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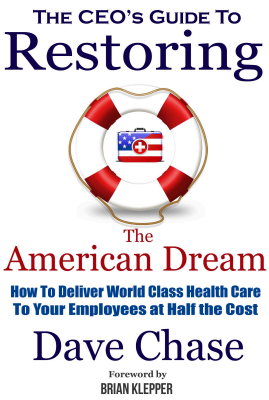

The CEO's Guide to Restoring the American Dream

How to Deliver World Class Health Care to Your Employees at Half the Cost

Dave Chase

This collection of essays about the US health care system, its out-of-control costs, and how companies and insurance buyers can better manage them delivers an important and urgent message. Dave Chase heads the Health Rosetta, a nonprofit and public benefit corporation that shares practical and nonpartisan fixes to health care. As its CEO, he demonstrates expertise and passion in this insider's guide to managing your company's health care benefits.

Take-Aways

- The system of employer-provided health insurance resides at the heart of US health care problems today.
- Though health coverage for employees constitutes enormous expense, most firms don't scrutinize their spending.
- Despite the money poured into medicine and hospitals, 200,000 Americans die every year due to preventable medical mistakes.
- The FBI estimates that health care fraud costs the nation about $300 billion each year.
- Spiraling health care costs mean that the US middle class is worse off than the generation before it.
- No generation stands to lose more than millennials, who are now challenging the health care system's absurdities.
- Many employers have given up trying to contain health care costs, but a growing number are fighting back.
- Organizations that successfully manage health care costs often opt for self-insurance.
- Organizations that successfully manage health care costs also demand quality and safety data from providers – hospitals, doctors, and the like. Switch providers if they refuse to give it to you.

Summary

The system of employer-provided health insurance resides at the heart of US health care problems today.

World War II brought tight wage restrictions to employers. To compete for workers, they increased benefits and many began offering health insurance. This uniquely US model blinds workers to the real costs of health care and creates a perverse incentive that discourages preventative and chronic care while rewarding far more expensive acute and reactive care.

> *"Every employer who has slayed the health care cost beast has recognized the importance of proper primary care."*

Almost one-third of Medicare spending occurs in a patient's last six months of life and covers mostly unnecessary and/or harmful treatments that line the pockets of the health care industry. Another third of the $3 trillion spent on US health care amounts to fraud and waste – enough to make college free for every high school graduate or to insure every uninsured American six times over.

Though health coverage for employees constitutes enormous expense, most firms don't scrutinize their spending.

Health care is often a company's second-largest expense after payroll. As much as 10% goes to fraud and up to 30% to other waste. Few CEOs would tolerate that in any other line of business. CEOs and CFOs must look at their health care spending as a source of competitive advantage and not a benefit that HR handles.

> *"Good health not only improves morale and productivity; it enables you to spend less on health care and more on growing your business."*

The average employer pays 260% of the approved Medicare rates for procedures; many pay three, five or even ten times more. Hospitals and insurers win with higher prices. The health care industry pushes the most expensive treatments, even if they don't benefit patients. CEOs should demand fair and transparent pricing, so they and their employees can make better-informed choices. When proper primary care is in place, surgeries drop by one-third to one-half for musculoskeletal ailments like lower back pain. Meanwhile, the lower-cost, more beneficial options, like physical therapy, surge.

Insurers pay hospitals' primary care physicians incentive bonuses to get them to refer patients to specialists – which drives up costs. Instead, company health plans should focus on independent, ethical primary care. Trusted primary care physicians save money because, except where necessary, they avoid specialists and drugs by treating root causes and consulting with patients about more effective treatments.

Preferred provider organization (PPO) networks within insurance plans raise prices and do not focus on quality. Allowing price-gouging providers into networks means high costs for employers and often generates the worst outcomes. The best hospitals in the United States, including the Mayo Clinic and others, generally avoid inappropriate treatment, as seen when you compare them to typical hospitals. High-quality physicians and hospitals practice evidence-based medicine to reach high standards, avoid surgery where possible and lower costs.

