Part II

How and Why Employers Are Getting Fleeced

The health care industry has been extremely deft at persuading employers to accept hyperinflating costs you wouldn't accept in any other area of your operations. In this part of the book, we highlight the most common ways the industry ensures their revenue and profits grow inexorably. We delve into three of the biggest areas that are least understood.

For example, it would be logical to assume that an insurance company could aggregate their buying power to get your organization a better deal. While this certainly is possible and can happen to an extent, just the opposite generally happens. The much-vaunted PPO networks actually ensure that you pay for the privilege of greatly overpaying for health care services. Then there's criminal fraud. While it's impossible not to know about cybercrime and cybersecurity issues, most CEOs don't know that as much as 10 percent of all claims their company pays are fraudulent as a result of a lack of oversight. Finally, we debunk the notion that workplace wellness programs will have any demonstrable impact on costs. While there may be reasons to have workplace wellness programs, cost reduction isn't one of them.

CHAPTER 5

7 TRICKS USED TO REDISTRIBUTE PROFITS FROM YOUR ORGANIZATION TO THE HEALTH CARE INDUSTRY

The health care industry has been remarkably effective at extracting as much money as possible from the U.S. economy. Employers and individuals pick up the majority of this tab.[64] Unlike virtually every other input in your supply chain where the value proposition improves every year, the norm in health care for decades is to pay more and get less. Unlike nearly every other industry, health care hasn't had a productivity gain in 20 years.[65]

In other words, for the last two decades there has been a redistribution "tax" from highly efficient companies to the least productive industry in America.[66] On top of this, the waste is beginning to potentially create personal legal exposure for you and your financial and HR executives that is snapping many of your colleagues into action. Here's what you need to learn first about what they know.

Costly Health Care Industry Tricks

This list is not exhaustive but does highlight some of the largest cost issues. Once you know what to look for, you can overcome these issues by applying the strategies and lessons from Parts III and IV of this book.

While these tricks exist in both fully-insured and self-insured companies, the ability to take corrective action is largely limited to self-insured companies. Understanding that fully-insured employers already bear much of the risk of being self-insured, but without the benefits, helps simplify the decision to go self-insured. If you're a fully-insured employer and have higher-than-expected claims in one year, your insurance carrier will work to get as much back as possible in subsequent years through larger premium increases.

Employers with well-managed plans are already reducing health benefits spending by 20 percent or more with better results—directing savings toward higher uses, like cash reserves, profits, R&D, better wages, new benefits, or profit sharing.

And let me say before we plunge into the dark side of health care that there are many, many exceptional health care organizations and professionals—insurance carriers, plan administrators, benefits brokers, physicians, hospitals, nursing homes—that don't employ these unethical practices. Plus, a vanguard of doctors and others are leading the way to stamp out the bad actors for good. We already met a few of these rebels in Chapter 1.

Trick #1: Directing Patients to the Most Expensive Treatment Options, Even if They're Not the Most Effective

People often raise the specter of rationing care. In reality, it's overuse (i.e., unnecessary and potentially harmful care) that leads to reduced access by squandering enormous financial resources

that would be better used for individuals who actually need care and can't get it.

I asked Garrison Bliss, MD, the founder of the first direct primary care practice—a model for employers and individuals to directly contract with primary care clinicians in high-value, cost-reducing arrangements—how they were able to achieve a 30 to 50 percent reduction in surgeries. The answer was remarkably simple: Let people choose.

For example, one of the most common reasons people go to the doctor is back pain, one of the most overtreated symptoms around. Having personally experienced searing back pain, I would do almost anything to make it go away. If I'm told that surgery and opioids are the only way to go, that's what I'll probably do. However, it turns out that physical therapy is very often more effective than surgery. According to Bliss, individuals will virtually always choose the least invasive and safest treatments when they're clearly told about the pros and cons of effective potential options.

