FOREWORD

Brian Klepper

One of American health care's deep mysteries has been employers' and unions' 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.

Health care's lobbying grip on national and local policy, and its immense market strength make it seem all but unstoppable. In 2009, the health care industry spent $1.2 billion to influence the Affordable Care Act.[1] 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.[2] 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.[3] This, more than nearly anything, is destroying the American dream.
- Musculoskeletal disorders consume 4 to 4.5 percent of the *entire* U.S. GDP.[4] We perform about double the musculoskeletal treatments of other industrialized countries, yet get no better health outcomes.[5] This means ~2 percent of our entire economy is wastefully consumed by just one sliver of our health care system. Benefits purchasers that have tackled this one area have reduced their total spending by 4 to 11 percent.
- A 2015 study found that two-thirds of cancer drugs approved by the FDA from 2008 to 2012 have no evidence that they actually work.[6] "Our results show that most cancer drug approvals have not been shown to, or do not, improve clinically relevant endpoints," the study's authors wrote, which is researcher-speak for "most cancer drugs don't work."
- U.S. companies are at a 9 percent cost disadvantage in international markets compared to countries like Germany, Australia, and Korea as a result of our higher spending

U.S. health care is complicated, powerful, and doing everything possible to maintain the status quo. That said, meaningful change generally finds its genesis in small, seemingly insignificant acts. When Dave Chase's columns first appeared on the *Forbes* website, his breezy, attention-grabbing style and shockingly indisputable facts about health care's outrages and solutions resonated with employer, benefits, insurer, and care provider communities looking for what's possible.

Dave has connected the health care dots in a highly insightful and actionable new way, clearly describing:

1. The root causes of dysfunction
2. The gravity of their implications
3. The practical solutions that provide a way out
4. What rules a new health care paradigm must adhere to

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.

Dave's tireless devotion to laying out the health care industry's problems and solutions is fueling a new energy around out-of-the-box, high-value programs and practical solutions. Perhaps more than anyone else, his thoughtful optimism in an all-but-hopelessly corrosive health care industry has become a rallying point for many Americans eager to build a new health care system based on transparency, evidence, and accountability.

It is hard to imagine a more worthwhile goal than that.

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A NOTE FROM A FELLOW TRAVELER

Tom Emerick

Author's Note: *Addressing misdiagnosis and overtreatment in cancer, musculoskeletal procedures, organ transplants, and other high-cost areas has a greater impact on patients than any blockbuster drug. 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. He's been walking the path this book lays out for decades.*

When I travel around the U.S. giving speeches I often ask for a show of hands of people who have had relatives harmed by a major misdiagnosis, bad surgery, botched treatment plan, etc. Nearly every hand in the room always goes up and everyone is always incredibly surprised to see this. I then share that if they know ten people who have died of cancer, likely three of those ten were misdiagnosed and given a useless or harmful treatment plan. Jaws drop, but it's true.

I follow this with "how are we spending $3 trillion on a health care system that is harming so many people?" How is this hap-

pening? We've all seen bad medical events with our own families and friends, but we don't realize how common and costly it is. This is also the core insight behind what's wrong with the U.S. health care system.

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.

1. Lack of accountability

Health care providers aren't accountable to anyone for the quality of care provided in the U.S. A clinician can misdiagnose 20-40 percent of patients, which many do, yet nobody prevents it or stops them. The biggest care quality failure is misdiagnosis. Anything that follows harms you and your wallet. Data shows that misdiagnosis rates in some categories of major care are 20-40 percent! We have an epidemic of misdiagnosis.

2. Status quo lobbying power

Health care institutions in America are very powerful. Few, if any, sectors of our economy have more powerful lobbies at both the national and local levels than health care providers and health insurers. They have $3 trillion reasons to protect the status quo and spend more than anyone to protect it.

3. The American health care exceptionalism fallacy

There is a fallacy in the U.S. that we have the best health care. This is simply not true. We may have the easiest access to care or the most providers in certain categories. However, the cost and quality of this doesn't really stack up to our peer countries in any critical systemic metric. Our health care is twice as expensive with significantly worse results.

4. Limited individual purchaser influence

The individuals and corporations that pay for over half of health care lack the individual power or influence to offset that of our collective health care institutions. Our government pays the other half, yet even Medicare and Medicaid do a poor job of managing many issues, including the widespread misdiagnosis and over-treatment of patients discussed in this book.

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.

