CHAPTER 9

STEPS FOR BUSINESS LEADERS LOOKING TO PREVENT LOANS & LAYOFFS

COVID-19 put American business leaders in a tough spot. Shelter-in-place orders and social distancing made the people in charge of making payroll nervously eye their bottom lines and think through difficult decisions involving loans, layoffs, and even permanent closure.

Some businesses were better off than others, and not necessarily because they were deemed essential. As Kaiser Health News reported, Harris Rosen of Rosen Hotels had a leg up on other employers planning for the reopening of their business. Why? "Employers with on-site health clinics are best positioned to test because they likely have access to the supplies and the providers needed to administer them," Mike Thompson, CEO of the National Alliance of Healthcare Purchaser Coalitions, is credited as saying in the article.

More broadly, the best-positioned employers – in "normal" times and even in times of crisis – are those that have more control over their health plan. To demonstrate the magnitude of the opportunity, consider this: A mature, low-margin company, Pacific Steel & Recycling, reduced its spending from over $8 million to under $3.5 million. The company would

have had to have sales revenue increase ~25% to have the same bottom-line impact.

Note: Employees also saw improvements in their health benefits such as eliminating cost-sharing and having a member champion to help navigate the health care system.

For public sector entities, modernizing health benefits is the only plausible way to avoid cutting services in times of dramatic tax revenue reductions. Fortunately, countless public entities (towns, counties and school districts) have demonstrated health benefit reductions of 40% or more when they reset/improve their health benefits strategies.

The good news is, all leaders can find similar successes – and by sharing five simple, easy-to-remember steps, benefits advisors can help them figure out how to do so. (The first letter of each action item spells out a word we all know, "LOCAL")

Step 1. *L*earn How to Be Liberated from the Status Quo

When it becomes necessary to cut costs, for most employers, the last major area to modernize is health benefits — striking, considering health benefits are often their second biggest expense after payroll. As such, this is the area with the biggest room for improvement.

However, benefits advisors should be prepared for business leaders to be hesitant to undertake a health benefits transformation, because they are likely afraid the change may be viewed negatively by members. That is understandable given that most changes in health benefits for the last 20 years have meant paying more for less and less coverage. Plus, change can be scary and there's always some comfort in the status quo.

Nevertheless, it's important for benefits advisors to communicate that business leaders maintaining the status quo could cost them their business (or lead to services/staff cuts if they're a public entity) and may be the riskiest move of all. They know health benefits are expensive, forcing them to often increase employees' cost-sharing to offset the annual 5%-50% increase their benefits broker says is essential. But they might not know just how miserable status quo health plans are. They have lower satisfaction rates than cable companies, and for good reason: 70% of those who filed for bankruptcy due to medical bills — the No. 1 driver of bankruptcies in the U.S. — had "insurance" that failed to insure against financial ruin.

As we have said, while it may seem backwards to business leaders, the best way to slash health care costs is to improve health benefits; that all starts with learning how to be liberated from the status quo.

Usually, liberated employers realize two things:

1. The shift from a renter to owner mentality (switching from a carrier-controlled plan to an independently administered employer-optimized plan) is a logical progression for CEOs/leaders who have long said that employees are their most valuable asset. As stewards of that asset, those spending 20%-55% *less* per capita on outstanding benefits packages, have shown the way for all employers.
2. Wise health plan design isn't complex and has been successfully tackled in case studies we've published from employers as small as seven employees to many thousands. Michael Lewis put it well, "If it wasn't complicated — it wouldn't be allowed to happen. The complexity disguises what's happening. If it's so complicated that you can't understand it — then you can't question it."

In line with item one, liberated employers cut ties with their status quo plan from an old-line insurance carrier. In an employer-optimized plan, the company directly pays for its employees'

medical claims. In reality, it was already paying for them before but with middlemen taking exorbitant fees. Did you know that clinicians — doctors, nurses, PTs, etc. — only get $0.27 of every dollar ostensibly spent on healthcare?

