total cost trend from an increase of 8% to 10% per year to an average of 4% per year, whereas the national average continued to increase at over 9% annually.[3] This cost savings amounted to a total of $24 million, or an average of $6.3 million per year, representing a 13% reduction in the year-over-year spending and a 25% reduction from the predicted trend spend (Figure 1).

The trend line in Figure 1 seems to indicate that PSHMC experienced just a one-time cost savings between the years 2005 and 2006. However, notably, the PSHMC workforce increased by over 15% from 2006 to 2009. Even with this increase in the workforce, the medical center was able to remain approximately $5 million per year *below* the projected total cost. Further, from the perspective of per member per month (PMPM) costs, the savings and reduction in the rate of cost growth are equally dramatic. As Figure 2 shows, the PMPM costs decreased after the initial implementation

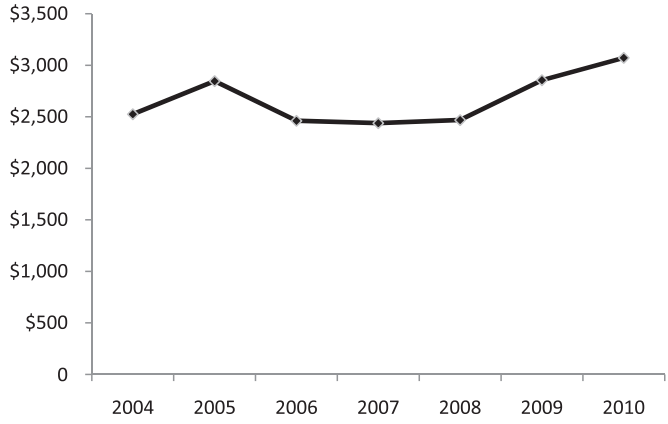

Figure 2 Cost of health plan to Penn State Hershey Medical Center (PSHMC) per member per month following the 2006 benefit redesign. Source: PSHMC, Office of Human Resources, health benefits cost data.

Table 2

Features of the High-Deductible Health Plan Package Offered to Employees of Penn State Hershey Medical Center (PSHMC), Following a 2006 Employee Benefit Redesign, Compared With National Averages*

	PSHMC		National average	
Feature	Employee	Employee + family	Employee	Employee + family
Worker contribution to premium	$712	$1,992	$799	$3,604
General annual deductible	$1,000	$3,000	$1,737	$3,577
Out-of-pocket maximum	$1,000	$3,000	$3,622	$7,096
Amount (%) of employer contribution to health reimbursement arrangement	$550 (55)	$2,050 (68)	$907 (52)	$1,619 (45)

*Sources: PSHMC, Office of Human Resources, benefits data and Claxton G, DiJulio B, Finder B, et al. Employer Health Benefits: 2010 Annual Survey. Menlo Park, Calif: Henry J. Kaiser Family Foundation; 2010.

of the new benefits structure. Even with increases in recent years, the annualized rate of increase in PMPM cost since 2004 has remained low at 3.61%.

This cost savings is partially created by a reduction in the administrative fees that the AHC pays for the plan. By offering just one plan through just one carrier, PSHMC has been able to reduce its administrative fees by $1 million annually, accounting for 20% of the total savings. Additionally, by having a 10-year contract with Highmark, both organizations are able to coinvest in wellness and health promotion programs without fearing the expenses of PSHMC possibly switching to another plan administrator. Though the savings in administrative fees is significant, importantly, the remaining $4 million in annual savings is attributable to medical cost savings achieved through plan redesign and active employee engagement in their health care choices.

Whereas nationally the majority of employers have increased employee contribution to benefits,[4] PSHMC employees have seen a reduction in the average amount they contribute to the health plan, from 19% to 17% of the total premium. In 2010, the employee contribution was $711.36 annually for employee-only coverage and $1,992.17 annually for employee-plus-family coverage. These costs are substantially lower than national averages; according to the Kaiser Family Foundation, in 2010, employees receiving health coverage were contributing an average of 19% of the total premium, or $780, for employee-only coverage and 30%, or $3,516, for employee-plus-family coverage.[5]

Compared specifically against other HDHPs, PSHMC has favorable employee contribution premiums, deductibles, and HRA contributions (Table 2). For example, the out-of-pocket maximum for PSHMC employees is $2,622 lower than the national average for employee-only coverage and over $4,000 lower for employee-plus-family coverage—even while, nationally, the trend toward higher employee contributions and out-of-pocket maximums is continuing to rise.[6]

Home network use has also increased under the new plan, increasing from 50% in 2006 to 75.3% in 2009. The value of paid claims that were redirected from other network providers to home network providers from 2006 through 2010 was $32.5 million. As PSHMC continues to expand clinical capacity, with, in particular, the addition of new outpatient clinic sites throughout the region, the rate of home network use is anticipated to increase further.

