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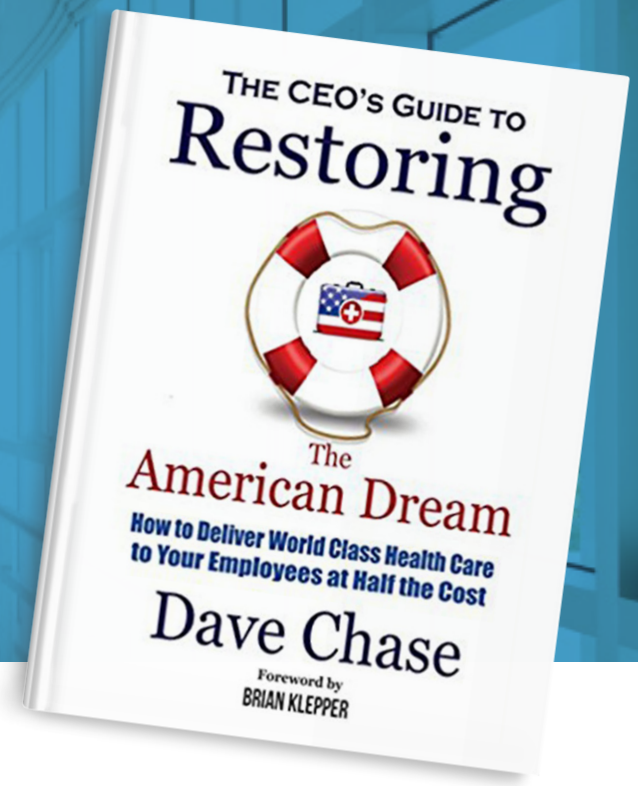
THE CEO'S GUIDE TO RESTORING THE AMERICAN DREAM

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



An eye-opening insider look at why healthcare is so expensive and practical solutions on lowering your company's costs from experts who have accomplished it.

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*Featuring insights from AMPS CEO Mike Dendy

DAVE CHASE

Dave Chase, named one of the most influential people in health care strategy due to his entrepreneurial success and thought leadership, just released a new book that delves into the problem of hyperinflated health care costs. Chase observes that most CEOs, HR leaders, and others have been led to believe that controlling health benefits spending is impossible, and demonstrates that this simply isn't true.

Keep reading for a synopsis of the book, as well as a complete look into Chapter 6, provided by AMPS.

Author's Note *by Dave Chase*

How could we have so many smart and passionate doctors, nurses, clinicians of all types, and other professionals—and spend far more than other countries— yet have largely abysmal health outcomes? The root cause I found is that we purchase health care incredibly ineffectively. Medicare, Medicaid, private & public employers. Everywhere.

I decided to focus on employers and unions for practical reasons.

- The overwhelming majority of non-poor, non-elderly get their benefits through their job.
- As a general rule, employers and unions—including public sector employers—are especially ineffective at purchasing high value health benefits.
- Wise public employers and unions are already showing how to dramatically increase health care investment value. This simplifies spreading the best solutions to public programs like Medicaid and Medicare.
- Employers and unions can innovate independently without an act of congress or top-down master plan. The best solutions can be broadly replicated, creating a self-reinforcing dynamic to get us out of this mess.

Foreword *by Brian Klepper*

One of American health care's deep mysteries has been employers' reluctance to challenge the health care industry's excesses that deeply threaten their finances, our lives, and our country. At least some people and **organizations in every health care sector—drug and device companies, care provider organizations, insurers and health plan administrators, health IT firms—extract far more money than the value they create.** This is even though many, if not most, individuals in the health care industry are good people working within an enormously broken, yet immensely powerful, system.

Even as health care costs have soared, the public and private employers that pay most of the tab for 150 million Americans have largely accepted this as unavoidable. This book shows that tackling costs while improving care isn't just unavoidable, but simpler to do than you think.

Back in 1980, the editor of the New England Journal of Medicine, Arnold Relman, warned of a medical industrial complex that now dwarfs the military industrial complex that President Eisenhower feared. Almost 40 years later, it is astonishing to appreciate how serious the impacts of this are throughout our society.

Wasteful health care spending consumes 79 percent of household income growth, leaving just 21 percent for everything else. This, more than nearly anything, is destroying the American dream.

U.S. health care is complicated, powerful, and doing everything possible to maintain the status quo.

