CHAPTER 10

HOW TO PICK A BENEFITS CONSULTANT

David Contorno

Recently, a Blue Cross plan offered brokers a $50,000 reward for switching self-insured clients back to more lucrative, fully-insured plans. In sectors like financial services, that kind of undisclosed conflict could land a person in jail. In health care, however, such clear conflicts of interest commonly exist and are often taken for granted.

For most companies, health care spending is one of the largest expenses on the P&L, often in the top two or three. However, few CEOs give it the resources, attention, or professional consulting they give other areas much farther down the list of expenses. Some businesses still leave benefits up to the HR department, which can lead to ill-informed decisions, however well intentioned, that are contrary to the company's (and often employees') best interests. While HR is critical when it comes to rolling out and administering the plan, financial decisions are best left to officers with financial backgrounds.

Knowing how to select a benefits advisor or consultant* who has the right skill set and experience in an industry that is often deliberately opaque can make all the difference in delivering true value to your employees.

How We Got Here

Some historical context is important here. In the '70s and '80s, when provider networks were first created, it was generally perceived as a very good thing for the industry and overall health care costs. For the first time, an insurance carrier could negotiate lower, predetermined prices and, in return, drive patients to the providers that agreed to accept these prices.

This allowed insurance carriers to differentiate through the discounts they negotiated with providers, a marketing message that continues to this day. Further, it allowed them to grow market share and, at least in some areas, drive health care financing costs. One thing that didn't change was paying brokers a commission on the premiums of the policies they sell, which dates back to the first life insurance policies sold in the 1800s.

Fast forward to 2010 and the passage of the Affordable Care Act (ACA). One provision, known as the Medical Loss Ratio requirement, was created with good intentions. The premise was that requiring carriers to spend a minimum of 80 to 85 percent of premiums (depending on plan type) on paying medical claims would prevent them from being overly profitable and would help control costs. It hasn't turned out this way for several reasons. First, after paying medical claims, broker commissions, and normal administrative costs, payers weren't making an unreasonable profit in the first place. In fact, it is a far smaller percentage of revenue than most businesses would be able to survive on, albeit a small percentage of a VERY large number.

Second, because profit is now tied to a percentage of premium, which is a function of underlying medical costs, the carrier now has an increased financial incentive to ignore increasing

* *The more common term is broker and there are certainly some excellent brokers that do more than connect insurance carriers and employers, but the terms advisor or consultant speak to the need for a trusted partner who works closely with you to provide a broader range of services and better alignment with your interests. It reflects common usage in the self-insured market, but you should look more deeply than what someone calls themself.*

medical costs, so long as their costs don't rise any faster than those of competitors. This certainly existed before 2010 but the ACA turbo-charged the dynamic.

The common impression that insurance carriers' large networks and client pools gives them greater leverage in negotiating prices with providers could not be further from the truth. The more patients a hospital system treats from any particular carrier, the more leverage *the hospital system* has to increase fees. And employers unwittingly empower the provider's abuse by threatening to leave the carrier if they are unable to come to an agreement to keep that large local health care system in the network, even if it performs poorly.

For many years, all but the very largest employers have been fully invested in this arrangement. Brokers were paid a percentage of premium, employers deferred the entire responsibility for controlling costs to the insurance carrier, individuals consumed whatever care their clinician advised, and everybody was supposedly happy. But as underlying medical costs have gone up, the only winners are the insurance company, care providers (especially hospitals) and, of course, brokers.

A Broken Process

Here's what typically happens every year for those companies that are fully-insured. We will talk about how this works for self-insured companies shortly.

Around 60 days prior to the contract renewal date, your broker gets a renewal offer from the current carrier that has VERY little information explaining the proposed new premiums, which they can now use to shop around the market for a better offer. Note that this market is now tiny. Where there were 23 national health insurance carriers in 1990, there are now just four.

Let's pause for a moment to consider that the broker often gets no information at all if you have fewer than 100 employees. Even larger employers do not get full transparency, let alone pro-

active tools to address the underlying medical costs supposedly driving the new, higher rates. If your carrier released more data on your spending, their competitors would be able to "cherry pick" the money-making groups, weeding out the minority that lose them money every year.

