CHAPTER 3

WHAT YOU DON'T KNOW ABOUT THE PRESSURES AND CONSTRAINTS FACING INSURANCE EXECUTIVES COSTS YOU DEARLY

For all the recent talk about accountable care organizations, there is a distinct lack of accountability when it comes to health care costs. Hospitals blame insurance companies, insurance companies blame hospitals, providers blame the government, and everyone blames drug companies. Even though many employers have woken up to the fact that they can get better bang for their buck if they are self-insured, most self-insured employers still don't pay close attention to the critical details that often have the most dramatic impact on their bottom line.

Here's why: Virtually every conversation I have with employers reveals a profound lack of understanding of market dynamics, constraints, and incentives that health insurance company executives face. For the most part, these executives are good people operating perfectly rationally, given the drivers and constraints of their business.. These constraints include care provider organization practices, Wall Street profit expectations, employer demands (yes, you!), individual employee behavior, and regula-

tory issues. Unfortunately, the net result incentivizes redistributing profits from companies like yours to the health care industry. In short, their incentives are not aligned with yours. Like hospitals (the biggest recipient of your health care dollars), insurance companies win when health care costs go up.

Understanding the specific pressures facing insurance company executives will help you more effectively negotiate and drive better value from your health dollars. Plus, several of these pressures are a direct byproduct of employer behavior you can do something about.

The items below came directly from seasoned executives in national and regional health insurance companies. They asked for anonymity, as they are either still working in these organizations or don't want to face market blowback.

Pressure to Include Less Desirable Hospitals in Networks

This is caused by pressure from employers to have every possible provider in their network so their employees don't complain about lack of choice. Of course, having every provider means that you have lower- and higher-quality providers in the same network. This also means higher costs because the lower-quality providers are generally less efficient and deliver improper, excessive, or low-value care, which leads to complications and overtreatment.

In addition, contracts between insurance carriers and hospitals in some regions include anti-steerage language. This language requires the insurer to include a given health system network in all of its plans. For example, in northern California, UnitedHealthcare might have an agreement with Sutter Health that prevents them from excluding Sutter from any employer agreement. Or in Dallas, Texas Health Resources might demand the same thing of Blue Cross. The Affordable Care Act (ACA) made this worse by allowing hospitals to aggregate in ways that enable oligopolistic practices.

Plus, employers often seek to include their local hospital and every physician in-network to minimize employee complaints, regardless of the hospital's or physician's quality (or cost).

Poor Service from Carriers Is a Natural Byproduct of Medical Loss Ratio Rules

This is a direct effect of the ACA. Because the Medical Loss Ratio prescribed in the ACA requires that 80 or 85 percent of premiums be spent on medical care (depending on type of plan), carriers are forced to cut customer service employees for fully-insured plans—considered overhead—to escape penalties under the ACA. This is exacerbated as companies move from fully-insured to self-insured status (in part to escape ACA regulations). Because customer service functions are often shared across fully-insured and self-insured business, the lower-margin self-insured business puts further pressure on carriers to find cost savings. Generally, self-insured plans have less than 10 percent the profit opportunity of fully-insured plans.[46]

In addition, Medical Loss Ratio requirements cap insurance company profits, meaning that the only practical ways to increase revenue (and thus profits) is to reduce service staff, raise premiums, or process more claims. The carriers have no choice but to tighten their expenses to still make profit margins, even paring back on high-cost executives.

This dynamic parallels what I observed in the shift from high-margin mainframes and minicomputers from IBM, DEC, Wang, Data General and others to low-margin PC manufacturers. At a time when there was a dramatic need for reinvention and innovative new offerings, those organizations lost most of their best (and most marketable) leaders, leaving them with the risk averse, mediocre performers. The result for most was a death spiral—IBM being the exception because of the leadership of Lou Gerstner. Unsustainable cost structures and weakened manage-

ment devastate incumbents in times of great change, whether you are a minicomputer maker or health insurer.

New Fees to Replace Lost Margin

The co-dependent relationship between insurance carriers and hospitals is evident with out-of-network charges. Remember, when health systems impose egregious out-of-network charges, insurers are happy to pay them immediately and with no review whatsoever (and with your money), because it generates more revenue for them in a number of ways. Naturally, they can't say this. Plus, employers have been haranguing them for decades any time an employee complains about any delayed or denied claim, or balance bill from a care provider. So in response to this profit incentive and an attempt to give you what your benefits managers ask for, they sell this as a benefit for you: You and your employees won't be bothered by hospital collections departments!

They follow this up with "re-pricing" that discounts charges to seemingly more reasonable levels—on your behalf, of course. What may not be clear is that the insurance carrier gets paid a share of the repriced claim. This encourages the hospital to push the pre-discount prices ever higher, which pushes the discount up and, with it, the fee paid by the employer and net amount of each claim.

Another fee opportunity is so-called "pay and chase" programs, in which the insurance carrier doing your claims administration gets paid 30-40 percent for recovering fraudulent or duplicative claims. Thus, there is a perverse incentive to tacitly allow fraudulent and duplicative claims to be paid, get paid as the plan administrator, then get paid a second time for recovering the originally paid claim.