And expanding on item two, I know that all this is possible because I've seen it play out with my own two eyes in every corner of the country. In public and private employers both large and small, health plans that follow the Health Rosetta framework really do accomplish what they claim. Highlighting success stories can prove powerful for benefits advisors trying to convince business leaders to carry on with a health benefits transformation.

Step 2. *Optimize* Health Plan Infrastructure

Once leaders liberate themself from the status quo, they'll probably feel a few things, empowered and exhilarated, but also daunted about what to do next. That's why step 2 is all about picking the right people and tools to help.

As vital as this step is, it can get a bit technical and boring since it concerns the underpinnings of the health plan. However, if business leaders do a good job selecting a properly aligned benefits advisor, they will not have to deal first-hand with many of these "in-the-weeds" issues.

We know that not all benefits professionals are the same. Unfortunately, the model of the industry has been to have benefits brokers paid by carriers, pharmacy benefits managers (PBMs) and others who have a fiduciary duty to their shareholders to have healthcare spending increase — we find as many as 17 undisclosed revenue streams where someone purporting to represent a buyer earns their income from sellers. Obviously, this works directly against business leaders and other health care purchasers.

Leaders who are taking the next step to liberate themselves from the status quo need to make sure they have a benefits professional that is going to work in their best interest. Asking their current benefits broker the following three questions is a good start, as I have previously described to *Entrepreneur*:

1. What kind of commissions and bonuses do you receive from carriers, in total? *Note: Be sure to ask about indirect compensation they or their brokerage firm may receive from carriers or PBMs.*
2. Do you receive more than half of your compensation from one carrier?
3. Can you meet with me now?

Questions one and two help leaders ensure their benefits professional is most incentivized to help them. The third is more a question of strategy, because the longer their broker delays their time to meet, the less time the business leader has to shop elsewhere. It's a common trick that can put business leaders in a tough spot.

Any ethical benefits broker will happily complete this simple compensation disclosure form, attesting where they or their office receives compensation. If an organization's broker is not willing to share this information, nor meet early and often to discuss options, it is time to find someone new.

Even if an organization's broker does have the "right" answers to the above questions, managing an employer-optimized plan that improves outcomes and saves money will take a special kind of advisor with expertise in this space.

Ideally, benefits advisors will know to effectively "spring clean" the underpinning of the health plan. They'll know how to spot the provider and vendor contracts that have "gotcha" clauses, and they'll be familiar with the fact that the most sophisticated and heavily resourced legal departments in the world have laden so-called "standard" agreements with an almost endless litany of value-extraction devices. We have seen wise benefits advisors clean out $1000 per employee per year in savings from carrier-controlled health plans, even without changing any of the core benefits elements – just the way they contract and oversee the health plans.

Savvy benefits advisors should also know a thing or two about stop-loss insurance, which is necessary to protect business leaders from shock claims; sadly, many benefits brokers have

scant knowledge and farm out this important decision. In addition, they should be able to point business leaders to a vetted list of better providers and vendors, including the carrier-independent third-party administrators (TPAs) they'll need to process claims and make sure things run smoothly.

Step 3. Carve out PBM

Targeting pharmacy benefits provides additional savings opportunities. The average person in the street probably is not familiar with the term "pharmacy benefit manager" — "PBM" for short — yet the dominant Big 3 PBMs are all Fortune 50 companies. In fact, they are so big, in 2018 they were able to acquire one of the biggest health insurers in the world, (Aetna).

Interestingly, there is not one purely pharmaceutical company in the Fortune 50. How is that so?

That's because PBMs are organizations that liaise as technically non-pharmaceutical middlemen between drug manufacturers and pharmacies. In exchange for placement of their products on pharmacies' formularies, PBMs negotiate rebates and discounts off drug prices with the manufacturers. The problem is, many PBMs practice opaquely, pocketing the rebates they should be passing along to the pharmacies and their consumers. Rebates are just the tip of the iceberg on PBM shenanigans that transfer money from employees' wallets to theirs.

