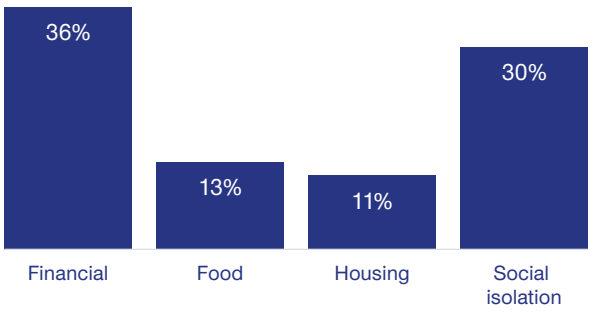
Community insights:

Key factors that influence employee health

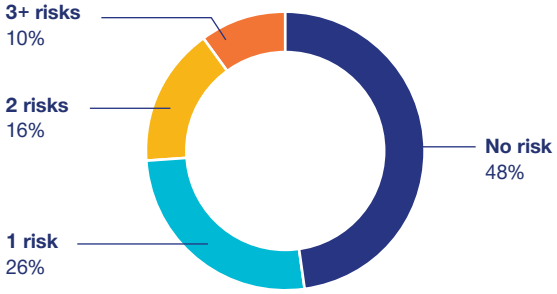
Seven years ago, in the first **annual white paper,** Health Action Council (HAC) and UnitedHealth Group analyzed Community Health data specific to HAC employer populations. It reinforced that communities influence employee health care outcomes and productivity; and it highlighted some significant inconsistencies across communities.[1]

This year's white paper provides a fresh look at the factors that contribute to employee health based on geographic location and associated social determinants of health (SDOH). SDOH factors are the conditions in which people live, learn, work, play and worship that affect quality of life and a wide range of health outcomes and risks.[2] The analysis conducted validates that geographic location, Community Health and SDOH risks are contributing to poorer health outcomes and higher costs,[3] as detailed in the sections below.

Percent of adults with high SDOH risk



Percent of adults by number of SDOH risks



The analysis explored a range of factors and HAC plan sponsor claims data associated with 217,779 employees, whose average age is 34. Fifty-one percent of the population is male. The review included claims incurred between April 2022–March 2023 and paid out through June 2023.

continued

What are the greatest influences on employee health?

Given that 80% of a person's health can be influenced by factors outside the health care system,[4] it's important to understand the 2 categories having the greatest impact on population health outcomes: Community Health and SDOH.

Regional variations in Community Health and associated SDOH data suggest that employers should seek to understand the communities where their employees live. What may work strategically in one region may not work in another.

Community Health

Indicators that can inform how an employee interprets and sets health priorities[5]

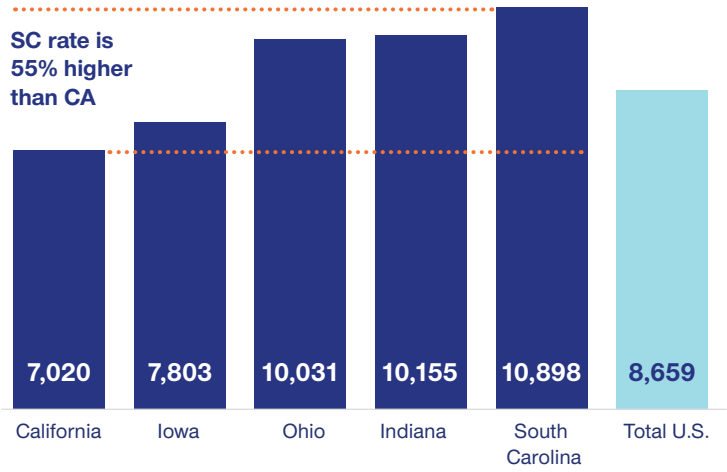
- Socio-demographics
- Health status/quality of life
- Health risk factors
- Health resources

SDOH

Conditions in the environment where an employee was born, lives, works, plays and worships that affect quality of life and health outcomes and risks[2]

- Financial insecurity
- Food insecurity
- Housing insecurity
- Social isolation

Mortality:
Premature deaths before age 75 (per 100K)



The findings shared here showcase how daily challenges (such as food and housing insecurity) or health disparities (such as gender bias, level of education and geographic inequities) can pose significant health risks.

