



**Strategic Health
Planning: A Guide
for Senior
Executives**

By Randall K. Abbott

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Employee health has become a total business issue for many companies, as fast-rising health benefit costs outstrip revenue growth and usurp an ever-greater share of the total compensation dollar. In addition, American corporations have begun to focus on employee health as an asset to the business enterprise, recognizing that workforce performance can be significantly eroded when poor health increases absenteeism and causes workers to be less effective on the job. The discussion which follows is designed to summarize the issues and key questions that the board member, senior financial executive, operations or human resources manager not usually involved in health benefits planning should consider when engaging with their health, wellness and employee benefits professionals.

Historically, American business has focused on managing employee health benefits as a cost of doing business, aggressively monitoring year-over-year claims costs and continually raising the employee's share of costs. In 2002-2003, it was common to see larger mainstream companies covering 73-78% of total plan costs with employees contributing the remainder of costs as an offset to premiums via payroll deductions and paying a share of expenses at point-of-care through co-payments, deductibles or coinsurance. The member's share of costs has risen dramatically in recent years. As of 2005, the author's analyses showed that mainstream companies were assuming 66-70% of total costs with the median of the Fortune 500 falling at about 66-68%. As of 2008, the employer share has dropped even further with the median of the Fortune 500 now at 65-66%, leaving 34-35% of total costs to the employee.

While cost-transfer to members helps the corporate budget, it simply reallocates who pays, rather than focusing on the drivers of cost growth and reducing the rate of future cost escalation. Many employers now feel that they have reached a saturation point where they cannot realistically ask employees to pay more. Employee premium contributions for traditional preferred provider (PPO) plans now frequently fall in the range of 20-22% with employees bearing an additional 12-15% at the point-of-care. As the discussion turns from cost-shifting to other strategies, business is now examining issues related to unit labor costs, global competitiveness, sustainability of the health plan in the face of rising costs, the impact of worker health on productivity, longer term workforce planning and the need to reconsider the role of company-provided retiree health benefits after age 65 due to the introduction of the Medicare Modernization Act, or Medicare "D."

For the Board member, Benefits Committee member, or senior executive not fully familiar with the complexities of healthcare benefits design, financing and delivery, it's easy to get mired down in the jargon. A key aspect of the emerging discussion should be the recognition that corporations must have a health strategy, not just a health benefits

strategy. Health benefits are an important part of the total rewards package and need to be considered in that discussion. A health strategy transcends the health benefits discussion by positioning the organization to optimize the health and productivity of its workforce by improving worker health, reducing health risks, improving employee performance and reducing the future cost of poor health to the business.

The following fifteen questions are designed to pinpoint areas where key information should be elicited. (Suggested probing questions are included in bolded italics.)

1. **What is our health benefits strategy today?**

Sounds like a simple question, but often the “strategy” has been getting through a year’s renewal, coping with open enrollment each fall or reacting to changes made by peer companies or area competitors. A health benefits strategy should articulate the organization’s philosophy regarding the provision of health benefits and highlight key principles to guide decision-making. Health benefit strategy statements generally incorporate three broad dimensions: health benefits as a stand-alone benefit, health benefits as one element of total compensation and health benefits as a vehicle designed to integrate with broader initiatives to optimize workforce health and productivity. The best statements incorporate all three. Whether it is long or short, simple or complex, having a formal and written health benefits strategy demonstrates a clarity of purpose, while guiding principles provide the guideposts for making decisions consistent with that philosophy.

Research conducted by Watson Wyatt and the National Business Group on Health has consistently demonstrated that the most effective organizations have a clear, multi-year healthcare strategy. (*Key questions: Do we have a written health benefits strategy? Guiding principles?*) As you review the information provided, look for a recognition of where health benefits fit within total rewards and how they are to be positioned from a competitive perspective. Beware of statements regarding “quality” healthcare or promises of “comprehensive employee protection” that could find the company in a courtroom should a plan member experience an unsatisfactory outcome or a limit to the plan’s coverage in a given situation.

2. **Do we have a workforce health strategy?** This is different than a health benefits strategy which merely focuses on the health benefit one receives when illness or injury occurs. A workforce health strategy transcends health benefits strategy by establishing an organizational position on the health and wellbeing of the workforce as an asset to the business.