INTRODUCTION

The U.S. middle class has gone backwards financially in the last 20 years. The culprit is our health care system. This was the conclusion of a groundbreaking 2013 RAND study, which found that:[7]

- Health care expenditures, including insurance premiums, out-of-pocket expenditures, and taxes devoted to health care, nearly doubled between 1999 and 2009.
- This increase substantially eroded what an average family has to spend on everything else, leaving them with only $95 more per month than in 2007.
- Had health care costs tracked the Consumer Price Index, rather than outpacing it, an average American family would have had an additional $450 per month— more than $5,000 per year—to spend on other priorities.

We all know health care is broken. Yet we all believe that most health care professionals—at least the ones we know—are amazingly talented and altruistic. How can this be? The problem isn't the people, it's systemic: our health care system is crushing the altruism right out of physicians and nurses. At the same time, it's crushing the hopes and dreams of middle-income families.

Before you think hope is lost, I want to make one critical point. Why read this book at all? Isn't reducing health care costs like solving Middle East peace? No, it's not, despite what we've all heard over and over. Push this myth out of your mind forever.

This book's singular purpose is to persuade you to make a powerful mindset shift. You can improve your organization's bottom line, your employees' bottom line, and improve the quality of health care your employees receive. This book will show how and get you started down the path.

I've seen all types of organizations make the shift and create amazing results. Large and small. Public and private. All across our country. Following suit just requires making the shift and following through.

Step one of the shift is to accept that you run a health care business. It's likely your second largest operating expense after payroll. Just ask your CFO. You'd probably prefer not to run this business, but it's there, whether you like it or not. Step two is to act and stick with it.

To help persuade you to make this mindset shift, here are a few major ways it will benefit your business, employees, bottom line, community, and country.

1. **Help save our country and communities –** As we'll discuss in more detail, waste in health care's status quo is running our country off a cliff. It's a primary cause for personal bankruptcies, broken public budgets, wage stagnation, and much more. If we don't make the shift, health care could consume all household income in less than 20 years.
2. **Take better care of your employees –** Every day, you make decisions that affect the lives of your employees and their families. I know the pressure. I've been there as an entrepreneur and executive. I also know that making the shift is a uniquely impactful way to put our money where our mouth is when we say our people are our greatest asset. Doing so leads to a higher-performing, more satisfied workforce.
3. **Materially improve your financial performance –** Health care spending is likely one of the last major buckets of operational expenses you haven't already intensely optimized. Reducing your spend using the approaches in this book can tangibly improve your financial performance, freeing resources

to improve wages, R&D, exit values, market caps, and more. Plus, the savings are recurring and compound over time.

I suspect the above reasons are more than enough to persuade you to make this essential mindset shift. Just in case they're not, let's go negative for a second. If you're already self-insured or plan to become so, emerging ERISA fiduciary duty issues we'll discuss could potentially create personal liability for you. You're likely to avoid this if you make the mindset shift and act on it.

There's really no reason to not make the shift. It's better for you, your employees, your community, and your country. And the good news is that not only is it possible, there are many examples to show the way. Let's get started.

So How Did We Get Here?

Why is health care so broken? Following the money is a good place to start. Our problems started with tax policy in the 1940s. During WWII, we had wage controls, but employer-paid benefits didn't count as wages. To attract employees, employers started offering more and more health benefits without paying attention to what these benefits cost. This is our original sin. It could also be our fount of redemption.

Over time, this practice sheltered us from the true cost of the care we buy, creating enormous dysfunction in what care we pay for and how we pay for it. We ended up focusing on a certain type of high-technology, acute medical care—which we financially reward far more than lower-level preventive and chronic care—without regard for the quality of the outcomes or value of the care. Because what difference does it make? Most of us get our care paid for by our employer or a government entity, who are just as ignorant about the true costs as we are. And here's the kicker: Most doctors and hospitals don't even know what it really costs to provide care because no one has held them accountable for such a long time.

This has big consequences. Our system's financial incentives aren't aligned with the outcomes we want, which most of us define as staying healthy in the first place and receiving high quality care when we need it, while still being able to afford and live a satisfying life. Instead, over decades, our health care system has made millions of small decisions to increase the quantity of care provided, which increases revenue, resulting in hyperinflating costs. Ultimately, we undervalue what keeps us healthy.

It's a sad equation: Poor financial incentives + we all want care + decades of small decisions = where we are today. The Kaiser Foundation found that "[s]ince Medicare passed, per capita [health care] spending has grown more than 50-fold. This far outstrips per capita spending on all other goods and services by at least 5 times."[8] The trend is only accelerating. Figure 1 is from the *Wall Street Journal* and shows that health care takes 25 percent more of middle-income household spending than in 2007, just ten years ago.