Consider the mortality rate for HAC employees working for 1 company across 5 different states. Employees in South Carolina face a 55% less chance of reaching age 75 than employees in California.[6] In South Carolina, suicide rates are 46% higher than California and drug deaths are 52% higher.[7] Similarly, employees living in Ohio are 16% more likely (than the national average) to die before the age of 75.[6]

Interestingly, Ohio had the highest rate of smoking among HAC's top 10 member states. The state reports that 18% of residents over 18 years old are tobacco users.[6] In California, that number is 9%.[6]

Where your employees live influences your benefits program outcomes

The analysis further revealed that a disproportionate number of HAC employees—66% compared to 36% of the overall U.S. population—live within the 20 lowest-ranked states, based on outcomes across 87 health measures.[6]

HAC plan sponsors and other employers in those states have greater headwinds in their population's health and cost. In fact, if the population analyzed lived in the top 20 healthiest-ranked states, **the total covered per member per month (PMPM) cost may be reduced by $61M—7% of spend or $24 PMPM.**

Additionally, those living in the 10 least healthy states are 13% more likely to face high-risk SDOH. This shows that the health of the state in which employees live may lead to increased health challenges and consequently higher costs for employees and employers.

Employees who live in less healthy states cost employers more

Covered PMPM differential

Current	If 66% were in top 20 states	
$491	$467	-7% / -$61M

State rankings[6]	Percent of HAC employees	Percent of U.S. population	HAC covered PMPM	Percent of adults with high risk SDOH
1–10	4%	13%	$454	47%
11–20	7%	10%	$469	52%
21–30	23%	41%	$472	50%
31–40	55%	24%	$507	52%
41–50	11%	12%	$478	60%

13-point differential

Taking action

By analyzing Community Health and SDOH factors, you can better understand the needs of your employee population before a claim is submitted, helping you optimize your health improvement strategy.

Putting the pieces together: Community Health and SDOH risk have widespread impact on employees and employers

What are the implications of Community Health challenges and SDOH risk? While a variety of factors play a role in the health of employees, those who experienced disproportionate challenges or risks:

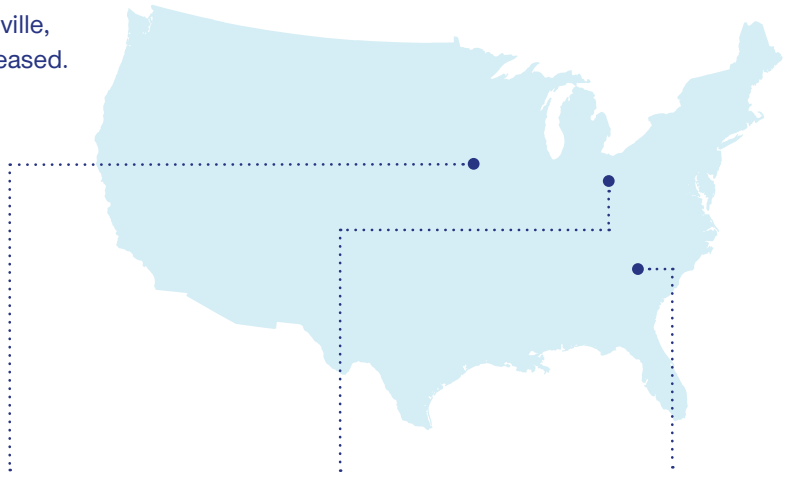
- **Made less-optimal decisions**
- **Utilized the ER 41% more**
- **Were less likely to participate in preventive care or well visits**
- **Were more likely to receive behavioral health diagnosis**

Higher PMPM costs[3]

A tale of 3 cities: Measurement by market

In a comparison of Des Moines, Columbus and Greenville, covered PMPM costs increased as state ranking decreased. This was also true for the prevalence of SDOH risk and emergency room (ER) utilization.[3]