Increasingly, organizations are recognizing that poor employee health does more than just create expensive health benefit claims: poor health increases absenteeism and reduces employee effectiveness on the job. For some employers with very high turnover, it may not make sense to invest enormous dollars in helping workers improve their health, but for those who keep employees 5-7 years or more, there are significant opportunities to impact employee health and wellbeing, reducing lost time,

pping productivity on the job and reducing the risk of expensive chronic conditions in the future.

Some employers have approached workforce health improvement incrementally by adding key components to corporate wellness programs and health benefits or services. Others have embarked upon a “culture of health” where there is a holistic and concerted effort to make workforce health a core value of the business with substantial investments in programs and resources. ***Key questions: Have we evaluated the health risks in our population through a wellness assessment and/or biometric screenings? Do we have a population health profile to understand the health risks and the improvement opportunities in our workforce? Have we conducted an analysis of our health claims to know the key cost drivers and the cases which can be modified or prevented going forward? What health improvement programs and services do we have in place and what are the results?***

Ideally, those responsible for employee health should be able to point towards “must do” programs like a robust wellness assessment being completed by 30-40% or more of employees, in place “must do” initiatives like smoking cessation, weight management, nutrition, and stress reduction programs, plus an understanding of how to measure workforce health. Listen closely for an understanding of not only health claim impact, but also the effect on lost time and “presenteeism” (defined as the effect of poor health on worker effectiveness on the job.)

3. What is our health spend and what is our cost trend?

Granted, it’s two questions in one but they’re closely related. Financial types probably already know the answers to most of the questions below, but it’s still good to validate definitions since plans can operate with widely different assumptions or measures. And, you’ll want to validate whether the cost of health to the business is being measured solely in year-over-year health claim dollars or the broader definition of health costs referred to as “the burden of illness.” (The burden of illness on the organization includes not just “direct” costs like medical and drug claims, but also the cost of occupational and non-occupational lost time plus the impact of health-related functional impairment on the job.)

The “direct cost” or health benefit costs should be expressed per employee per year and per member per year, as well as in the aggregate and as a percentage of payroll. It’s important to know the aggregate numbers, but the specifics per employee or per member are much more telling. Aggregates or percentages can mask increases or decreases in employee headcount, family size or variances in payroll or health expense. The author has seen companies claim that their health costs are flat year-over-year by comparing aggregate dollars spent to the prior year. In reality, headcount dropped and health costs rose...the real increase was double digits. ***(Key questions: What are our total gross health benefit costs and our net costs—after employee premiums are subtracted—per participating employee? How do they compare to***

last year? Is it an apples-to-apples comparison or were there plan changes or other events that skew the comparison?)

Understanding health benefit cost trend is critical. To provide some context, for 2008 the median increase for larger employers—before plan changes or premium contribution increases—was 9%. After plan changes and contribution adjustments, year-over-year trend dropped to 7%. (Watson Wyatt/National Business Group on Health, 2008). This figure incorporates medical benefits and prescription drugs for active employees and excludes dental costs as well as retiree costs. For 2009, indications are that median gross trends will be hovering around the 8% level with net trend around 7% although significant variations can and do occur. ***(If your trend rate seems high, ask for the factors that contributed to it....large claims? An inadequate projection basis in the prior year? Overstatement of a projected plan change?)***

Be clear on the figures you are seeing...look for gross trend before any changes as well as net figures which reflect the impact of changes. Be careful in comparing your rate of cost increase to norms or benchmark data. Some surveys include medical care, drug and dental figures while others include medical and drug only. Some show net increases after plan changes or increases in contributions to plan members and still others reflect gross trends. Similarly, various surveys capture different employer respondents with some skewing towards very large groups and some reflecting more of a small group or mid-market respondent base. Avoid relying solely on normative trend to project your organization's future costs. Every group has its own internal rate of trend or "observed trend." While only very large groups are in a position to treat their own trend as fully credible, it's worth looking at. ***(Key question: Have we looked at our own internal rate of trend in addition to the formula trend rate?)***

Focusing on cost is important, but it's also essential that the program deliver value—defined as the health outcomes per dollar spent. ***(Key question: Have we examined value-based strategies for our plan?)***

4. **Do we know our total burden of illness?**

Chances are the answer is "no," but it's worth starting the discussion. As noted earlier, the burden of illness to a company is the cost of direct claims plus lost time plus the impact of poor health on-the-job performance, known as presenteeism. Most employers capture their direct costs, some identify lost time and few track lost productivity. Add up what is known, but when it comes to the total burden, chances are it's 2-3 times direct medical costs. As the organization considers its total health strategy, the "BOI" on the business is a critical measure to consider. Studies conducted by major companies have consistently demonstrated BOI of this magnitude. A Watson Wyatt study conducted in 2007 and published in 2008 studied the correlation between the effectiveness of a company's health and productivity practices and its business results. The data found that those companies with the top practices outperformed those with less effective practices with 20% more revenue per

employee, a 16.1% greater market premium (the excess of market value over assets, expressed as a percentage) and a 57% higher total return to shareholders.