Fortunately, there are high-value PBMs out there, making it possible for business leaders to have transparent pharmacy benefits, and, in turn, low-cost, high-quality health plans.

Once leaders decide to free themselves from the status quo and find the right benefits professionals to help them, it's time to start where the lowest-hanging fruit is and establish transparent pharmacy benefits; since profiteering is so extreme, yet easy to fix, it can have a hugely positive, nondisruptive impact on health plan members.

With transparent pharmacy benefits, business leaders and their benefits advisors work together to access, understand,

and utilize pharmacy claims data. That requires PBM contracts to make clear that the business owns its claims data as the purchaser of services, and that business leaders have the right to use that data to make informed decisions.

The best-informed decisions are made when business leaders pair their own data with unbiased consultants equipped with analytical know-how, pharmacy industry knowledge, and vendor insight to negotiate better PBM contracts. This will ensure they have a clear understanding of the terms and conditions that are often the source of hidden costs — even definitions left in *or* out of a contract can be financially devastating.

This is especially true when it comes to "guarantees." Average Wholesale Price (AWP), with its associated "discount," is the common method for evaluating PBM financial performance (aka "Any Wild-assed Price" or "Ain't What's Paid.") Because it is often confusing and misleading, AWP can reduce leverage in negotiations.

Another issue is distribution channel pricing variability, such as mail order and specialty. Mail order prescriptions could actually be costing you more than the same drug at retail. In contrast, some mail order and specialty pharmacies offer services for "cost plus a management fee," which can be far less expensive than the AWP model. So, when evaluating a PBM's channels, businesses will want to consider carving out mail order and specialty pharmacy services from the PBM contract, and determine whether it makes sense to leave all of the PBM services with one vendor.

Using strategies like these, the state employee health plan for New Jersey has already saved over $2 billion on drug spending. Caterpillar didn't see overall healthcare costs go up for a decade despite only focusing on drug procurement. Pacific Steel's Rx procurement strategy was a big part of their effort to rid themselves of profiteering and resulted in dropping their spending by more than 50%. And many much smaller health plans are seeing similar savings using exclusively high-value PBMs. Our movement's experience has been that pharmacy spending can be cut 20%-30%, resulting in an overall health care spending reduction

of 5%-10% depending on how heavily drugs are used in a health plan.

All this is a testament to the fact that knowledge is, indeed, power in a health benefits transformation. What's equally powerful, however, is value-based primary care.

Step 4. *Add* Value-Based Primary Care

There is no well-functioning health care system in the world not built on proper primary care. The same can be said about health plans.

The difference between "proper" and "improper" primary care is a matter of fee-for-service (FFS) primary care versus value-based primary care (VBPC). The former is sadly the status quo, in which most primary care practices are owned by health systems/private-equity firms and serve as milk-in-the-back-of-the-store to drive patients to high margin services.

In this fee-for-service system, every service and procedure have a charge — and businesses are billed for each regardless of how helpful they are to the beneficiary. As a result of this flawed incentive structure, primary care appointments are usually very short and often drive referrals to unnecessary, high-margin services such as scans and specialists. It also has a tendency to result in an over-reliance on prescriptions.

While Steps 1-3 are changes that can be made invisible to the employee, this step is clearly visible to members — in an incredibly positive way! Did you know that 75% of Americans surveyed didn't have a relationship with a primary care physician? A Walmart vice president shared that surveyed shoppers (each week they see 140 million Americans) who were asked if they had a relationship with a primary care physician, and only 50% said they did. Of the 50% who said they did, only half could name their doctor or said they had seen him or her in the last two years. Outdated health plans have enabled this and systematically decimated primary care over the last two decades.

By comparison, in a value-based system, providers typically

charge a monthly, quarterly, or annual membership fee that covers all or most primary care services including acute and preventive care. The fee is paid out of an individual's own pocket, by a sponsoring organization such as an employer or union, or by a health plan offering commercial or government programs, such as a Medicare Advantage plan.