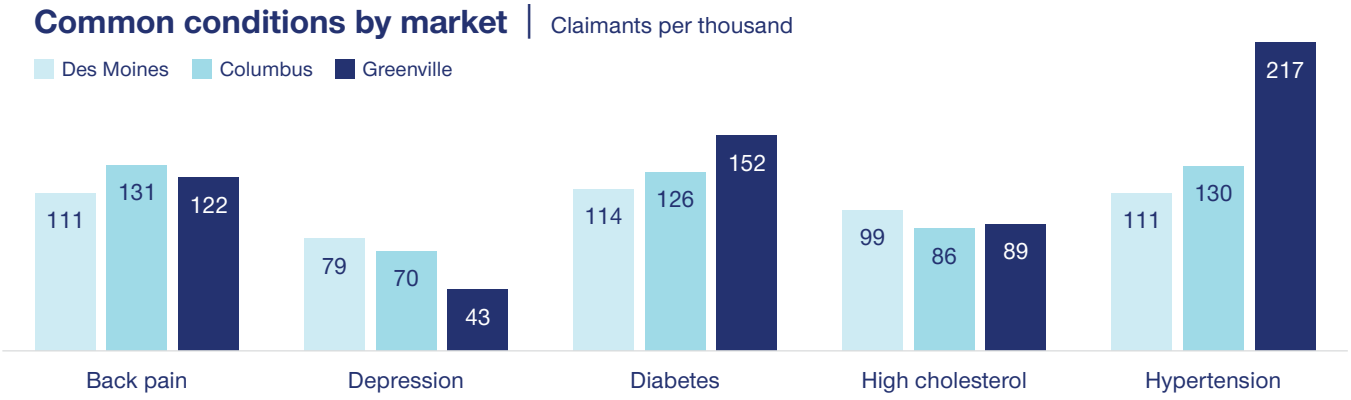
Metabolic conditions were higher in Greenville, as were the number of adults with high SDOH risk. Columbus accounted for the most behavioral health claimants, and had the highest percentage of primary care provider (PCP) engagement. It also accounted for the highest number of adult well visits per year.[3] Des Moines is the healthiest, with the lowest PMPM spend and the lowest number of people with SDOH risk.[3]



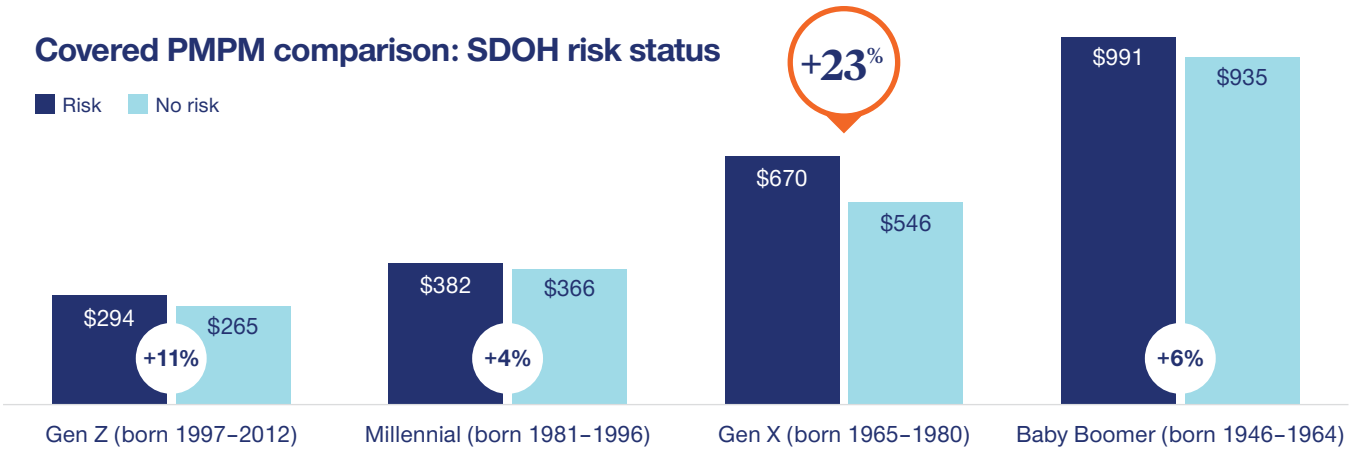
	Des Moines, IA	Columbus, OH	Greenville, SC
	15th	37th	41st
Average age	32	33	36
PMPM	$354	$529	$543
Adult well visits	43%	48%	23%
ER visits per 1K	114	205	309
Engagement with PCP	64%	71%	63%
Adults with metabolic conditions	44%	43%	51%
Behavioral health (adult)	178	209	139
Behavioral health (child)	176	183	111
Adults with SDOH high risk	51%	53%	65%