The final cost savings have been in the form of HRA investments. PSHMC invests all of the actuarial savings resulting from the use of deductibles back into the health plan through employer HRA contributions. As of 2009, PSHMC had seeded over $31 million into employees' HRA accounts and had contributed an additional $2.5 million as incentive payments for completion of wellness programs. Over 50% of employees have enough money in their HRAs to fully fund the cost of their deductible. Collectively, employees have been rolling over approximately $3 million annually in their HRAs.

The new health benefits have also improved members' use of wellness programs. Over 5,000 employees have completed a health risk assessment at least once since the program began. In addition, 2,500 employees have completed information on a biometric screening process, and 1,000 have participated in the 10,000 Steps walking program, which promotes physical activity and a healthy lifestyle.

Through providing incentives to get annual checkups, vaccinations, and cancer screenings (including colorectal, mammography, pap, and prostate exams), PSHMC has increased the use of preventive services. The incentives include, as mentioned, both no co-payment for annual use and increased HRA reimbursement for completing a wellness profile that reflects use of screenings, vaccinations, and checkups. The change in benefits has yielded significant results. For example, as Table 3 shows, the number of annual checkups for children and adults alike increased between the years 2008 and 2010. The increase in the number of children receiving checkups over this period was modest, but the increase in adult visits, from 1,024 to 1,417, was dramatic.

Immunizations have remained at a consistently high level throughout the change in the benefits structure. PSHMC has maintained the level of immunizations by offering free immunizations to health plan members and by operating a robust immunization program throughout the organization. Each year, the immunization program administers approximately 5,000 influenza vaccinations to employees and family members. Finally, the number of cancer screenings among PSHMC employees has risen dramatically. Between 2008 and 2010, the overall number of screenings for breast, cervical, prostate, and colorectal cancer increased 712%, from 410 exams in 2008 to 3,329 exams in 2010.

In alignment with the principle of encouraging both employee wellness

Table 3

Number of Adults and Children Covered by Penn State Hershey Medical Center (PSHMC) Health Care Benefits Receiving Annual Checkups, Following a 2006 Employee Benefit Redesign*

Type of patient	2008	2009	2010
Child	1,680	1,722	1,763
Adult	1,024	1,267	1,417

*Source: PSHMC health benefits utilization data, provided to PSHMC by Highmark.

Table 4

Number and Percentage of Penn State Hershey Medical Center (PSHMC) Employees Reporting Change in Awareness of the Cost of Their Health Care Benefits, Following a 2006 Employee Benefit Redesign*

Response	Respondents, no. (% of 1,972)
Much more aware	696 (35.3)
Slightly more aware	397 (20.1)
Same	860 (43.6)
Slightly less aware	11 (0.6)
Much less aware	8 (0.4)

*Source: PSHMC employee survey, 2006.

and active engagement in health care consumer choice, PSHMC offers financial incentives for employees getting screenings, immunizations, and checkups and for participating in other wellness initiatives. Of all firms in the United States offering wellness benefits to their employees, only 2% make additional contributions to employees' HRAs for participation in a wellness initiative.[5] By making this financial commitment, PSHMC emphasizes its dedication to employee wellness and to supporting the integral role that wellness plays in overall cost containment.

When analyzing the results of the health plan implementation, PSHMC believed that evaluating employees' perspectives on the effectiveness of the plan was as important as measuring use and cost; thus, with exemption from the Penn State College of Medicine institutional review board, PSHMC conducted a survey in mid-2006 to assess employee perspectives. As shown in Table 4, employees became more aware of their health care costs. Of those who took the survey (n = 1,972), 55% answered that they were much more or slightly more aware of costs under the new plan. By introducing transparency and price comparison, employees could educate themselves about the true cost of health care, which in turn enabled them to make more informed decisions while also bending the cost curve for PSHMC.

PSHMC also measured employee satisfaction with the new health plan. Overall, as Table 5 shows, most employees (55%) who responded to the survey were at least satisfied with the plan, and only 15% were not at all satisfied. Over 51% of employees reported that they "like" having an HRA. These PSHMC data mirror national trends; nationwide, people who have health insurance view HRA plans as a desirable and affordable form of health benefits.[7] Although trend (pre–post health benefit design) data for employee satisfaction are not available, PSHMC leadership can report anecdotally that employee acceptance has improved over time, particularly because HRA balances have increased. Since 2006, more and more participants have maintained sufficient balances to fully fund their deductibles. An additional indicator of relative satisfaction with the plan is the fact that the two labor unions representing employees at PSHMC were generally accepting of the new plan when it was first introduced, and since then changes to the plan have not been the subject of bargaining by either the Service Employees International Union or the Teamsters.

