BREAKING THROUGH THE STATUS QUO

How Innovative Companies Are CHANGING THE BENEFITS GAME To Help Their Employees AND Boost Their Bottom Line

Proven Strategies from Leading Business Consultants & NextGeneration Benefits Advisers

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Dedication

This book is dedicated to those business leaders who are open and willing to embrace fresh, new approaches to create more positive and sustainable results for their organizations and their employees.

CHAPTER 12

BEST PRACTICES DEBUNKED

Craig Lack

What if the best practices are not the best? What's wrong with the process? Is there a better way to lower health care costs? I think these are important questions to ask because the best practices that are applied today haven't really changed significantly in the past decade.

It's the same story over and over again — ineffective and reactive. Before we can debunk the best practices, let's first review the various stages of the "status quo" related to the annual healthcare renewal process.

The 'Status Quo' Annual Healthcare Renewal Process

Step 1 — Carrier Develops a Renewal Proposal
Step 2 — The Pricing Formula
Step 3 — Broker/Consultant Validates the Formula
Step 4 — The Market Scare
Step 5 — The Employer Decision

Step 1 — Carrier Develops a Renewal Proposal

Sixty to one hundred twenty days prior to renewal (sometimes even farther), a carrier releases to the employer an annual renewal proposal. This renewal proposal contains proposed rates and benefits for the next year. It also provides general information about the account, some summary population data, and perhaps experience or utilization data, if available. The latter is sometimes omitted and a basic renewal exhibit is presented to the client.

The carrier delivers the renewal via electronic or hard copy format to the broker/consultant. Sometimes, the carrier delivers the renewal in person to the broker/consultant, especially if the news is not so positive and the proposed renewal is high. Delivering the renewal in person provides the carrier a chance to explain the basis of their renewal rate development.

The renewal proposal is only an offer to renew. It does not typically represent the final rates until the employer or their broker/consultant accepts the proposal.

Step 2 — The Pricing Formula

The carriers develop health insurance rates using past population and utilization experience. The most popular rate development methods are Manual Rating and Experience Rating. Carriers applies a combination or one of these methods.

The pricing formula and derivatives of it have been around, believe or not, for over 50 years. Its main premise is to utilize past experience as the basis for future expected costs. There may be some adjustments made but the formula has always been the same.

Claim or medical expenses of the past are adjusted to make sure outlier claims are not considered in the calculation. Expenses are trended forward, in simple terms, this means inflationary factors are applied and added to the medical expenses to predict future expenses. Administrative costs and margins are added to determine the final rating. Sounds simple but there are many opportunities to play hide and seek with undisclosed margin. For my article on this go to: *http://insurancethoughtleadership.com/hide-seek-healthcare-profits.*

Step 3 — Broker/Consultant Validates the Renewal

As part of the process, a broker/consultant validates the renewal. This means all of the factors used in the renewal pricing and the formula are once again reviewed to determine whether the renewal rates are fair and reasonable.

Consulting firm and their representatives examine the renewal process closely, questioning every data point, and formula. The end result is quite predictable as almost always the broker/consultant finds the renewal to be unreasonable, too high, or overstated. It's rare that the result is any different. Then the broker/consultant takes a further

step and will negotiate down the renewal based upon his/her own underwriting or analytics.

It's all about performing due diligence and to show that an evaluation occurred and the renewal was not accepted in its original version. There are tremendous inefficiencies in this process but yet it is repeated year by year.

Step 4 — The Market Scare

Along the renewal process, if the broker/consultant is not pleased with the proposed renewal and progress of negotiations, the traditional we will advise the client to market approach comes into play. This creates a sort of "scare tactic" which forces the carrier to re-evaluate its position and determine if there is any further reduction or adjustment that can be made to avoid approaching the market for competitive insurance quotations. By definition, it is implied that action is required from the carrier if it wants to eliminate the risk of not renewing the case.

It's the stick of the carrot and stick approach. From a carrier's standpoint, the moment a case goes to market their chance of losing the business increases. Or, if the carrier retains the case, the pricing may be greatly reduced.