This doesn't typically happen though. A primary reason is that hospital-employed primary care doctors receive financial incentives to refer patients to high-margin specialty practices. In Chapter 9, we'll learn that 90 percent of back surgeries performed at Virginia Mason Hospital & Medical Center were unnecessary and that musculoskeletal (MSK) procedures account for roughly 20 percent of all health care spending. By simply deploying an evidence-based MSK program, a large tire manufacturer improved its earnings by 1.7 percent. Had it been able to get all of its employees who have MSK issues into the program, its positive earnings impact could have been 5 percent. How many corporate initiatives can increase earnings by 5 percent?

Trick #2: Turning Primary Care into a Milk-in-the-Back-of-the-Store Loss Leader

Dr. Paul Grundy, IBM's chief medical officer and director of health care transformation, shared with me how IBM undertook a two-year study from 2005-2006 of its $2 billion annual global

health care spend. The results reinforced what many already knew—a strong bias against primary care that has been highly effective at undermining this valuable resource in favor of higher-cost specialty care. One consequence of this is the 10-minute primary care appointment, which leaves little time to delve into the root cause of whatever issues bring an individual to the office. This pressures physicians to take shortcuts to satisfying patients—ordering a test or prescribing a drug.

This pattern is also a key driver of the opioid crisis, along with well-intended patient satisfaction surveys that feature questions about the patient's happiness with the pain control measures they were given. A provider's scores on these surveys is an increasingly significant factor in how much they're reimbursed for government-sponsored programs like Medicare.

Trick #3: Using Intentionally Bewildering and Absurd Drug Pricing

Drug pricing is bewildering by design and an increasingly large share of your benefits spending. It's part of the strategy to get away with exorbitant prices. Pharmacy benefit management (PBM) firms are well-known for hidden fees, shell game pricing, and taking drug manufacturers' money to promote specific medications.[67] With the breathtaking spike in specialty drug prices in recent years, these practices are costing shareholders, employees, and employers dearly.

Recently, two very well-known PBMs added a brand drug called Duexis to their formularies, which currently sells for more than $4,000 for a 90-day supply. Duexis is a combination of two drugs you likely have in your medicine cabinet that together cost only a few bucks—ibuprofen and famotidine (common household names, Motrin and Pepcid). Vimovo is another expensive combination drug that is just delayed-release omeprazole (Prilosec) and naproxen sodium (Aleve).

PBM consultant CrystalClearRx pulled data to show the drastic difference in pricing for a 90-day supply of comparable

drugs and identical dosages for these two brand drugs and their generic counterparts.[68]

Duexis	**Ibuprofen+Famotidine**
$4,680	$20 to $40
Vimovo	**Omeprazole + Naproxen Sodium**
$2,279	$20 to $40

In these cases, the brand drugs are 50 to 234 times more expensive for functionally the same drug. PBMs are incentivized to add these kinds of drugs to formularies so they can tout big discounts off high-cost drug costs. It also lets them capture high-margin revenue from hidden rebates they receive from drug manufacturers. Rebates are a form of arbitrage where PBMs receive money back from drug companies on each claim for a particular drug. They typically either don't refund this to you at all or only partially refund it.

PBMs are also sometimes owned insurance carriers and are not held to the margin requirements the ACA imposes on the insurance carrier. The PBM reaps enormous profits, while allowing the carrier to cry "poor" and raise your rates.

Enough said.

Trick #4: Not Suggesting Management Strategies for Rare but Astronomical Claims

Benefits manager Tom Emerick, co-author of *Cracking Health Costs: How to Cut Your Company's Health Costs and Provide Employees Better Care*, pointed out how outlier claims are the biggest driver of the health care cost explosion. During his time with BP and Walmart, Emerick typically found that 6 percent of employees in a given year accounted for 80 percent of company medical costs. Walmart set up a Centers of Excellence program to address the most expensive cases, in which they send employees and

family members needing heart, spine, and transplant surgeries to six of the most highly rated and thus most cost-effective health care organizations for free care—if they need it.

Often they don't. Emerick's book explains how Walmart found that 40 percent of planned organ transplants at local hospitals were deemed medically unnecessary when their employees visited top-notch providers such as Mayo Clinic for a second opinion. In a study published in 2017, Mayo Clinic reported that as many as 88 percent of patients who visit the clinic for a second opinion on a complex procedure go home with a new or refined diagnosis—changing their care plan and potentially saving their lives.