This reinforces that there are a multitude of factors influencing the health of a workforce outside the health care system and that it's important for employers to fully understand the unique challenges that their communities may be facing.

As we look at the most common conditions, we also see a direct correlation between community and illness. Des Moines had the lowest prevalence of metabolic disease and the highest identified rates of depression, while Greenville had the highest rates of metabolic disease and the lowest rates of identified depression.

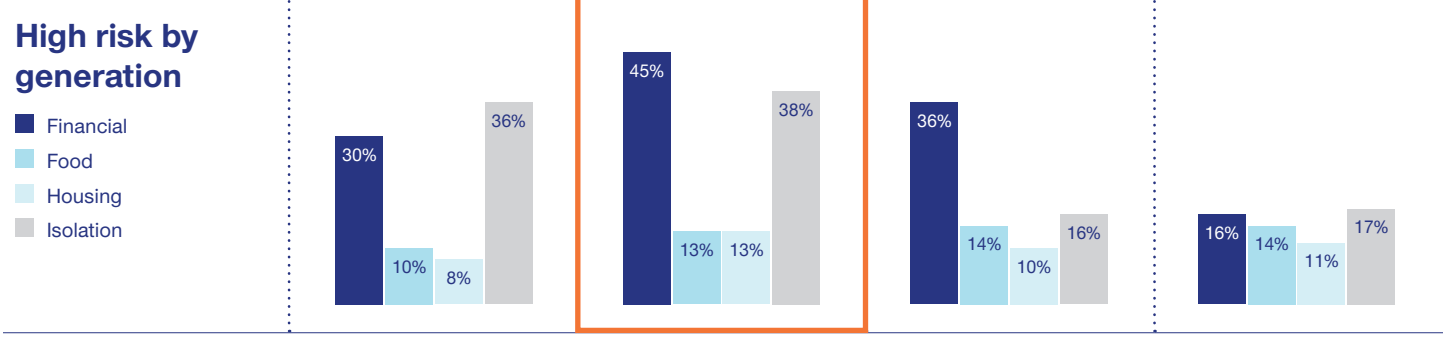


Cutting across generations: SDOH risk prevalence by age



Younger HAC employees tend to have increased SDOH risks when compared to Baby Boomers. And, not surprisingly, employees with SDOH risk also had slightly higher PMPM spend. The greatest difference in risk, however, was seen among Generation X employees.[3] There was a 23% risk differential in this group; more than twice that of the next highest differential.

	Gen Z	Millennial	Gen X	Baby Boomer
Number of members	**18%/29K**	**31%/52K**	**35%/58K**	**17%/28K**
3+ SDOH risks	11%	13%	8%	6%



The analysis further evaluated the percentage of the population by generation having 3 or more SDOH risks. It reveals that Millennials have the highest rate of SDOH risk, particularly in the areas of finance and isolation.[3] For more details about Millennials and their children, please review our **2023 white paper.** From a gender standpoint, there is little difference in the SDOH risk between women and men. The one outlier? Men tend to see their PCP less frequently, so chronic conditions may be under-diagnosed.

Taking action

Implement measures to address SDOH early and across generations, as it can directly affect employee health and claims spend.