5. What health metrics are we tracking?

Traditional health metrics focus on health benefits costs and utilization of various health related services. This “cost and utilization” data is often expressed as rates per 1000 members or a unit cost per member per month. The data is important—as is the cost trend data discussed earlier—but needs to be supplemented by other measures of workforce health today and predictors of health for tomorrow. Ask to see the latest cost and utilization data, but also ask if other measures are being tracked as well, such as the number of employees and dependents getting recommended preventive care, immunizations and screenings. If there is a health risk appraisal or “wellness profile” being used with employees, ask about the latest summary report of top risk factors and what actions are being taken to address these risks. Ask if biometric screenings are done (these are worksite screenings, typically including height/weight and body mass, blood pressure, cholesterol levels and a diabetes screening or blood glucose test via a “finger stick” blood draw.) (*Key questions: Are we tracking claim data alone or are we trying to understand the underlying health risks of our workforce? How are we doing it and what data are we capturing?*)

6. How are we financing our health benefits?

About 75% of larger health plans are self-funded with some degree of “stop loss” insurance to protect the plan sponsor against catastrophic losses. Chances are your plan is self-funded, but it’s wise to ask. If it’s still insured, ask to understand why. Self-funding is always less expensive over time—insurance costs money—but there are instances where insurance may make sense due to cash flow volatility or a carrier that has under-priced its premiums below true plan costs. If you’re self-funded, it’s important to understand the stop loss coverage in place. (*Key questions: Do we have specific stop loss for individual large claims? At what level? Does it cover medical claims only or both medical and drug expenses? Do we have aggregate protection if overall claims significantly exceed our estimates? Are we comfortable that the coverage is appropriate for the size of our plan and our experience?*)

7. How are we addressing our longer term retiree health benefits strategy post-Medicare D?

In the short term, most organizations who subsidize post-65 retiree health benefits are taking the government subsidy for retiree drug coverage, but taking the subsidy should be just one part of a longer term plan for how retiree health benefits should be positioned. The introduction of the Medicare drug benefit affords companies sponsoring retiree benefits an elegant opportunity to consider changes. Based on recent survey data, some companies are electing to drop post-65 coverage, others are cutting back their plans to cover medical benefits only (leaving the drugs to Medicare), some are monetizing their obligations by funding a retiree medical

account (RMA) with access to an unsubsidized retiree medical plan sponsored by the company, while still others are mixing a variety of approaches.

Since Part D was implemented, national vendors have emerged with products that capitalize on the new generation of Medicare HMOs—known as Medicare Advantage Plans—as well as “participating drug plans” or “PDP’s” which can deliver an alternative to traditional employer sponsored medical or drug benefits for retirees eligible for Medicare. ***(Key questions: What is our longer term game plan for post-65 coverage now that Medicare covers prescription drugs? Should we be keeping our plan, restructuring it or even eliminating it? Have we looked at replacing our drug benefit with a PDP? Would a Medicare Advantage plan make sense?)***

Increasingly companies are thinking in terms of “stratification.” This means looking at each segment of the active and retired workforce and considering the best solution for each group. For example, a company may choose to leave current post-65 retirees and those within a few years of retirement unchanged, but restructure the “deal” for those who have more than five or ten years before retiring. Some are eliminating benefits for new hires and those under a certain age and service level. Some are terminating all benefits. ***(Key question: Should we be considering a strategy that stratifies our current actives and retirees?)***

Pre-65 retiree plans should not be ignored. While it is tempting to eliminate the plans as a cost-cutting measure, many companies find that the absence of an early retirement health plan can be a challenge from a workforce planning perspective...often employees interested in leaving pre-65 (or those one would like to encourage leaving before 65) are loathe to depart if coverage is not available. If pre-65 coverage does exist, it can be subsidized or “access only” where the retiree pays the full cost. That being said, early retiree health costs are often 35-80% higher than similarly situated actives (sometimes even more). If coverage is being offered, it should be priced accordingly or the implicit company subsidy should be recognized. ***(Key question: Are our pre-65 retiree rates self-supporting or do we subsidize them?)*** If they’re the same rates as actives, they’re probably not self-supporting and constitute not only a current cash cost but also a liability under Financial Accounting Standard 106.