As a result of the health benefits redesign, PSHMC's spending has increased at a slower-than-expected rate compared with other employers offering health benefits. Over a five-year period, from 2006 to 2010, PSHMC was able to contain rate increases for the total cost of the plan, including employee and employer contribution, to 13.9%; over the same time period, the average national growth rates were 16.0% and 16.6% for, respectively, employee-only and employee-plus-family coverage[8,9] (Figures 3 and 4). This savings amounts to an average cost difference of $164 annually per contract. As applied to PSHMC's entire workforce, this savings amounts to nearly $1 million in 2009 alone. As health care costs continue to outpace inflation, the ability to control overall health benefit costs will be a key factor in cost saving for organizations offering health benefits to their employees.[10,11]

Table 5

Number and Percentage of Penn State Hershey Medical Center (PSHMC) Employees Reporting Their Level of Satisfaction With the Health Benefit Plan, Following a 2006 Employee Benefit Redesign*

Level of satisfaction	Respondents, no. (% of 1,964)
Completely	75 (3.8)
Very	225 (11.5)
Satisfied	779 (39.7)
Partially	584 (29.7)
Not at all	301 (15.3)

*Source: PSHMC employee survey, 2006.

Conclusions and Lessons Learned

Through the implementation of a new health benefits plan that focuses on controlling costs, providing incentives to use the home network for care, and promoting preventive care and wellness programs, PSHMC was able, between 2006 and 2010, both to save over $24 million and to reduce by 5% the rate at which health care costs increased annually. PSHMC has invested these cost savings back into the health and wellness of employees, contributing up to 75% of HRA fees annually and offering additional incentives for completing wellness programs. The new

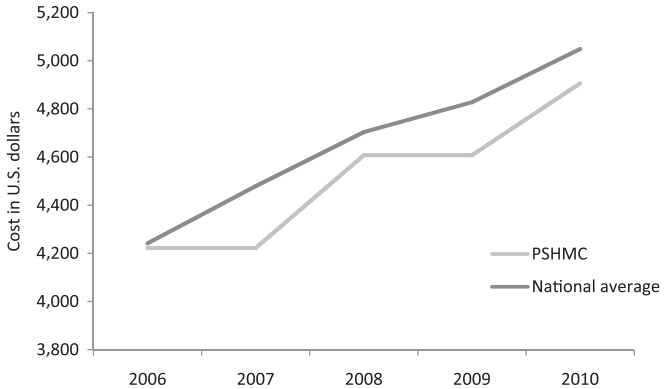

Figure 3 Annual rates paid by each employee for health coverage (employee-only coverage) at Penn State Hershey Medical Center (PSHMC) following the 2006 benefit redesign. Sources: PSHMC, Office of Human Resources, benefits data; Claxton G, McHugh M, Whitmore H, et al. Employer Health Benefits: 2010 Annual Survey. Kaiser Family Foundation; Health Research & Educational Trust; and National Opinion Research Center, 2010.

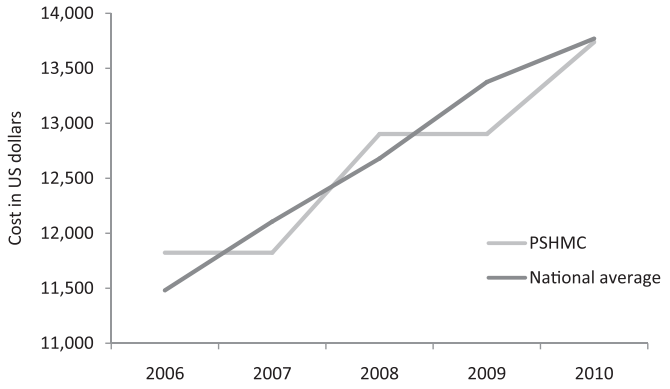

Figure 4 Annual rates paid by each employee for health coverage (employee + family coverage) at Penn State Hershey Medical Center (PSHMC) following the 2006 benefit redesign. Sources: Penn State Hershey Medical Center, Office of Human Resources, benefits data; Claxton G, McHugh M, Whitmore H, et al. Employer Health Benefits: 2010 Annual Survey. Kaiser Family Foundation; Health Research and Educational Trust; and National Opinion Research Center, 2010.

health benefits plan has proven to be a sustainable model, offering continued cost savings for the organization during the five years that it has been implemented. In the early stages of the transition, employees viewed the change as difficult. However, through continued education and communication from senior leadership and the human resources department, employees now feel that the plan is favorable and affordable, as determined both anecdotally and by employee satisfaction surveys.[12] At new employee orientation sessions, employees coming to PSHMC from other employers commonly report that PSHMC's plan is superior in terms of both coverage and cost.