Most commonly, the practice has been devoted to the particular sponsoring entity (e.g., an onsite or near-site clinic for employers/unions), but models that serve multiple clients are maturing. Direct primary care (DPC), which offers care directly to individuals, plan administrators, and employers in a range of practice models from solo practitioners to national organizations, is one example of that.

Without the overhead that FFS carries, VBPC practices can offer a more proactive care model that delivers a substantially better experience for patients, often in one or more of the following ways:

- More time with their provider
- Same day appointments
- Short or no wait times in the office
- Better technology, e.g., email, texting, video chats, and other digital-based interactions
- 24/7 coverage by a professional with access to their electronic health record
- Far more coordinated care
- Improved provider experience and professional satisfaction, which, in turn, is known to improve the quality of care

From a business standpoint, this model can also lead to significant reductions in downstream costs. The better-quality care from the outset means less follow-up care — and associated spending — is needed later. And when the focus shifts from reactive, episodic care to a continuous care relationship that takes lifestyle factors and chronic illness into consideration, higher-quality, preventive care management will lead to better health

outcomes — and potentially less spending — year over year.

When coupled with the other steps, organizations such as the Bennett School District, Pacific Steel, and Rosen Hotels are literally spending half what other employers are spending per capita. For a low-margin business, that can mean the equivalent of a 25% increase in sales revenue. For a budget constrained organization such as a school district, it's the difference between maintaining programs and providing teacher raises versus what's happening in too many school districts — cut programs and cost-shifting to teachers.

I've seen multiple organizations — and even entire communities — transformed by employers prioritizing value-based primary care and using saved dollars for higher and better purposes (see books and website for case studies), none better than Rosen Hotels. My TED talk takes a deeper dive into the details, but in short: Rosen Hotels spends 55% less per capita on health benefits than the average employer, connecting their employees to not only value-based primary care physicians, but physical therapists, behavioral health specialists, health coaches, and other health professionals.

Step 5. *L*eave Behind Value-Extracting PPO networks

At this point, leaders may be wondering, *"What about all the other clinics and hospitals outside primary care my employees might have to visit? How will I be able to ensure lower-cost, high-quality care in other areas?"*

The answer savvy benefits advisors will be: Do not stick with your old PPO network. In fact, the physicians described in Step 4 are aware of this and are integral in guiding their patients to high-value health care delivery organizations.

Wise health care purchasers evaluate pricing in health care by looking at what is being charged as a percentage of Medicare pricing. Why? Because Medicare uses a rigorous process to

develop pricing that considers actual hospital costs (which are often inflated) and market variances. It is common for PPO network pricing to be 3–5 times Medicare rates or, as it is often called, "300% of Medicare" or "500% of Medicare." Yes, you read that right. Despite hospitals being legally bound to report costs to the federal government that Medicare rates cover, they price gouge at many times that rate. While there are some markets where average commercial payer pricing is lower, there are many more where the number is significantly greater — as high as 1,000% of Medicare in some places. In contrast, independently owned medical practices typically are paid between 90%–120% of Medicare rates and are quite profitable.

Note: Rural and critical access hospitals are exempted from these generalizations. They refer to well-heeled hospitals in urban centers and the suburbs.

A common trope by highly profitable hospital chains is to claim they "lose" money on Medicare. Despite health outcomes that are inferior to the rest of the developed world, U.S. hospitals charge far more than the rest of the world on just about everything. Said another way, they are very inefficient operations. At a recent Health Rosetta Summit, one of Fortune's 50 Greatest Leaders, Marilyn Bartlett, reported on the "Follow the money" study she has been doing for RAND. She outlined the myriad other payments hospitals — especially tax-exempt hospitals — receive that cover so-called "underpayment" by Medicare and Medicaid that are often left out of calculations. They also leave out the vast sums many make through a program called the 340B program that allows tax-exempt hospitals to get extremely low pricing from pharmaceutical companies, yet they charge the typical high prices to employers. In other words, the profit shifts from the pharmaceutical company to the hospital.