An even broader consideration is the organization’s overall retirement strategy: healthcare is a major need in retirement as is an adequate retirement income to pay for it. ***(Key question: Are we coordinating our retiree health planning with our broader retirement strategy?)***

8. Should we be selling off our post-retirement life or health obligations?

This opportunity is best when the company is in a strong cash position and has the opportunity to capture a material balance sheet gain by transferring its obligations to a “successor entity.” This entails evaluating a variety of legal, financial and administrative considerations, determining the cost of selling off the liability, the

balance sheet implications and the net economic benefit to the business. Most commonly, the liability is funded via an annuity purchase which is used to establish a trust for retirees. The trust then purchases needed health coverage, manages the financing and administration of the program prospectively and retirees are notified of the transaction. A similar approach can be applied for retiree life insurance liabilities by funding a single premium and transferring administration to the insurer.

This approach monetizes the retiree benefit commitment and eradicates it from the balance sheet, removing all future volatility. It is typically viewed positively by retirees since the trust is a secured, stable entity and the obligation is funded with no future involvement by what may have been seen as a less-than-benevolent former employer. While the approach requires current cash, the impact can be advantageous financially and also in terms of eliminating ongoing administrative efforts and outside actuarial or advisory costs prospectively. ***(Key question: Could we benefit from funding our retiree life and/or health obligation currently and transferring it to a successor entity?)***

9. How are our health benefits positioned competitively?

As health costs have consumed more and more of the total compensation dollar, the historical view of having “best in class” benefits or benefits that are demonstrably better than other employers has eroded in favor of a broader total rewards perspective. Today, many large companies are seeking to reduce benefits as a percentage of the total compensation pie in favor of more monies being allocated to salary and especially incentive compensation. Ideally, the benefit plan should be a neutral factor in recruiting and retention. (It is the rare employer that wants to attract or retain an employee because they simply value the health benefits.)

That being said, health benefits should be “competitive” to the extent that they should not detract from hiring and retaining the desired workforce. Recently, many employers are positioning health benefits at or around the median of their industry or peer group...some are consciously doing otherwise—higher or lower—based on a larger total compensation view. Benchmarking should be undertaken periodically, but competitive positioning should always be based on a broader view of the employment deal. If the total pay package, career opportunities, culture and climate of the organization are appealing, one should recognize that benefits are only a part of the equation.

In examining competitive positioning of health benefits, it is easy to bog down in examining minute plan features or design differences. An excellent alternative is to look at the employer-provided value of the benefit, the percentage of costs borne by the employee in the form of premiums and the percentage of costs absorbed by the employee at point-of-care. By focusing on these elements, health benefit benchmarking can be simplified and viewed more holistically. ***(Key question: What is the employer-provided value of our health plan versus our competitors? And,***

how do our employee cost-sharing percentages stack up in terms of payroll deductions and average point-of-care costs?)

Keep in mind that all benchmark data is a rear view mirror. Today, employers are rapidly changing their plans and their premium contributions as well as implementing newer account-based approaches (more on this later.) Be sure to ask what others are doing prospectively in addition to relying on historical data. Don't be focused exclusively on the result...keep it in the perspective of the bigger employment deal and total compensation package. Competitive differences in health benefits are only an issue if they're getting in the way of hiring and retaining the people you need.

10. What are we doing about consumerism in healthcare?

Educating plan members on how to be better healthcare consumers should be a key element of your healthcare strategy whether you have a so-called "consumer driven health plan" or not. The reality is that many employees simply do not understand that their own behaviors drive health expense...whether its lack of self-care, imprudent choice of treatment settings, inappropriate or unnecessary use of the plan or poor health behaviors that cause higher claim costs. Healthcare consumerism is all about educating employees on the cost of healthcare, the options they have available for the care they receive, using the tools and resources available to help them understand their health conditions and aiding them in reducing their health risk factors.

Research by the Rand Corporation shows that 25-30% of healthcare received is unnecessary or inappropriate; 40-42% of most employers' healthcare claims are due to modifiable or preventable lifestyle related conditions (Watson Wyatt research). A shocking number of employees don't understand what the cost of their care is, nor the fact that employers pay the lion's share. Many think the cost is borne by "*the insurance company*" and don't understand the idea that their costs are charged to their employer via the experience rating of an insured plan or directly in claims due to self-funding.