For CEOs, CFOs, and benefits executives, the strategies here are refreshingly straightforward and proven approaches to a seemingly intractable problem. They reduce health care costs while improving the quality of care.

Brian Klepper, PhD, is a health care analyst and principal of Worksite Health Advisors, based in Orange Park, Florida.

A Note From a Fellow Traveler *by Tom Emerick*

Tom Emerick has more experience with these types of claims than few, if any, other benefits leaders. He was Walmart's Global VP of benefits and ran benefits at Burger King, British Petroleum, and American Fidelity. He's the author of Cracking Health Costs and created one of the first centers of excellence programs for large employers, subsequently making it accessible for any self-insured employer. -Author's Note from Dave Chase

I've had the unique experience of being behind the scenes for more than 30 years. This has let me identify seven* high-level systemic problems with the US health care system. All are the result of various flawed incentives Dave covers in the following pages. These problems enormously damage our country, both individually and collectively. This book addresses these issues and practical solutions in a systemic way I've not found elsewhere.

5. Widespread conflicts of interest

The world of health care insurers, providers, vendors, buyers, brokers, and advisors is a bizarre world rife with conflicts of interest we just wouldn't accept elsewhere in society. For example, benefit managers generally hire benefit consultants paid by health insurers and providers. This is a textbook conflict of interest. If Fred hires Bob to sue Joe, Joe would be off his rocker to hire Bob to defend him. Yet this kind of nuttiness is the default approach throughout the purchasing, administration, and delivery of health care in America. Enough is enough.

6. Poor internal financial oversight

Health care plans are one of the biggest areas of spending and financial risks facing public and private employers, yet they've been placed in the hands of human resources managers. Taking care of employees is in HR's DNA and many are very good at it. Unfortunately, this same trait makes many of them poor benefits managers, risk assessors, and financial analysts. Many just have not made the necessary decisions to maximize the quality and minimize the cost of health benefits.

This isn't from a lack of solutions. They exist. They give employees better quality care, save employees out of pocket spending, and save employers money. **Many HR managers are just not willing to shake up the status quo. Alas, the status quo needs to be shaken up badly.**

7. Reimbursement is more a wealth transfer than an economic transaction

Expense reimbursement models in health care are not really economic transactions. If a consumer goes to a doctor who treats the consumer, but is paid by a third-party—an employer, insurer, or government entity—this is more a wealth transfer than a classic economic transaction. Market economics do not apply when third parties pay consumers' bills. Yet this is how health insurance works.

This book will explain these problems and the root causes behind them in detail, then offer you common sense ways to take control of health care costs and improve the quality of care your employees receive.

It is do or die time. If you think it wise to save our country and health care system, things need to change and change now.

*For a more complete understanding of all seven problems, download a copy of the full book **here.**

Introduction *by Dave Chase*

The Annual Benefits Kabuki Dance

Much of this dire situation is due to what benefits expert Craig Lack calls the annual kabuki dance of employers and health plans. Lack, CEO of the consulting firm ENERGI and co-author of Think and Grow Rich Today, says **employers have been led to believe the best they can hope for is merely a less bad rate increase—despite the fact that there has been little to no increase in the underlying costs of medicine.** Lack has said the following about this issue.

Every year, CFOs ask their human resources (HR) team for a budget increase target. The overburdened and risk-averse nature of HR at most organizations is to preserve the status quo. **The insurance companies know this and typically come in with an increase of 11-14 percent; the insurance brokers know this and "negotiate" a less bad increase, staying below the CFO's budget, and there you have it.** Check the box, health care can be put to bed. See you next year. That's what passes for health care risk management at far too many organizations.

This system has continued because of two directives CEOs have long given HR: Keep people happy and don't get us sued. This may have made sense when health care benefits were a small percentage of the company's budget, but decades of hyperinflating costs have made it the second or third largest expense. Also, it's hard to make the argument that a company is keeping employees happy when health insurance has the lowest customer satisfaction of any industry and high deductible plans have suddenly become the norm.

The Legal and Fiduciary Implications of The Annual Kabuki Dance

Employers collectively pay the largest share of the health care tab and non-retirees overwhelmingly get their health insurance from work. If health care's status quo is the immediate cause of the economic depression of lower-income and middle-class workers, the primary underlying cause is this hidden-in-plain-view Kabuki dance.