Perhaps the most surprising finding about health care is that prices are flat in the real market made up of patients who pay cash (due to high deductibles) and direct contracts between employers and health care providers. Flat prices are less surprising once you understand that clinicians are paid pretty much the same way as they were during the past decade.

Carriers love out-of-network claims and approve them rapidly because they make more money – 30% or more of so-called savings – when they help drive up the mythical "medical trend." This shift to out-of-network pricing also gives them an opportunity to "reprice" a claim, even if they never should have paid it in the first place. Companies should make it easy for employees to use high-quality providers. For instance, they can offer care navigators to guide employees to high-value providers, thus eliminating out-of-pocket costs and saving money for the employee and the employer alike.

Carrier executives promise Wall Street to drive profit growth of between 10% and 15% annually; this pressure leads to unsavory tactics, including the bonuses paid out to insurance brokers – clearly putting the interests of carriers above their clients. A brokerage can earn an annual bonus of half a million dollars if it retains 90% or more of an insurer's customers. This incentivizes brokers to maintain the status quo, even if they could find a better deal with another insurer. Ask brokers about bonuses and compensation from insurance firms and whether their largest clients provide health care services like hospitals and clinics do. Don't assume that your broker works for you.

> *"It's unconscionable to blindly send an employee to a hospital with little or no information on its safety record."*

Between 6% and 10% of a typical firm's employees will account for about 80% of claims and pricey blockbuster procedures like organ transplants or cancer treatments. Ask for a second opinion from a first-rate center like the Mayo Clinic or Virginia Mason. One-quarter of cancer treatments and 40% of transplants prove to be unnecessary. Beware insurers' claims about wellness program ROI. Virtually no firm in the history of these programs has achieved a positive ROI from a wellness program.

Despite the money poured into medicine and hospitals, 200,000 Americans die every year due to preventable medical mistakes.

The US medical-industrial complex encourages doctors to feed patients into its system. Technologies and advanced procedures like cardiac catheterization, for example, save lives, but their vast overuse in some cases harms or kills patients.

> *"Health care is a $3 trillion dollar industry and 30 cents of every one of those dollars spent on health care is wasted…In 2009, that was $750 billion."*

All this spending delivers a health care system that ranks as mediocre among the world's wealthiest nations and generates the lowest customer satisfaction among all industries, including cable TV. Only about 10% of physicians recommend health care as a career.

The FBI estimates that health care fraud costs the nation about $300 billion each year.

Insurers play the "pay and chase" game. Because they get paid a recovery fee, they pay obviously fraudulent claims and investigate afterward to retrieve the money. Insurers never recover most of the money paid out in fraudulent claims.

> *"Estimates of fraud, waste, and abuse in health care range from a low of 30%…to over 50%…but are little known among employers."*

Insurance firms and their unwitting customers facilitate fraud, in part, by pushing the "auto-adjudication of claims." Under this system, claims administrators pay virtually every claim automatically, no matter how flimsy the invoice sent by the provider. Credit card companies leave no stone unturned in rooting out fraud, and health care fraud is 14.3% higher than credit card fraud. Better investigative techniques and more use of AI and sophisticated algorithms for pattern recognition – such as those used by credit card firms – would eliminate much health care fraud.

Spiraling health care costs mean that the US middle class is worse off than the generation before it.

At the heart of the American Dream is the expectation that each generation will surpass the one before it in prosperity and quality of life. That Americans can no longer fulfill this dream is due not to lower wages or higher unemployment, but to profiteering and price-gouging.

> *"Hyperinflating health costs have been 95% responsible for 20 years of income stagnation and decline for [the American] middle class and our most vulnerable citizens."*

If health care costs had increased with the pace of inflation since 2007, the average US family would have $5,000 more to spend after taxes each year. Health care, as a percentage of GDP and

household spending, keeps increasing. If costs increase at their current trajectory – an average of 8% each year – families will have nothing left to spend on anything else by 2033. This causes so much hardship that experts identify it as a leading cause of social ills, including the opioid epidemic. In many jurisdictions across the United States, health insurance and related costs for one municipal employee exceed the remaining budget for entire departments or volunteer fire stations. As a result, road repair ceases and parks fall to ruin just so municipalities can pay worker health care costs.