To add insult to injury, PPO networks charge access fees of $12-$20 per employee per month (PEPM) for what you might call

the privilege of wildly overpaying for health care services. The story insurance carriers continue to push on employers is that their employees won't be able to see a doctor or be admitted to a hospital outside the PPO network relationship. This is every bit as ludicrous as it sounds. Care provider organizations are often eager to develop direct payment arrangements that are far better than typical PPO rates.

The business leaders that choose to take care provider organizations up on that offer through reference-based pricing — where they shop around and negotiate for prices for certain procedures/services off of what Medicare pays — will often pay roughly 150% of Medicare rates. Their logic is that the government has arrived at a price that would enable health care organizations to sustain themselves, so hospitals should be willing to take a 50% premium on top of that. Some accept 120% or less—still far better than what the PPO offers.

With some help from Health Rosetta-certified benefits advisor Scott Haas, Pacific Steel did this and cut spending in half. By directly contracting with nearly 5,000 provider organizations, which were more than happy to do direct deals, Pacific Steel went from spending over $8 million to under $3.5 million.

However, if a business leader and their benefits advisor is going to go through all the work of reaching out to the best physicians, specialists and even centers of excellence — they need to make sure employees utilize them. Otherwise, all will be for naught and both the business and their employees could wind up spending significantly more than you must.

Some ways for business leaders to ensure employees visit their specified medical professionals is to offer incentives like waived copays, coinsurance, and deductibles. Another is to offer employees customer service-style concierge services. A concierge service or navigator can direct employees to the highest-value providers. They also give employees easy access to the human and other resources they need, including hassle-free appointment scheduling, medical records transfer, and both web and mobile access.

That's how it should be, and that's how it can be. With some help and guidance from properly aligned benefits advisors, it's never too late for leaders to start over — setting themselves up for success in the long-term and freeing up enough previously squandered dollars to get them through any current or future economic crisis.

Key Takeaways and Things to Think About:

- There are five straightforward steps to improving benefits while lowering health care spending 20%-40% or more.
- Nothing happens until there is a mindset shift. Most people mistakenly believe that solving health care is like trying to solve Middle East peace. They would like that solved to, but it seems hopeless and out of their control. Fortunately, proven approaches to slaying the health care cost beast abound in every corner of the country, in rural and urban settings, in large and small organizations and in public and private sector plans.
- Hardly a health plan exists that does not need a serious case of spring cleaning. Some employers have found $1,000 of savings per employee per year just by getting rid of junk fees, conflicts-of-interests and watching over claims even through outdated health plans. As employers understand the level of shenanigans in their contracts, they become open to where the bigger opportunities lie such as moving to post-PPO health plans. Without cleaning up damaging contractual terms, some strategies such as direct contracting with willing and able local providers are barred.
- Shenanigan-central is the drug portion of your health plan. Countless employers have dropped their Rx spending in half without employees noticing other than if cost-sharing is removed due to wiser drug procurement.
- The first change that is noticeable to employees is adding proper primary care which many have forgotten exists.

Employees are delighted when they can access their doctor 7x24 and via modern methods rather than waiting weeks to get in and then still having to wait for an interminable time in a waiting room (aptly named!). Let's not forget that it is impossible to price gouge or surprise bill a patient for an ER visit that never happened.

- The last step is the one that has the highest reward. However, it is the one that requires thoughtful planning. In the hands of amateurs, leaving behind value-extracting PPO networks can create problems for members such as balance billing. In contrast, a well-planned rollout generates a highly positive response from members. Everyone loves leaving behind the bewildering array of bills, EOBs (that do not really explain anything) and financial stress of astronomically high deductibles. Instead, wise employers have members champions that help guide people to the highest value providers. The only paperwork the member deals with is a thank you survey.