The issue goes far beyond just a poor process. There is growing discussion that the way health benefits dollars have been managed could be a breach of fiduciary duty under ERISA (the Employee Retirement Income Security Act of 1974), which governs most health plans. ERISA regulates both health and retirement benefits plans. It requires plan trustees to prudently use plan money for the benefit of plan beneficiaries, i.e., their employees. **Overall, employers do this well in retirement benefits plans, but are seriously bad at it in health benefits plans.**

These strategies could create personal liability implications for officers and directors.

A broader analogy shows the absurdity of such low expectations for those we rely on to help us provide health care benefits. Someone in 401(K) financial services could face serious consequences, even jail, for not disclosing the sort of financial and non-financial conflicts of interest and incentives that are standard operating procedure in health care benefits purchasing and administration. For example, securities laws require brokers to fully disclose all financial compensation. Investment advisors must go beyond this and act as fiduciaries of their clients. They must act in their clients' best interests and can only place their money in investments suitable to each client's circumstances. Those who don't meet these standards face serious consequences. **By comparison, benefits brokers rarely fully disclose compensation or conflicts, such as cash bonuses for keeping 90 percent of their clients in disadvantageous arrangements with specific insurance carriers. Just like we'd never accept our financial advisor not disclosing how they get paid on an investment before making an investment, we shouldn't make one of the single largest expenditures in our budgets without similar expectations.**

One idea we've discussed with others is to require that ERISA health benefits plan dollars be subject to the same fiduciary practices as ERISA plan retirement plan dollars. Technically this is already required, but it's not general practice. It's a high-potential path to providing protection to directors and officers, removing widespread lack of transparency and conflicts of interest, and raising the bar for how we buy such a critical resource.

Health care's redemption is a classic example of solutions hidden in plain sight. Remember the The Big Short and Moneyball? The films' shared theme is that in the face of a mountain of evidence, no one paid attention. Wall Street and federal regulators didn't downgrade the credit ratings of mortgage-backed securities, and no one paid attention to on-base percentage, even when the issues were right in front of them. The same goes for health care.

Turning Things Around

Mike Dendy predicts the PPO concept will die out over the next few years. Dendy is CEO of Advanced Medical Pricing Solutions, a Georgia-based company that does health cost management for self-insured employer health plans. They help employers beat back costs using tools like close scrutiny of bills, the formation of narrower networks, direct contracting between providers and employers, and reference-based pricing services, often based on Medicare reimbursement rates. Dendy said providers commonly charge 300 to 500 percent of Medicare's rate and even the largest employers pay 250 percent on average, including both in- and out-of-network claims, although he's seen hospitals creep up to 700 percent.

> **"The last report I saw showed the average spending by an employer group last year was about $18,300 per employee," he said.**
>
> **"It's getting unsustainable—and every 4 or 5 percent increase now is a lot bigger than it was 20 years ago. The situation can be remedied, but you need consumerism to make it happen: incentives or disincentives for the consumer. And then you need technology and information immediately available, so people can make the correct decision in non-emergency situations."**

Dendy further predicted that the insurance market will move toward defined contribution plans, where an employer's spending would be limited in scope. He compared employer health policies with travel policies. If you're traveling for the company, he said, the company limits your outlay.

"Nobody thinks they're being grossly burdened by not being able to stay at the Four Seasons and eat steak five times a day (unless they're paying for it themselves). But under current health insurance arrangements, via a PPO, an employee is free to choose an expensive MRI or an expensive hospital—and that raises everybody's premiums," he said.

CHAPTER 6

PPO Networks Deliver Value—And Other Flawed Assumptions That Crush Your Bottom Line

A preview of "The CEO's Guide to Restoring the American Dream" by Dave Chase, featuring AMPS CEO Mike Dendy.

Albert Einstein famously said, **"We can't solve problems by using the same kind of thinking we used when we created them."** And yet, this is exactly what health care does over and over. Baked into our thinking about health benefits administration are many assumptions that turn out to be flawed on deeper examination—at best outdated, at worst outrageous.