Let's assume you are in that minority of money-losing clients. Why wouldn't your carrier just make an astronomically high renewal offer? They have to offer you something by law. They won't because if they actually want to get rid of you as a customer, an offer with too large an increase scares off all the other carriers—bringing them bad PR to boot.

Playing the Competition

Generally, carriers that want to win your business try to price their offer as high as they can while staying low enough to motivate you to move. That "motivation" used to be around a 10 percent premium increase, but with costs so high and employers accepting that switching carriers is just part of the game, the delta has shrunk significantly in recent years. Say your initial renewal offer from your current carrier is 18 percent. One of the other carriers believes you'll move for a 6 percent spread, so they offer a 12 percent increase over your current rates.

If your broker is loyal to a particular carrier—and they usually are, because the more clients they have with one carrier, the bigger their bonus income—he or she will share that 12 percent offer with their preferred carrier. Naturally, that carrier doesn't have to offer as much because you are already their customer, so maybe they match the new offer or come in at 1 percent above or below it.

Some brokers stop right there. They've shown their "value" by reducing the renewal rate by 6 percent, which can equal hundreds of thousands of dollars in some cases! Plus, you get to keep your current plan and stay with the "preferred" carrier in your state. Oh, and your broker gets a 12 percent pay raise for his

efforts—and possibly additional bonus compensation.

Some brokers will send the 12 percent offer back to the other carrier, pitting the two carriers against each other and maybe squeezing out another few points. Either way, your rates are no longer about the cost of your employees' care. They are now about the carriers charging as much as they can and still keeping your business. Note that, in the unlikely event your broker were able to save you 20 percent on your premiums, he or she would also take a 20 percent cut.

The Bottom Line

Once the bottom-line number is reached, if the increase is still more than your budget can handle, the broker will then bring alternatives to reduce it that inevitably reduce benefits. One impact of reduced benefits has been a dramatic increase in employee out-of-pocket (OOP) costs in recent years, which has made the average worker afraid to even use their plan. Of course, this causes a delay in care until the person is much sicker, creating both a larger claim down the road and additional upward pressure on future rates.

One last trick to beware of: Brokers love to wait until the last minute to meet with you to review your upcoming plan renewal. Why? It may be that they are proverbially "fat and happy" and see no need to cater to your needs or perspective. It may be that they have bad news to deliver and prefer to delay tough conversations. Most likely they feel it will reduce your ability to talk with other brokers and perhaps make a change.

Why do so many brokers support this system? For one thing, it's all they've known. The average age of the typical broker is well into their 50s. For another, as premiums go up, so do their commissions, and carriers offer large bonuses to brokers when they both sell new business and keep the old business where it is. With few exceptions, most states allow for very large "incentive" compensation to brokers. This can mean lavish trips and, more important, as much as a 67 percent increase in pay over the per-

cent paid for the same business to a less loyal broker.[99]

The Self-Insured Market

How does this translate to the self-insured market? Most consultants (although not all) that support self-insured plans are far more sophisticated than the brokers profiled earlier. If they're not, self-insured plans can be a financial disaster of epic proportions. Let's assume this is not the case. A consultant in this space needs to know (1) how to set up a plan and build it out component by component and (2) how to put protections in place for your company to ensure your liability is no greater than you can financially stomach. After all, now you're the insurer and "no lifetime cap" can be a scary proposition. However, a properly set up self-insured plan actually gives you far more control of costs than a fully-insured plan. With stop loss protection, it also lets you tailor your level of comfort with risk.

Here are the main components of high-performing self-insured plans.

- The third party administrator (TPA) that is responsible for paying claims (with your money) according to the specifications you set up and the supporting plan documents
- The network (usually "rented" from a large carrier) that provides discounts off billed charges
- Balance billing protection. Employers have a duty under ERISA to only pay fair and reasonable charges. After that price is determined and paid, some providers will try to get additional payment from an employee. A proper plan protects an employee against providers pursuing this. In extreme cases, that can include legal services for the employee.
- A pharmacy manager to handle the pharmacy network
- Pricing contracts
- Stop loss protection to pay for large claims

So now you are self-insured and are seeing a level of claims and spending detail you've never seen before. Yet costs are still going

up each year at a similar rate or you saved some money the first couple of years. But now what? This is where the rubber meets the road for the more advanced consultant.