Many of the fraud prevention tools used by claims administrators are laughably outdated and weak compared to what they are up against. Modern payment integrity solutions can stop fraud and duplicate claims, but aren't being used by most self-insured

companies' claims administrators. In a report on fraud, Accenture found, "Estimates by government and law enforcement agencies such as the FBI place the loss due to health care fraud as high as 10 percent of annual health care expenditure."[47] This is roughly $300 billion per year! Payment integrity experts, such as Dave Adams, CEO of 4C Health Solutions, tell me stories of companies that have paid the same claim 25-50 times because the claims administrator didn't use modern tools to stop it. Many times they don't do anything about it. Other times they do a bill review and try to recover those monies, getting the "pay and chase" recovery payment.

It's worth noting again that employee behavior is often a primary root cause of these practices. Whenever employees get a bill from a care provider as a result of a denied claim, they complain to your HR department or broker, who in turn complains to the insurance carrier, leading them to give your company what you ask for. As with most dysfunction in health care, simple incentives and behaviors often have enormous, counterintuitive, and costly consequences.

Dancing the Frustrating Kabuki Dance

Why does an insurance carrier give you a renewal rate and then keep reducing it until you bite, especially when you're fully-insured? Because the insurance carrier makes ten times more on premiums from fully-insured clients than on fees from self-insured clients.[48] Because of this, insurance executives face enormous pressure to keep and grow their fully-insured books of business. Bonuses and other incentives for benefits brokers and consultants to keep business with the same carrier cement this dynamic. Increasingly, carriers even offer early renewals to keep fully-insured business. Often these early renewals come with no-shop clauses. So, a 20 percent rate increase may only be 15 percent if you sign today and agree not to shop the competition.

This should be viewed as a red-flag, not a great deal on a premium reduction. The first thing to do if you ever get a no-shop offer is to warm up the RFPs and start shopping.

Your Claims Data Somehow Belongs to the Insurance Carrier

Amazingly, insurance carriers have convinced employers to accept that their own claims data are proprietary to the carrier—and they refuse to share them. Equally amazingly, employers often agree to contract terms that severely limit their access to audit claims, often being able to audit just a tiny subset.

There are only three reasons insurance carriers would say the data is proprietary.

1. Their reporting and data systems are so poor that they literally can't share. This is much less likely these days.
2. If they release the data, a good actuary consultant could dive in and raise lots of questions they don't want to answer. For example, they could see that an organization pays a large multiple of market pricing or has questionably high use of a particular test or procedure.
3. They want to maintain the status quo. This means protecting pricing opacity at all costs. If you could see the prices you actually pay, you might begin to wonder why a hospital with a large market share but mediocre quality outcomes is paid exponentially more than a smaller, high-quality provider in the same network.

It should be clear that numbers two and three are more likely. Hospitals and insurance carriers want to avoid defending or explaining pricing and the various fees they bake in. This largely comes from the pressure insurance and hospital executives face to keep growing profits by 10 to 15 percent year over year.

Inflated Health Care Cost Trends

Insurance executives are under huge pressure to grow their business, even if it is self-insured accounts. One way insurance carriers try to prevent independent third-party plan administrators

from winning employer business is inflating the medical trend (the rate at which health care costs are increasing) for their fully-insured clients by 1 percent. This additional money is then used to create bonuses (override programs) for benefits brokers, workplace wellness programs, and broker implementation credits (additional payments for help rolling out a program). These incentives further help win or maintain fully-insured and self-insured clients. Think of this as robbing Peter, unknowingly, to pay Paul. As a result, fully-insured clients are cross-subsidizing low-value workplace wellness programs or paying to fund broker override programs that do not impact them at all.

Broker Incentives that Preserve Status Quo Inertia

Insurance carriers often have programs that require a broker to maintain a 90 percent retention rate to receive a year-end bonus. These programs help carriers retain clients and can be $300,000 to $500,000 for each local office of a brokerage. This amount often represents most of the net profit for an office and can heavily influence brokers who might otherwise advise you to move to a self-insured plan. Because bonuses are based on the total business a particular broker brings to an insurance carrier, they typically aren't included in the list of claims costs, commissions, or fees, unless the broker has a transparent practice—which most don't.

If it seems like your broker makes your current carrier's renewal plan look better than other options, this is probably why. You might want to ask if he or she gets paid any bonuses from particular carriers. To simplify this, Appendix C has a disclosure form you can use to understand your broker's overall financial incentives and potential conflicts before making a purchasing decision.[49]

In short, the broker you treat as your buyer's agent is actually compensated as a seller's agent, creating a conflict you wouldn't accept in other contexts.

Carriers and Brokers Are Soft on Area Hospitals

When your insurance carrier also administers the health plan for hospital employees or your broker represents the hospital, there are additional forces working against you. Hospitals are often one of the larger employers in a town or region, so the insurance carrier won't risk losing them as a client. Since the hospital provides a large revenue stream, the carrier typically goes easy on them when negotiating pricing on behalf of other clients—like you. Additionally, some brokers get as much as 30 percent of their revenue from hospitals and other care providers. You should always ask your benefits broker or claims administrator if a local hospital is a client, as that is a clear conflict-of-interest, especially when the hospital itself owns the insurance carrier.

State Mandates

One benefit of self-insuring is avoiding state mandates and regulatory requirements that apply to fully-insured plans and that can meaningfully increase your overall costs. This benefit disappears if your insurance carrier incorporates these into their self-insured plan offerings. Why would they do that? Different treatment of different business lines and employer accounts creates complexity that insurance carriers want to avoid. Logical and efficient for them. Costly for you.