Understanding the familial impact: SDOH risk influence on behavioral health

Among HAC employees, SDOH risk translates to a 12% to 90% higher likelihood of behavioral or mental health diagnosis per 1,000.[3] A similar story can be told when it comes to children of families with SDOH risks. For example, 41% of children were identified as having parents experiencing at least 1 high risk SDOH condition. Those children had an increased prevalence of suicidal ideation and depression, higher PMPM spend and more ER visits per 1,000—despite having 10% fewer claimants for anxiety per 1,000.[3]

Regarding preventive care: Children of HAC employees with SDOH risk had similar—or even higher—rates of well-care and immunizations compared to children of employees without risk.[3] This means that, even though parents may be putting off their own screenings and wellness visits, their children are seeing a PCP and receiving their vaccinations.

	Adults with risk vs. no risk	Children in families with risk vs. no risk
Anxiety	↑ 12%	↓ -10%
Depression	↑ 22%	↑ 16%
Suicidal ideation	↑ 90%	↑ 53%
Alcohol-related	↑ 17%	
Substance use	↑ 45%	

Taking action

Plan sponsors can educate employees on when and where to access care, and monitor behavioral health provider access and promote virtual solutions where access is challenged.

Mapping risk: State investment affects employee health

In the U.S., health care is decentralized and primarily managed at the state level. Each state has its own set of regulations, licensing requirements and oversight bodies governing health care providers, insurers and facilities. This approach often results in varying standards of care, public health funding, coverage and accessibility—all contributing to a complex health care landscape.

As the chart shows, the states with the largest Community Health funding (Iowa and California) had the highest state health rankings and employers had the lowest PMPM costs. Iowa and California spent almost double per person when compared to the lower-ranked states.

Most populated HAC states	Percent of HAC employees	State health ranking	Community spending per person	HAC covered PMPM
Iowa	3%	15th	$161	$363
California	3%	22nd	$138	$449
Pennsylvania	3%	25th	$83	$454
Illinois	4%	26th	$109	$485
North Carolina	5%	30th	$76	$443
Indiana	3%	35th	$76	$476
Ohio	39%	37th	$75	$519
Texas	6%	38th	$74	$471
Missouri	3%	39th	$80	$482
South Carolina	3%	41st	$102	$535
		Average U.S. ▶	$116	$491

Taking action

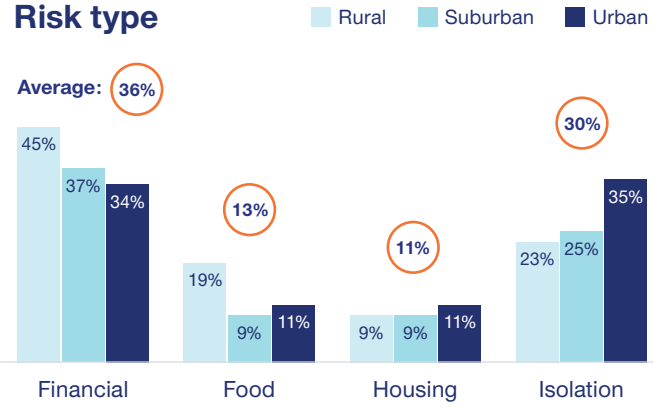
Become familiar with local and state public health policies and priorities that may affect the health of your employees, and their access to care and costs.

Digging deeper: Rural vs. urban risk

Beyond state variations in health and SDOH risk, rural versus urban- and suburban-dwelling employees also face unique challenges. Overall, risk in rural areas was more than 6% higher than in suburban and urban areas.[3]

While rural employees had more financial and food insecurity than their urban and suburban peers, rural employees faced a lower risk of housing insecurity and social isolation. However, at 23%, the risk of isolation still remains significant.[3]

Among HAC employees, financial insecurity is the most common SDOH risk type, followed by social isolation. Housing insecurity impacted the fewest employees.[3]



Location	Diabetics with food insecurity	Depression with social isolation
Rural	21%	27%
Suburban	10%	32%
Urban	14%	42%

Taking action

State-by-state risk varies based on the kind of community in which your employees live. Understanding the rural/suburban/urban makeup of your workforce can strengthen your ability to develop a relevant health improvement strategy.

Conclusion: A broader perspective to advancing health

We have come to the end of an era where benefits and benefits strategies are developed solely on retrospective claims data and company culture and budgets. As health care and health care outcomes are inconsistent, employers must open their lens to additional data and micro sets of data. It's essential that the geographic location of employees and the associated Community Health and SDOH data be reviewed and incorporated into health improvement strategies to improve the health outcomes, productivity and associated costs of their employee populations.