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, which he described to me in a memorable conversation. 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

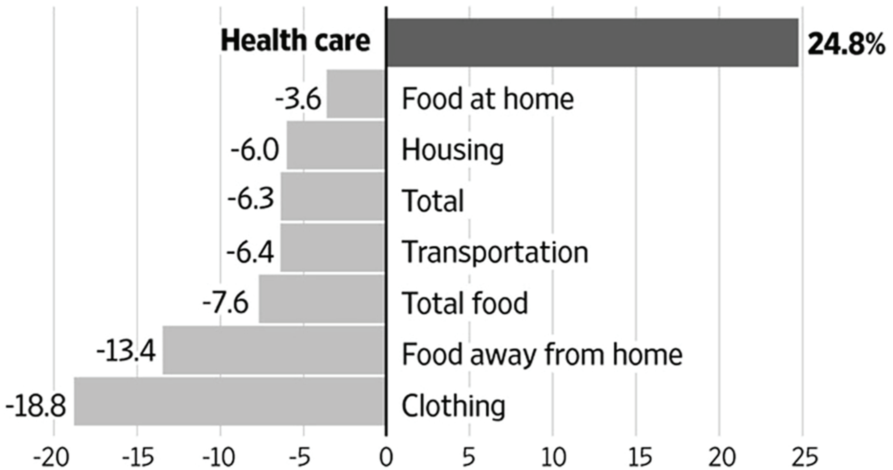

Figure 1. Source: "Burden of Health-Care Costs Moves to the Middle Class," Wall Street Journal, August 25, 2016.[9]

> 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 satisfac-

tion of any industry and high deductible plans have suddenly become the norm.

I'm regularly asked to speak to benefits consultants, business coalitions, nonprofit associations, and public-sector organizations about how to tackle this situation. The overriding sentiment I find is that organization executives and benefits leaders have reached their breaking point. They are no longer willing to accept that every year they're obligated to get less and pay more for health benefits.

The Legal and Fiduciary Implications of The Annual Kabuki Dance

While we rightfully pay enormous attention to the Obamacare exchanges, Medicare, and Medicaid, the fact is that employers collectively pay the largest share of the health care tab and non-retirees overwhelmingly get their health insurance from work.[10] 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.

To understand how this issue could play out, it's worth looking at what's happened in a highly-analogous context, 401(k) plan litigation. Here's an example. Employees of Edison International brought a class action suit against the company, alleging that Edison breached its fiduciary duties by offering participants in the 401(k) plan retail share classes of mutual funds when low-

er-priced institutional share classes were available. The employees won a unanimous verdict at the U.S. Supreme Court. There are some legal issues that prevent this exact type of plan beneficiary suit, but there are similar strategies being developed now that could be far more successful. These strategies could create personal liability implications for officers and directors. It's still early, but we've been following the issue enough that it's high on our radar at the Health Rosetta Institute. This issue could change rapidly as cases are filed.

A broader analogy shows the absurdity of such low expectations for those we rely on to help us provide health care benefits. My partner, Sean Schantzen, is a former practicing securities attorney who is relatively new to health care. He's pointed out that someone in 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. The recently adopted Fiduciary Rule heightens these requirements even more. 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.[11] 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. There

are uncertainties and complexities to this approach, particularly around developing critical safe harbors for employers. However, 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.[12]

The Health Rosetta

I believe the Health Rosetta is the way forward. The Health Rosetta is an ever-evolving collection of principles and best practices that I and many like-minded professional colleagues have put together that's a blueprint for sustainably reducing costs and improving care. It's built on real-life successes, not theory. It simplifies the path for you to achieve similar results.

In the old model of health care, the supply side dictated the pricing and terms. Today, forward-looking organizations refuse to leave these areas unmanaged. The wisest are turning health care costs, which many view as a liability, into a source of competitive advantage. They have found they can reduce spending by 20 percent or more per capita while providing better benefits than 99 percent of the workforce. In other words, the best way to slash health care costs is to improve the quality of those benefits. The Health Rosetta makes it easier to follow these leaders.

The nonprofit Health Rosetta Institute's mission is to accelerate adoption of the Health Rosetta. It focuses on practical, nonpartisan fixes to how we pay for care, what we buy, and how we manage benefits. It helps public and private employers and unions reduce health benefits costs while providing better care for the 150 million Americans who receive health benefits through their jobs.

The focus of this book is on nongovernment paid health care. However, the Health Rosetta isn't employer-specific or even U.S. specific, for that matter. As I've spoken with people around the U.S. and world, it's clear that no country is without problems in

how it purchases health care. Perhaps the biggest missed opportunity at the state and federal level is that the public sector is a large employer itself, representing a broad cross-section of society. The fact is public sector employers have all the same opportunities as private sector employers to greatly improve the value they receive.