Dialysis management is another source of extraordinary bills. More than 25,000,000 Americans have chronic kidney disease, and 100,000 start dialysis each year. This is inevitable, but employers can turn the huge disparity among costs for the same services, from $100,000 to more than $500,000, to their advantage by scouting out the lowest-cost, high-quality services.

Trick #5: Hiding the Use of Accessory—and Often Out-of-Network—Physicians

It happens all the time: You have the insurance carrier's authorization for your physician, who is part of your plan's PPO network, to perform a procedure like a surgery or colonoscopy. Everything seems straightforward—until you get the bill and see charges from an anesthetist, a pathologist, or a radiologist you don't know and who turns out to be out-of-network, is not subject to negotiated discounts, and requires paying a larger out-of-pocket share because they're out-of-network.

This is what happened to Gap Inc. and it had much larger consequences than just paying more for care. Their HR leaders have been named in a lawsuit for breach of fiduciary duty for not applying proper care in managing their health plan.[69] (See Chapter 18 for more discussion of employer fiduciary responsi-

bilities issues under ERISA.) Some employers have tried to head off this situation with much-touted "wrap networks," designed primarily to cover employees who need care when they're away from home. But the wrap network rates are typically significantly higher than the rates under your PPO network. And it may actually cost more to file a claim under a wrap network than to have your benefits administrator negotiate a disputed claim.

Trick #6: Delivering Inappropriate Oncology Treatment

Sadly, way too much cancer treatment is unproven. Cancer centers may not follow evidence-based treatment guidelines for certain cancers and too often have limited regard for the devastating side effects patients experience during and after treatment. Also, financial conflicts are rampant at cancer centers, which may not inform individuals and their families about costs, copayments, and co-insurance before treatment.

Dr. Otis Brawley, MD, chief medical officer for the American Cancer Society and author of *How We Do Harm: A Doctor Breaks Ranks about Being Sick in America,* famously said that "the talk should not be about rationing care but about rational health care." He described taking over the care of a patient with colon cancer that was dumped by their doctor after losing their insurance. Dr. Brawley found that the patient was on a chemotherapy regimen that was 15 years out of date and taking unnecessary drugs on which the first "greedy" doctor was receiving a substantial markup.

"I've seen so many times," wrote Brawley, "where doctors really have failed to evolve and… learn as the profession and the scientific evidence have changed over time."[70]

Putting his experience in context, the *BMJ Quality and Safety Journal* has estimated that 28 percent of cancers are misdiagnosed in the first place.[71]

Trick #7: Suppressing Quality and Safety Data

Not only is it statistically safer to be in an airplane than a hospital, it's also statistically far safer to deliberately jump *out* of that plane (skydiving) than to be in a hospital.[72] Surprised? That's just how the health care industry wants it.

Industry lobbying power—health care lobbyists outspend the oil, financial, and defense industries *combined*—is on full display when it comes to hiding quality and safety information from the public.[73] Fortunately, other people are determined to dig that information out and get it to you.

Leapfrog, an independent nonprofit founded by leading employers and health care experts, promotes health care transparency through data collection and public reporting initiatives. You can check Leapfrog Hospital Safety Grades online for your local hospitals.[74] Their quality grades are based on a voluntary annual hospital survey they conduct, but only around 1,800 hospitals of 5,564 in the U.S. currently participate. They also publish safety grades based on publicly available data and the survey results for participating hospitals.

You can also go to Medicare's Hospital Compare, which provides data on the 4,000+ hospitals that are Medicare-certified, to find out how hospitals in your area are performing on some 60 measures, everything from serious complication rates to the percent of patients who report being given information about what to do after discharge and during recovery.[75]

You can also find safety and other data about physicians at Vitals.com, RateMDs.com, and HealthGrades.com.

None of these ratings efforts are entirely satisfactory, some less so than others, but it's a start. More important, you can ask questions. As an employer, it's your job to find out as much as you can about the care available to your employees and you have the ability to do so—no matter what the industry says.