Making employees and their families aware, educating them on the issues, telling them what they can do, how they can do it and motivating them to act are the vital aspects of consumer education. Education and awareness helps position for needed change in the future and the foundation for broader social action when the nation finally recognizes the profoundness of the healthcare crisis. Sy Syms said it best decades ago, "the educated consumer is our best customer." (***Key questions: What are we doing in consumer education? What tools and resources are we making available? What can we do to encourage this?***) If your benefits team says the company's not "into" this or doesn't see value in it, aggressively challenge them. In all likelihood they are confusing consumerism with an account-based solution.

11. Should we have a consumer directed health plan?

Here is where semantics get in the way. In the current jargon, Consumer Directed Health Plans or “CDHPs” are arrangements that are designed to financially engage plan members by tying an account funded by employer money (and sometimes employee money) with a high deductible health plan. The idea, simply put, is that employees will use the monies in the account for more manageable everyday health expenses or fund the claim out of their own pockets. Since unused monies can roll over and accumulate each year, the thought is that employees will treat the money as their own and be more mindful of how they use healthcare. In the event of a major expense, health benefit protection is afforded after a deductible and then reimbursed subject to coinsurance up to an annual out-of-pocket limit for the employee or family.

These accounts tied to a deductible plan are known as CDHPs. More appropriately, they are referred to as “account-based” healthcare arrangements since they incorporate an account rather than the more traditional “defined benefit” style plans that predominate today. In reality, any type of health plan—account-based or otherwise—can incorporate consumerism. Today, two major account-based types exist: consumer directed plans known as “health reimbursement arrangements” which are enabled under Internal Revenue Code (IRC) Section 105 or health savings accounts coupled with high deductible health plans qualified under Section 223 of the Internal Revenue Code.

Introducing a CDHP/health reimbursement arrangement or a health savings account with a high deductible health plan is often done as an additional health benefit option and is sometimes introduced as a full replacement for a more traditional plan. Proponents suggest that account-based solutions are more effective than traditional plans in getting members to be more engaged in healthcare costs and consumer behavior change. Opponents view them as a vehicle that creates “winners and losers” between those who are healthy and those who need more healthcare. Some argue that few will elect the option; others will suggest they don’t really save money.

To date, about 54% of large employers have adopted account-based options and the number continues to grow. At the very least, an account-based option changes the conversation at open enrollment and creates a platform for future change. At worst, it will attain low enrollment levels in the early years. Designed well, the plans can be cost neutral to cost-effective. Early data shows the plans enjoy lower rates of cost growth and reductions in utilization. ***(Key question: Are we looking at an account-based health plan approach? Which one? Why that one? How do we envision positioning it versus other options?)***

If it’s not time to introduce an account, consider offering a high deductible health plan (HDHP) qualified under IRC 223 as an option so that employees interested in an account—a health savings account—can qualify for one...and can purchase the tax

advantage vehicle themselves independent of the employer-sponsored plan. Offering the HDHP is an invaluable aid in itself.

12. Should we be pursuing a health management or health improvement strategy?

Health management or health improvement efforts are designed to better manage the health of the covered population by reducing their health risks and managing chronic conditions. Targeted properly, these programs can be a break-even investment in year one and rapidly begin to reduce costs longer term by reducing the risk factors of the group or managing costly conditions more effectively. As noted previously, 40-42% of most employer's healthcare claims are related to modifiable or preventable conditions caused by lifestyle. If even a portion of these claims can be better managed or avoided, the impact can be significant. The alternative is to just keep transferring more costs to plan members.

Recent articles have questioned whether these programs actually save money; the key is analysis to identify the conditions most prevalent in the group that can be improved or prevented. Absent a quantitative approach, the results will be hit-or-miss. Virtually every employer health plan can benefit from a well run nurse healthline, available to employees 24/7 to help them triage their needs and respond to routine questions. Similarly, an emphasis on preventive care, getting needed screenings and education on "self-care" to avoid unnecessary doctor or emergency room visits pays for itself. Disease management programs, lifestyle behavior change programs and other targeted efforts require a good analytical foundation to assure that the money invested is being channeled to where it can do the most good.