This market scare technique is quite effective. In my opinion, most renewal reductions are attained by this basic technique. The main downside to this is that artificially lowering the premiums down through scare tactics means eventually the true utilization and cost of the program will reappear. Think of it like squeezing a balloon where pressure at one end results in expansion somewhere else. At some point, the renewal will be cost prohibitive and no competing carriers will be interested in quoting the group—leaving you trapped.

Step 5 — The Employer Decision

Under the traditional process, the employer receives the final proposal from the broker/consultant. The employer most likely accepts the recommendation. Additional changes may be made such as benefits changes or other adjustments that could contribute to further reducing the final renewal.

Debunking the best practices

So what's wrong with the current process? The main problem with this best practice is that it doesn't truly manage costs. It considers health care as a liability, something to be reduced and bargained down. There is no holistic approach and only symptoms are treated, not causes. It ignores the most important factor that affects cost — the health status of the users of medical care.

When carriers develop the renewal, the data that is utilized is old. It doesn't matter whether it was last month or 12 months ago, it has passed and may not accurately reflect the future. Additionally, brokers/consultants and employers are fortunate to obtain any meaningful data from carriers. Even if the data is available, how can we know they are correct and reflective of the population that will be using the benefits in the future.

Carriers rely solely on utilization of the past incurred and paid claims. It is not sufficient information to base future rating on. Many of today's high utilizers in a given group may not have even shown up last month or last year. How do we know who will have a heart attack or organ transplant? Yes, of course, an older population will have increased tendencies to have these expensive procedures, but it is not unusual to happen with a younger population. An older

person perhaps may be married to a younger person or have a younger dependent.

Demographic variables that are often ignored and can also impact the claim forecast include provider selection and utilization, product and plan design, Medicare eligibility and other payer eligibility.

The pricing formula is another big question. Let's suppose all the data is available and correct, then we have the issue of accepting the carrier's formula to be the most effective in pricing the health plan in the future. The formula hasn't changed much in the last 30 years and many of the factors are based on subjective values.

For discussion purposes, let's imagine that it is the most accurate. But accurate pricing doesn't manage the cost and make it reasonable. A high utilizer is still a high utilizer. Nothing in the pricing formula incentivizes the actual user to pay more or less. The group rate is averaged and all employees get the same rates. So the low utilizers basically are subsidizing the high utilizers. Not sure if employers are aware of this, let alone individual employees. One of the big disadvantages of fully insured plans is the fact carriers charge the risk of a few high utilizing members on to the entire group membership rates…every year…forever.

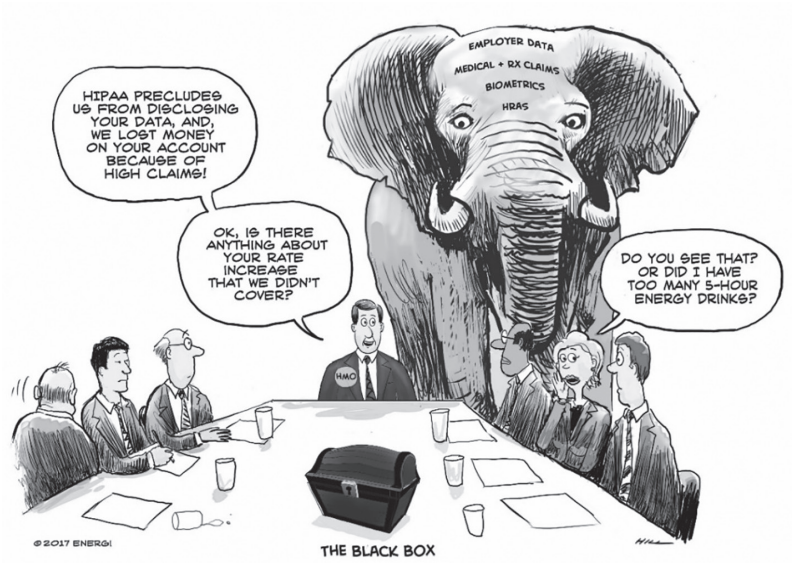
The broker/consultant certainly is a valuable resource in validating the renewal. Once again, what is the purpose of a drawn-out renewal evaluation when the final outcome is already certain that the carrier pricing must be reduced. Additionally, the renewal sometimes is requested so far in advance of the effective date that by the time the negotiations are completed the trend adjustment lowers the cost. The challenge always remains that negotiating lower pricing doesn't impact the utilization. More importantly, the true costs driving health care is not addressed. The prices charged by the health care providers are the largest culprits to perpetual increases.