Broadly speaking, the two biggest problems in the U.S. health care system are pricing failure (no correlation between price and health outcomes) and overtreatment. These problems are pervasive in both publicly and privately funded health care benefits. Policy makers would be wise to test and prove their models of reform with the public sector workforce. Fortunately, there are widespread examples of success they can follow. The Health Rosetta aggregates these into an understandable blueprint.

Here are a few of the Health Rosetta's foundational components.

- **Value-based primary care.** Properly conceptualized and incentivized primary care is the front line of defense against downstream costs.
- **Concierge services.** Navigating health care is complex, even for those of us in the industry. Employees need access to trusted, aligned resources.
- **Active ERISA plan management.** Employers deeply manage budgets in every other area of spend. Why not health benefits? Internal fiduciary oversight is critical.
- **Transparent medical markets.** Cost and quality are often inversely correlated in health care. Focusing on better quality and outcomes is the path to lower costs. This is particularly true for addressing high-cost outlier claims that make up the majority of spending.
- **Payment integrity.** Ensuring claims are paid correctly and tackling fraud is a critical step to high-performance benefits.
- **Transparent pharmacy benefits.** Purchasers need true transparency of data to control decision-making.

So, if the fixes already exist, why isn't everyone using them?

Health care's redemption is a classic example of solutions hidden in plain sight. Remember the *The Big Short* and *Moneyball?* As noted business consultant Ric Merrifield, author of *Rethink: A Business Manifesto for Cutting Costs and Boosting Innovation*, has pointed out, 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.

I think of health care as being in a similar place and following a similar path as the banking industry in the early and mid-2000s that partially led to the 2008 financial crisis. My hope is that this book will contribute to a health care turnaround more profound and longer lasting than that in banking.

A Note on Reading the CEO's Guide

The first two sections of this book, *The Current Situation* and *How and Why Employers Are Getting Fleeced*, explore in detail the case presented in this introduction, helping you understand specifically what has gone wrong with health care and what the consequences are to your employees, your organizations, our communities, and our country.

The last two sections, *Doing It Right* and *Health Rosetta*, will step you through key solutions you can start implementing immediately.

Throughout, you will find case studies of employers that have already achieved significant success implementing Health Rosetta components. The goal of these is to show how creative application of select strategies can be highly successful. Just copying them whole cloth is unlikely to work. You have to build a model that works for your geography, employees, claims experience, cost structure, and other variables.

Before we dive in, I want to cover a couple of issues to help you navigate the book. First, feel free to jump around. Each chapter generally stands on its own.

Second, I've tried to simplify the enormous complexity of our health care system. This means I'll skim or skip certain topics to avoid rabbit holes.

Third, health care always seems to use ten different words for essentially the same thing, each with some supposed slight variation in meaning that isn't even consistently used by those of us in the industry. To minimize confusion, I generally use consistent terminology in key topics.

- **People.** I use a couple different terms depending on context. *Individual* is the default. *Patient* is for people receiving care. *Member* or *employee* refer to individuals from a health plan's or employer's perspective.
- **Provider organization and clinician.** These terms cover the people and entities that provide health care services. This includes doctors, nurses, hospitals, health systems, and anyone else that provides health care services.
- **Insurance company or carrier.** These cover the organizations that provide insurance and/or self-insured plan administration services
- **Health plan.** This covers a specific health benefits plan, whether fully-insured or self-insured.
- **Plan administrator.** This is the organization that performs noninsurance pieces of a health plan, like claims adjudication. It includes Administrative Services Organizations (ASO) tied to insurance companies and independent Third Party Administrators (TPA). I use these more specific terms when distinguishing between the two.
- **Benefits broker, consultant, and advisor.** *Broker* describes those operating under the status quo, highly-conflicted approach to purchasing health benefits. *Advisor* or *consultant* are used to describe those operating under the modern, high-value, transparent approach. These three terms are often used

interchangeably in the real world, so typically aren't sufficient to identify high-value people and firms.

- **Workplace wellness program.** The term *wellness* has been co-opted by a large industry of vendors that largely sell no or negative ROI products. I'm a fan of the concept of wellness, i.e., well-being, just not these types of programs. I use this more specific term to refer to these programs.

Fourth, a couple chapters were primarily written by other experts I admire. Their names appear at the beginning of these chapters to easily identify them.

Finally, I've attempted to ensure every critical point, especially the more controversial ones, is well-cited. However, some sources are private conversations with other industry insiders who are uncomfortable being publicly cited. As a result, some citations for some points refer to private conversations and a few aren't cited.

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