While a return on investment is important, a variety of metrics need to be tracked to assure a sound, continuing result including participation rates, reductions in risk factors and an actual reduction in cost growth. *(Key questions: If we are pursuing health improvement, have we done an analysis to identify exactly what conditions we can influence for our own population based on our own claim and demographic data? What are the results? Was this done independently or by a vendor actually selling the program we're interested in? Do the results tell us what proportion of claims we can expect to reduce as well as the potential improvement in lost time? How was the business case developed? Can we see it?)*

Not all health improvement programs require data analysis to validate their effectiveness. Smoking cessation programs, weight management programs, nutrition and diet education and any initiative to get people active through walking, running, using the stairs or working out are always worth doing.

13. How are we using our healthcare, disability and lost time data to manage our workforce productivity?

Benefit professionals are deluged with reams of data, but little of it can be readily integrated or converted into information that can be used effectively. Historically,

only the biggest employers could afford to establish a data warehouse where medical, drug, disability and workers' compensation data can be integrated and evaluated in a uniform fashion against useful norms or benchmarks. Thanks to advances in technology and improvements in data reporting, this capability is within the reach of virtually all larger employers. If you keep hearing "we don't have data on that..." this may be the question to pose. Individual carriers or administrators can't do it...a data warehouse purchased directly through a service provider or through a national employer coalition like The National Data Cooperative may be the answer. ***(Key question: Do we have a data warehouse? If not, how are we integrating our data to make informed decisions on our workforce health and management of our burden of illness?)***

14. Should we bring health services onsite?

Years ago, nearly every employer had an onsite clinic staffed by a doctor or nurse to deal with occupational health and safety issues, urgent care and preventive services. Over the years these centers declined, but have resurged since 2000 as employers found employees not getting needed preventive services or screenings, leaving work for half a day to see a doctor, or not getting good health improvement or wellness support due to the demands being placed on their family doctors.

As a result, the latest (2008) Watson Wyatt/National Business Group on Health survey shows that about a third of large employers are operating, or plan to introduce, a clinic or "health center" onsite. When 1,000 or more employees are at or near a work site, there can be great value in establishing an onsite center to improve health, reduce lost time due to leaving work for doctor visits and offering the convenience of urgent care services for common ailments like a sore throat, an ear infection, pink eye or minor injuries. The centers can also be a valuable focal point for channeling employees into other health resources like an employee assistance plan. Employees value the resource. Employers find that services can be delivered at lower cost and time away from work can be reduced.

Thanks to the growth in third party vendors who operate these centers for employers, the employer need no longer hire its own medical staff nor be intimately involved in day-to-day operations, assuring employee privacy and a clear separation between the company and the care being delivered. ***(Key question: Have we looked at an onsite clinic or health center for our sites that have 1,000 employees or more?)***

15. Are we still managing the basics?

The basics still matter. In health benefits, broad access to the best provider discounts is still critical. ***(When was the last time we benchmarked our access and discounts against other options?)*** Administrative costs still need to be aggressively monitored. ***(When was the last time we benchmarked our administrative fees and services against the best market pricing?)*** And, prescription drug discounts, dispensing fees, administrative fees and rebates are in constant flux. Even a drug contract negotiated

18 or 24 months ago could be outdated. *(When did we last evaluate the terms of our prescription drug benefits contract? Even if it's a multi-year contract, if it's been more than 18 or 24 months, should we get it benchmarked to see if we can re-negotiate terms?)*

Beyond plan management, have services, contracts or claim administration services been audited to assure that the needed processes and controls are in place and performance standards are being met? Audits are especially useful in managing eligibility for coverage of dependents. Recent studies have shown that as many as 7% of dependents may be covered when they shouldn't be, increasing costs and burdening both the plan and those with legitimate dependents enrolled. *(Key question: Have we considered a dependent eligibility audit?)*

Finally are ERISA required plan documents, summary plan descriptions and claim fiduciary processes in place and up-to-date? *(Key questions: Do we have ERISA plan documents for all of our benefits? When were they last updated?)*

In Closing:

The purpose of this article is to highlight some of the high-level questions that the senior executive should be raising to help assure that he or she is sufficiently aware of the organization's health strategy and direction. By its nature, this commentary can't provide specific guidance for any one employer. As in any specialized area, nothing can replace in-depth experience or technical expertise. The prudent executive will want to engage internal benefits professionals or outside experts to assure a holistic assessment of organizational health and productivity strategy.

Aristotle Onassis once observed that "the secret of business is knowing something nobody else knows." For the executive seeking to understand organizational health strategy, it may not be a matter of knowing a secret, but rather knowing what questions to ask.

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