The market scare tactics only complicates the process even more. Making the relationship among the broker, consultant, and carrier too dependent on bargaining and negotiation rather than looking at one of the largest contributors to cost — frequency and severity of services utilized by the members. It becomes a temporary approach to solving the symptoms and not the real problem. Like masking the symptoms rather solving the cause…like most prescriptions!

Come to think of it, it's an exact reflection of our government lobbied politicians who refuse to address the primary issue facing health care in America — the wanton and unscrupulous charges billed for medical and pharmacy treatments by the Health Care Supply Chain.

The employer then is at the receiving end of an antiquated analog legacy process that doesn't solve the cause of health care cost

increases. Cost will eventually creep up and correct itself. Most likely, the outcome will be a significant increase to the premium rates. In the end, nothing else can be thrown at the problem but cutting core benefits and shifting costs to the employees as a desperate reaction to lower the health care liability. When the population is over utilizing and the premium is underpriced, reducing benefits will not matter much. Drastic cuts must be made to make a difference. Consequently, the result over time is that the coverage is more expensive for the organization and the employees, there is reduced access to care and fewer covered benefits.



The elephants in the room

The elephants in the room are obvious but not easily understood—health status of the membership and the prices charged by the providers. All health care pricing is ultimately based upon each member's utilization, health status and the cost of accessing the medical delivery providers. Unfortunately, too often the prices charged by medical

providers bear no relationship to the actual cost to deliver the treatment because of perverse incentives built into the system.

It is apparent that the traditional renewal and quotation process of health insurance doesn't address the problems at all. The system keeps avoiding the cause and creates a distraction to focus consumers and buyers on the financing cost of accessing medical treatments.

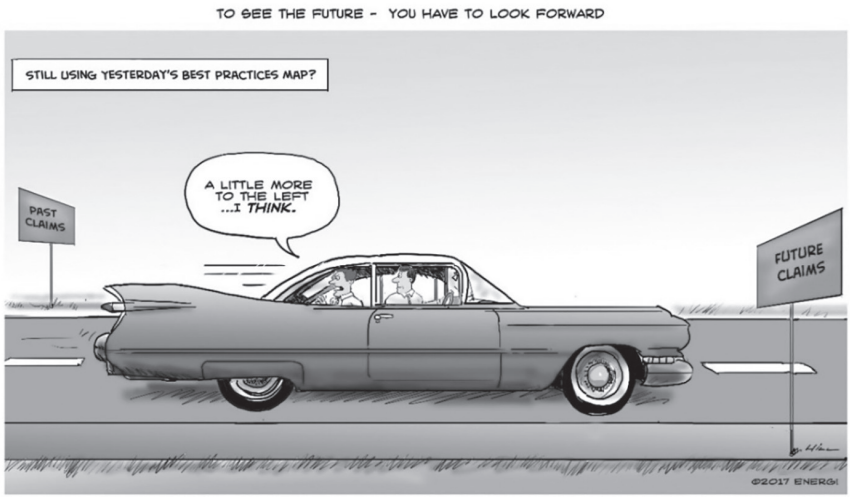
The ugly truth is that carriers hide behind HIPAA and refuse to release meaningful data to employers. Employers don't know their medical utilization, biometrics data or have meaningful claims data that may be indicative of future claims. Employers are in the dark when it comes to knowing what is driving their healthcare costs and the carriers provide no way of assisting employers in managing their emerging health care risks. Why is that?