No generation stands to lose more than millennials, who are challenging the health care system's absurdities.

Absent dramatic change, millennials stand to pay half their earnings to health care if current trajectories hold. They face a bleak future. Having fueled disruption in the retail, travel and financial services industries, millennials appear ready to demand and lead health care reform. They are questioning the system and demanding change so their future isn't jeopardized. Millennials are more insistent than previous generations about convenience, access to their personal medical records and mobile access to physicians.

Many employers have given up trying to contain health care costs, but a growing number are fighting back.

The Health Rosetta is a nonprofit firm that encourages organizations to adopt an approach to health care costs and quality that reduces costs, aligns incentives and improves outcomes. The Health Rosetta argues that organizations should focus on primary care and prevention. And it affirms the need for employers to apply financial standards to health care plans equivalent to those applied to employee retirement plans.

> *"Saving money in health care requires employees to be educated, engaged participants in their health."*

By following the Health Rosetta's principles, some firms realized health care spending reductions of 20-40% or more while improving the standard of care for employees. The Allegheny County Schools Health Insurance Consortium (ACSHIC) in Pittsburgh, for example, negotiated per teacher coverage of $4,661 per year compared with $8,815 in nearby Philadelphia – saving $199 million per year. Class sizes in Pittsburgh are a third smaller and teachers earn more money with better benefits. ACSHIC accomplished better health outcomes at lower costs by educating employees about the importance of primary care and by teaching them to prefer high-quality, evidence-based providers.

Rosen Hotels & Resorts in Florida has been applying these approaches for over 20 years and has cumulatively saved over $400 million compared to their benchmarked competitors – a full 55% less per capita despite having a high disease burden (for example, 56% of their pregnancies

are considered high risk). Rosen offers on-site health services staffed with health coaches, nutritionists and nurses. They also pay for the college education of employees and their children. Unsurprisingly, Rosen's staff turnover is about one-fifth the industry average.

Organizations that successfully manage health care costs often opt for self-insurance.

Employers who self-insure – that is, pay their employees' health claims directly – reduce their exposure to insurance carrier-enabled predatory PPO pricing by 90%. These firms take out stop-loss insurance to protect against shock claims and tend to come out ahead overall, especially when they partner with independent third-party administrators (TPAs) as opposed to insurance company–run administrative services (ASOs) – to build and administer health plans. Self-insured firms often work with preferred provider organizations (PPOs) – preferably national PPOs – that offer discounted rates.

> *"As with most dysfunction in health care, simple incentives and behaviors often have enormous, counterintuitive and costly consequences."*

The costs of medical procedures change only slightly each year, and some costs decrease. Firms that negotiate directly with health care provider organizations – like individuals who do the same – get better deals than insurance companies, whose prices escalate through layers of intermediaries and whose incentives favor higher prices.

Self-insurance is a sound strategy for firms seeking greater control over spending and the quality of the care they provide to employees ensuring they fulfill their fiduciary duty. This spells out a legal duty to shepherd health funds with the same diligence with which it manages employee retirement funds. Not understanding this fiduciary duty can put a firm at enormous risk. Working with competent benefits and legal advisers ensures this risk is well managed.

Organizations that successfully manage health care costs also demand quality and safety data from providers – hospitals, doctors, and the like. Switch providers if they refuse to give it to you.

Insist that providers release personal medical records to employees, so they can make better-informed choices. Insist on transparent package or "bundled" pricing for health procedures and pharmaceuticals.

Hire a health administrator with financial and statistical skills similar to those of your retirement plan administrator. Give your health administrator the authority and support to negotiate and manage your health care costs. If you self-insure, hire a properly aligned benefits consultant to help you build your plan with the safeguards you need to manage risk. Consider paying your consultants, at least in part, based on their performance and results.

For a free download of this book in its entirety, along with full versions of other books authored by Dave Chase, please visit www.healthrosetta.org/friends.

About the Author

Dave Chase also wrote *The Opioid Crisis Wake-Up Call*. He co-founded and helps lead the Health Rosetta, a nonprofit firm and public benefit corporation focused on transforming the US health care system.