PSHMC's experience reflects many of the trends described in the literature. By shifting to an HDHP/HRA plan, PSHMC has realized significant cost savings and has reduced the rate of increase in health care benefits costs. Employees at PSHMC report greater awareness of the cost of health care, which aligns with the findings of other research on employees at other companies that have shifted to consumer-driven health plans.[7,13] In addition, the incentive to use PSHMC for care has benefited the organization's bottom line. For health systems, benefits restructuring can also create a similar opportunity to create a system of incentives for using the home network. Indeed, the advantages of providing at least some medical care "in house" are evident to the growing number of companies that offer on-site or near-site clinics.[14] Similarly, though assessing the return on investment for wellness programs can be difficult, PSHMC's experience is consistent with the broader trend in which companies that provide wellness incentives have experienced a significantly lower rate of growth in health benefit costs compared with the national trend.[15]

One of the chief criticisms leveled at HDHPs is that they can be a deterrent to seeking necessary care, particularly for lower-income families and for those with higher-than-average out-of-pocket health expenses.[13] PSHMC's benefits structure minimizes the potential for this negative outcome by reducing or eliminating out-of-pocket costs for preventive care, offering incentives that encourage wellness and regular preventive care, and structuring premiums and employer contributions to HRAs in ways that reduce the cost impact on lower-income employees. Clear and ongoing communication to ensure that employees understand benefits, including coverage, out-of-pocket expenses, and wellness benefits, is essential; the lack of such understanding appears to be a significant factor underlying deferral of care, underuse, and dissatisfaction with benefits.[16]

From a plan-design perspective, PSHMC leaders learned several important lessons. Initially, the increasing cost share paid by more highly compensated employees was too much, and in April 2007, in response to negative feedback, PSHMC lowered the ceiling from 60% to 35% of total health benefits cost. Likewise, salary indexing of employer contributions to HRAs, which effectively resulted in the highest-paid employees receiving no funding, proved to be a dissatisfier, particularly among our physicians. In 2008, PSHMC eliminated salary indexing of employer HRA contributions. These experiences, listening and reacting to employee need, serve to further highlight the importance of communication with employees regarding benefits changes, not only before and during implementation but also on an ongoing basis.

For AHCs and other health care systems, one potential downside of switching to a single-plan administrator would be a negative reaction from the other payers not selected to administer the plan. In the case of PSHMC, leaders have not perceived a change in the relationship with other payers as a result of selecting Highmark as the single third-party administrator for the self-insured employee health benefit program. Further, the partnership with Highmark has also allowed PSHMC to look at other opportunities for collaboration, and the impression among PSHMC leaders is that Highmark is pleased with how the plan is functioning. Similarly, the increase in our employees' use of home network providers has not resulted in a negative response from other providers in the broader community. This relatively neutral or nonresponse may reflect the fragmented nature of, and the relative shortages in, the delivery system. Against the backdrop of health care reform in the United States and the restructuring of provider–payer relationships in the region served by PSHMC, attributing any psychological or economic effect on the broader community directly to PSHMC's restructuring is difficult, if not impossible.

PSHMC's experience suggests that an HDHP/HRA plan that combines increased cost-sharing and responsibility on the employees' part, with an investment in wellness-focused incentives on the employer's part, can be effective in controlling costs while minimizing negative consequences such as deferral of needed care. Furthermore, the way in which the new plan is introduced and communicated to employees is critical in shaping expectations and increasing satisfaction with the plan. PSHMC's experience supports the need to involve leadership, as well as the human resources department, in communicating the new benefits structure to employees, before, throughout, and after the implementation as a way of gaining support for the

change, ensuring that benefits are clearly understood and used appropriately, and engaging employees as stakeholders in a process that controls costs while supporting and enhancing health and wellness. This five-year experience at the PSHMC provides significant benefits to the institution and can work as a model for other employers.

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Previous presentations: An abstract of this study was presented by Dr. Harold Paz at the 2009 Annual Meeting of the Association of Academic Health Centers (AAHC) and by David Hefner at the 2009 Annual Meeting of the Association of American Medical Colleges.

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