Here are three that are doing your organization and employees serious harm:

1. Your broker works for you*

2. Insurance carriers want to drive down costs and PPO networks deliver the best pricing available

3. Auto-adjudication of claims is always good

** There are certainly some excellent brokers that do their best for employers, but the overwhelming majority have undisclosed conflicts of interest that favor of insurance carriers. In this book, the term benefits consultant or advisor refers to people who provide a broader range of services and expertise than simply signing up clients on behalf of a carrier. Many of them bring a more sophisticated brand of professionalism to their clients. See Chapter 11 for a more complete treatment of this critical subject.*

Together, these three flawed assumptions may seem minor, but together add up to significant costs and damage to your bottom line, your employees' bottom line, and your employees' health. Luckily, knowing about them is half the battle to counteracting them.

Flawed Assumption #1:
Your Broker Works for You

Organizations often treat brokers as a buyer's agent, but the reality is that their financial incentives typically make them a seller's agent for your insurance carrier and other health benefits vendors. Benefits consulting is a $22 billion industry, and insurance companies are the source for the majority of that revenue.

According to industry veterans, over 90 percent of the compensation models for brokers conflict with your objectives, because their income increases as overall per capita health care spending increases. In a proper model, one would expect exactly the opposite. Compensation should decrease as low-value spending increases. Over the last few decades of consistent health care spending increases, status quo brokers have won big while employers and their employees have lost.

We've found that most disturbing to CFOs and CEOs is that brokers generally don't disclose a significant portion of their compensation. For example, insurance carriers and other vendors work to retain clients by tying broker commission and bonus programs to the total business the broker places with the carrier, not just your business. Brokers must typically clear a specific threshold of business each year to get these bonuses. Your business is just one piece of the total, but keeping it with the same carrier can boost the broker's total compensation by 50 percent or more. Because this compensation isn't specific to you, status quo brokers will often claim they've disclosed fees and commissions. But they are actually only disclosing your account-specific fees and commissions that may not even be the most significant piece of their overall compensation.

Another way insurance carriers enforce loyalty is 30-day cancellation clauses in broker contracts that let carriers drop brokers on

30-day notice. If a broker gets over half of their entire compensation from a specific carrier–a common situation that can include annuity-type compensation built up over years–you can imagine how potent the threat to cancel the broker's agreement is.

Flawed Assumption #2:

Insurance Carriers Want to Drive Down Costs and PPO Networks Deliver the Best Pricing

Much of pricing in health care is set as a percentage of Medicare pricing. Why? Because Medicare uses a rigorous process to develop pricing that takes into account actual hospital costs (which are often inflated, but we cover that elsewhere) and market variances. The average PPO network pricing is 2.6 times Medicare rates or, as it is often called, "260 percent of Medicare." 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 percent of Medicare in some places.

To get a deeper perspective, I spoke with Mike Dendy, Vice Chairman and CEO of Advanced Medical Pricing Solutions, Inc. (AMPS), a health care cost management company. A 26-year veteran of the health care industry, Dendy was previously Chairman/CEO of HPS Paradigm Administrators, an independent third party administrator (TPA) services company that manages both private and public sector plans. Before that, he was the head of the community health system business at Memorial Hospital in Savannah, Georgia.

Dendy's company manages a large volume of claims. On average, he says they find that hospitals bill services (called gross billed charges) at about 550 percent of Medicare and that the major insurance carrier PPO network discounts are approximately 50 percent off those prices.

> **"It is amazing how little employers know about what they pay. I recently met with a Fortune 100 company that has 110,000 U.S.-based employees and asked their human resources vice president how much they were paying for health care relative to the Medicare benchmark. He had no clue and was flabbergasted when I gave him the answer. The BUCAs [Blue Cross, United- healthcare, Cigna, and Aetna] hide that information, of course."**
>
> - Mike Dendy, AMPS CEO

In comparison, employers who properly manage their health care spend will often pay roughly 150 percent 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 percent premium on top of that. Some will accept 120 percent or less.

However, most employers play the PPO's "discount" game without question. There is a "wink, wink, nod, nod" exercise that insurance carriers and health providers go through to arrive at a baseline PPO network price, which allows insurance carriers to say they "negotiated" a larger discount, say 52 percent. This makes it appear that the network can get you a better deal than you can on your own. I'll give you a 99 percent discount on anything if I get to choose the undiscounted price.

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 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 into 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.

Flawed Assumption #3:

Auto-Adjudication of Claims Is Always Good

Auto-adjudication is the term used to describe automatic payment of claims. Claims administrators will highlight one of three specific benefits, how your employees won't be hassled with bills, it's a sign of efficiency, or it's based on sophisticated

algorithms— typically all three. However, the best way to describe auto-adjudication is that you're giving another organization a blank check to withdraw money from your treasury based on minimal information that may or may not even be accurate.