Through this study, we have confirmed that employers can make decisions that positively impact the health of their employees, businesses and communities. Despite the location of their employees, HAC employers have experienced better outcomes and managed costs (over a 13-year period, and medical cost trend has been under 2%). Employer benefit decisions make a difference.

Here are a few thoughts to help you manage the health outcomes of your employees and their dependents:

1. As communities continue to tell us more and more about our populations, expand your data set to include geographic, Community Health and SDOH factors.
2. Within your benefits strategy, identify sub-populations in addition to the traditional common disease categories. This will provide additional insights into regional patterns for you to better develop and implement targeted clinical and communication programs.
3. Before hiring a new employee or opening a new office, consider the location, the state health ranking and Community Health spending for the region, as well as any prevalent SDOH factors that may be influencing the health of the population.
4. Educate employees on:
   - Where and when to obtain care
   - The value of a provider relationship and preventive care
5. Offer your employees tools and access to local community resources.
6. Encourage employee collaboration and interactions outside of emails and texting. Examples: Communal eating, in-person meetings, team building exercises, etc.
7. Engage and collaborate with your local provider system. Give voice to the needs of your population and work together to develop impactful tools and resources.

Learn more

Gain an advanced viewpoint of your employee population's health based on additional data points. For more details, contact Patty Starr of HAC or Craig Kurtzweil of UnitedHealthcare.

About HAC — HAC is a not-for-profit organization representing large employers that enhances human and economic health through thought leadership, innovative services and collaboration. We provide value to our members by facilitating projects that help to improve quality, lower costs and enhance individual experiences, and by collaborating with key stakeholders to help build a culture of health.

About UnitedHealthcare — UnitedHealthcare is dedicated to **helping people live healthier lives®** by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. The company offers the full spectrum of health benefit programs for individuals, employers, military service members, retirees and their families, and Medicare and Medicaid beneficiaries, and contracts directly with nearly 1.8 million physicians and health care professionals and 7,160 hospitals and other care facilities nationwide. UnitedHealthcare is one of the businesses of UnitedHealth Group (NYSE: UNH), a diversified Fortune 50 health and well-being company.

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[1] Health Action Council. Community Health Data: Improving Employer Investment in Overall Employee Health. Feb. 2018. https://e-i.uhc.com/content/dam/ei/microsites-content/healthactioncouncil/pdfs/UHC_HAC_WP-CommunityHealth.pdf. Accessed Jan. 31, 2024.

[2] Office of Disease Prevention and Health Promotion. https://health.gov/healthypeople/priority-areas/social-determinants-health. Accessed Jan. 31, 2024.

[3] This work contains UnitedHealth Group internal data based on a comparison of current medical and pharmacy plan data of Health Action Council plan sponsors from April 2021 through March 2022, paid through June 2022, as well as historical data dating back to 2012.

This case study is true. Savings calculated on book-of-business case rate savings for these programs. Savings for enrolled members are case specific. Results will vary based on client-specific demographics and plan design. Results will vary depending on the state where the insured policy is issued and the amount of engagement by employees.

Employer data was included based upon multiple but not mutually exclusive factors such as: effective date with medical carrier, pharmacy benefit manager and availability of data in carrier analytic systems. Every effort has been made to include data to the greatest extent possible.

[4] NCQA. NCQA_Health_Equity_Social_Determinants_of_Health_in_HEDIS.pdf. 2021. Accessed Dec. 12, 2023.

[5] Center for Disease Control and Prevention. https://www.cdc.gov/nchs/healthy_people/hp2020/hp2020_indicators.htm. Accessed Jan. 31, 2024.

[6] America's Health Rankings. 2022 Annual Report. Available: https://www.americashealthrankings.org/learn/reports/2022-annual-report. Accessed Jan. 31, 2024.

[7] America's Health Rankings. 2023 Annual Report. Available: https://www.americashealthrankings.org/learn/reports/2023-annual-report/. Accessed Jan. 31, 2024.