A common first misstep to lower costs is workplace wellness programs. As we saw in Chapter 8, at best, only a tiny percentage of such programs have a real ROI. At worst, they can cost a bunch more money, while irritating and potentially actually harming your employees. At least in the self-insured environment, you have access to data that can point you toward risk factors to focus on (or scuttle the entire program). But the initial excitement and enthusiasm of data access and your fancy new workplace wellness program quickly dies. Seventy-two per cent of companies have these programs and, I assure you, 72 percent of companies are not happy with their health care spending trends.

Instead, a progressive consultant brings you a multiyear health care plan designed to lower the quantity of care consumed, built on a proven approach to lower the actual cost of care for ALL employees—whether they are healthy or not.

The plan will generally reflect the following.

- Serious thought for ERISA fiduciary responsibility
- An emphasis on value-based primary care
- An emphasis on the highest-cost outlier patients
- Transparent medical markets/reference-based pricing (i.e. ways to know the actual prices you'll pay for services)
- Transparent pharmacy benefits
- Data proficiency

The plan will also include payment arrangements with providers and, importantly, complete disclosure of the consultant's sources of compensation.

Value Counts More Than Fees

However, none of this can take place if your company makes one very common mistake. You decide what consultant to use

at the same time as you select your plans and other benefits for the upcoming year. The progressive consultant will help you see these as two distinct decisions that should be made at separate times.

As you can see, the actual "insurance" is a smaller and smaller piece of what the nontraditional benefits consultant brings to the table. In the self-insured model, stop-loss is the only insurance policy purchased, generally accounting for less than 20 percent of overall costs. This person should be able to provide you with all the information you need to identify the best renewal options for noninsurance administrative functions and, critically, the right strategies to positively impact both the cost and quality of your employees' care over the long term.

You don't necessarily want to pick your consultant based on how low their fee is. That doesn't speak to their true value. The fee is generally a small percentage—in the low single digits—of your total health care spend. This is how most businesses make that decision and we all know how well that's been working. A truly innovative consultant will be willing to put some of their compensation at risk, based on performance, and turn the commission conundrum described earlier on its head. Imagine paying your consultant a percentage of money actually saved! Now that's aligning incentives.

While no one expects a CEO to be an expert in all these areas, you should be generally aware enough to ensure that the people trusted with handling one of your largest expenses are.

One way you can judge a consultant's skill, integrity, and expertise is whether they're certified by the Health Rosetta Institute. The certifications require transparency, expertise in key areas and strategies, and adherence to valid cost and outcome measurement models. Seasoned, high integrity professionals have already received this qualification. Learn more at healthrosetta.org/employers.

David Contorno is a benefit consultant helping midsize employers and is President of Lake Norman Benefits, a Member of the Hilb Group.

CASE STUDY

LANGDALE INDUSTRIES

Brian Klepper

Large American businesses with tens or hundreds of thousands of employees have recruited high-profile benefits professionals to orchestrate sophisticated campaigns focused on the health of employees and their families, and on the cost-effectiveness of their programs. Even so, few large firms provide comprehensive, quality benefits at a cost that remains consistently below national averages.

For midsized businesses—firms with 100 to 5,000 employees—the task is significantly more difficult without the right people and focus. Health benefits managers in these companies have far fewer resources, typically work alone without the benefit of a large staff, and are often overwhelmed by the complexity of their tasks. As a result, they often default to whatever their broker and health plan suggest.

But a few excel. For them, managing the many different issues—chronic disease, patient engagement, physician self-referrals, specialist and inpatient overutilization, pharmacy management—is a discipline. Barbara Barrett is one of them.

Barrett is director of benefits at TLC Benefit Solutions, Inc., the benefits management arm of Valdosta, Georgia-based Langdale Industries, Inc., a small conglomerate of 24 firms and 1,000

employees. Langdale is engaged primarily in producing wood products for the building construction industry, but is also in car dealerships, energy, and other industries.