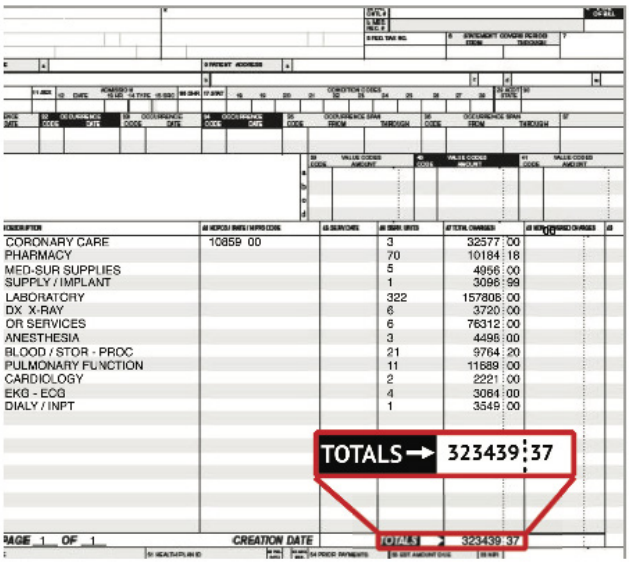
Claims administrators from the largest national insurance companies to the smallest mom and pop shops essentially all follow the same process. They receive a useless Uniform Bill (UB) from a hospital as an invoice, deduct the PPO discount from the total price, then pay the claim.

Figure 9 is an anonymized UB provided to me by Dendy. This one-page UB represents the entire invoice submitted by the hospital on this $323,000 claim. Note that 322 units of laboratory—completely unspecified—are billed at $157,808. No one in their right mind would ever accept such minimal detail if they're spending their own money. And yet the claims administrator in this case was prepared to write the check if AMPS had not intervened.

Further, BUCA administrators often charge $30 to $60 PEPM to pay bills using this see-nothing, know-nothing method. Pretty good gig if you can get it. Large insurance carriers typically auto-adjudicate 90 percent or more of all claims.78 Dendy's firm recently intervened on behalf of a Fortune 100 company on a hospital bill for well over $2 million. Even he was shocked to learn that the claims administrator was ready to pay on the basis of the single-page UB.

It's no surprise that claims administrators often have clauses in their agreements with employers that would only fly in health care. What's surprising is that so many employers are willing to sign them. For example, contracts stipulate that claims data is proprietary and owned by the carrier, meaning you don't get to see your own claims data. Sometimes they'll use HIPAA privacy as a smokescreen prevent you from having your data analyzed by an outside party, an issue HIPAA effectively accommodates.

Second, claims administrators will insist on extremely limited claim audit clauses. One large company I'm aware of with more than two million claims per year had an audit clause that gave it the right to audit just 200 claims of the administrator's choosing and only on the carrier's premises. That's 0.01 percent of all claims for what is often a company's first or second largest expense after payroll.



CORONARY CARE	10859 00	3	32577	00
PHARMACY		70	10184	18
MED-SUR SUPPLIES		5	4956	00
SUPPLY / IMPLANT		1	3096	99
LABORATORY		322	157806	00
DX X-RAY		6	3720	00
OR SERVICES		6	76312	00
ANESTHESIA		3	4496	00
BLOOD / STOR - PROC		21	9764	20
PULMONARY FUNCTION		11	11689	00
CARDIOLOGY		2	2221	00
EKG - ECG		4	3084	00
DIALY / INPT		1	3549	00

Figure 9. Actual deidentified uniform bill provided by Dendy.

Limited audit clauses often reflect an agreement between insurance carriers and health care providers. The insurance carrier will sign a PPO agreement with a hospital that, absurdly, doesn't allow the carrier itself to audit claims. The alleged reason is that it's all part of the give and take in negotiations, in which the carrier "demands" a certain discount in exchange for not auditing the claims they pay from that hospital.

This dynamic is why transparent medical markets featuring direct relationships between employers and hospitals have arisen (See Chapter 15 to learn more). By directly contracting with a health care provider, employers can secure significant savings. More direct, streamlined payment makes it valuable for high- value health care providers as well.