As an employer, if you don't know what your risks are, all you can do is react to your renewal every year and hope it's competitive (a less bad rate increase than your peer benchmark). The renewal process is like déjà vu every year—hope, shop, spread sheet, compare, shift costs, reduce benefits, limit access to care and add Best Practices that don't work and repeat every year.

Effective strategies that can impact the frequency and severity of the claims should reveal actionable intelligence on adherence, trigger claims that indicate future large claims, gaps in care and purposeful case management. Additionally, all controllable medical and pharmacy claims should be avoided, transferred, and evacuated whenever possible in a manner that is suitable to managing health care risk management to a fiduciary standard.

Big Data — Little Insight

Besides the elephant, carriers also remain reluctant sharing meaningful and reliable information in predicting costs. They look at the past 12 months, past 24 months, past 5 years. There we go, it's like driving to New York from California but only using the rear-view mirror for directions. Their front view is always uncertain because the predictive and meaningful data analytics are hidden in a carrier's box. And, don't assume the carriers' legacy claims systems are even remotely capable of producing insights because they auto-adjudicate the majority of their paid claims to contracted hospitals and providers.



The myth of national consulting firms

The perception of buyers is that large national consulting houses can negotiate better rates and are most likely to set the standards of best practices in health and welfare benefits strategies than smaller agencies or consulting firms. If size were a proxy for quality then clients

of national consultants would never have a rate increase. That bears repeating. If size were a proxy for quality then clients of national consultants would never have a rate increase.

Employers often feel confident that their benefits are in the best hands possible because of the name recognition of these large national consulting firms. Some even have offices all around the world. As you look deeper to examine the offering of these firms, you find that everything is not as it appears. For example, the primary growth model of the top national firms is M&A. This includes the acquisition of dozens of small agencies, boutique firms and the occasional platform agency.

The reality for employers is that practice variability and the broker you work with from the national firm is only a piece of the whole picture the firm presents. The recommendations you receive are predominantly a function of the experience of the specific broker you work with on an ongoing basis.

True confidence and certainty in purchasing health care should be measured on the outcome produced as a result of the consulting message, and not based on the size of the messenger.

Managing health care as a liability is not risk management

Managing health care as liability is not risk management because once health care is considered as an expense, like buying supplies and equipment, there is very little management of risk. The traditional way of procuring and renewing insurance includes few components of risk management. It's supply side thinking. Healthcare liability basically is reduced to the cheapest price and this is definitely not the best practice of applying risk management.

However, the new reality of health care in America is that the demand side (self-funded employers) can control the pricing of the delivery of medicine. Think of it as supply chain management for health care. The future belongs to solution providers who can meaningfully reduce the frequency and severity of medical and pharmacy claims while improving the quality of medicine for employees and their families. Anything less is just wasting money on activities that don't work! Health care purchasers should focus on measurable outcomes that predictably reduce claims. And, consultants should be prepared to risk all their compensation if their recommendations don't work.

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Inc. magazine calls Craig Lack, "the most effective consultant you've never heard of." As the creator of Performance Based Health Plans®, Craig consults with public and private C-level executives and independent health care consultants to eliminate employee out-of-pocket expenses, measurably lower health care claims, and drive more EBITDA to the bottom line.

He is a leading authority and a sought-after speaker at national conferences, business coalitions on health and to C-suite groups. Craig has appeared in *Forbes*, *Inc.*, *Fast Company*, Huffington Post, *Success*, and Yahoo Finance and has been featured on CBS, ABC, CW and FOX.

His mission is to help employees eliminate $1 billion in out-of-pocket expenses.

Inc. says, "Craig Lack is the most effective consultant you've never heard of." http://www.inc.com/logan-kugler/this-entrepreneur-gave-up-nba-dreams-to-make-millions-off-healthcare.html

Forbes calls Craig Lack a "Broker Whisperer for independent healthcare consultants." http://www.forbes.com/sites/davechase/2016/06/26/if-you-want-to-see-the-future-of-healthcare-watch-the-cable-industry-what-happened-to-newspapers/#3af3a2a16bb1

To learn more go to: www.craiglack.com
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