Valdosta is rural, which puts health benefits programs at a disadvantage. Often, as in this case, there is only one hospital nearby, which means little if any cost competition. Compared with those living in urban areas, rural Georgians are more likely to be less healthy and suffer from heart disease, obesity, diabetes, and cancer. So, the situation is far from ideal.

And yet, from 2000, when Barrett assumed responsibility for the management of Langdale's employee health benefits, to 2009, per employee costs rose from $5,400/year per employee to $6,072/year per employee in 2009. That's an average increase of 1.31 percent per year, compared to an average annual increase of 8.83 percent for comparably-sized firms nationally.[100] To put this in context, average firms spent $29 million more than Langdale from 2000 to 2009 to provide the same kind of coverage. Langdale's savings were $29,000 per employee—all without reducing the quality of benefits or transferring the cost burden to employees.

Langdale Industries

Actual Premium* vs. US Trend and Cumulative Savings

Year	US Trend**	Langdale (US Trend)	Langdale Actual***	Diff.	Diff. x 1,000 Eligible Emps.
2000		$5,400	$5,400		
2001	11.2%	$6,005	$5,741	$534	$534,060
2002	14.0%	$6,845	$5,542	$1,303	$1,303,065
2003	12.6%	$7,708	$5,615	$2,093	$2,093,989
2004	10.1%	$8,487	$5,689	$2,798	$2,798,941
2005	9.7%	$9,310	$5,763	$3,547	$3,547,612
2006	5.0%	$9,775	$5,839	$3,937	$3,937,601
2007	5.7%	$10,332	$5,915	$4,417	$4,417,301

2008	6.0%	$10,952	$5,993	$4,960	$4,960,756
2009	5.6%	$11,566	$6,071	$5,495	$5,495,583
Cumulative Savings $29,082,906					

**For Medical, Dental, and Pharmacy*
***Source - Kaiser/HRET 2009 Employer Health Benefits Annual Survey*
****Trended at an average of 1.31 percent between 2000 and 2009*

So how did Barrett approach the problem? Here are a few of her strategies.

- Langdale set up TLC Benefit Solutions, a HIPAA-compliant firm that administers and processes the company's medical, dental and drug claims. This allows Barrett to more directly track, manage, and control claim overpayments, waste, and abuse.
- It also gives her immediate access to quality and cost data on doctors, hospitals, and other vendors. Supplementing this data with external information, like Medicare cost reports for hospitals in the region, has allowed her to identify physicians and hospital services that provide low or high value. She has created incentives that steer individuals to high-value physicians and services and away from low-value ones. When necessary complex services are not available locally or have low quality or value, she shops the larger region, often sending patients as far away as Atlanta, three and a half hours by car.
- Barrett analyzes claims data to identify which individuals have chronic disease and which are likely to have a major acute event over the next year. Individuals with chronic diseases are directed into the company's evidence-based, opt-out disease management and prevention program. Individuals with acute care needs are connected with a physician for immediate intervention.
- Langdale provides employees and their families with confidential health advocate services that explain and encourage use of the company's benefits programs, again using targeted incentives to reward those who enter the programs and meet

evidence-based targets.

These are just a few of Barrett's initiatives in group health, but her responsibilities also extend to life, flex plan, supplemental benefits, retirement plan, workers' compensation, liability, and risk insurance. The results for Langdale in these areas include lower than average absenteeism, disability costs, and turnover costs.

The point isn't that you should just do what Barrett and Langdale have done. The point is that they've been proactive, endlessly innovative, and aggressive about managing the process. This attitude and rigor has paid off through tremendous savings, yes, but it has also produced a corporate culture that demonstrates the value of Langdale's employees and community. Employees and their families are healthier as a result and are more productive at work. This has borne unexpected fruit: The industries Langdale is in were hit particularly hard by the recession, and the benefits savings from Barrett's efforts helped save jobs.

Barbara Barrett and many others like her on the front line are virtually unknown in health care. Most often, their achievements go unnoticed beyond the executive offices. But they manage the health care and costs of populations in a way that all groups can be managed.

Editor's note: We checked in with Barbara recently and found that, even in the face of new challenges, such as extreme jumps in drug prices, Langdale continues to succeed where others have failed to carefully manage health costs.

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