APPENDIX C

HOW TO PICK A BENEFITS CONSULTANT L

David Contorno

Recently, a Blue Cross health plan offered their 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 are common and considered "business as usual."

For most companies, health care spending is one of the largest expenses on the P&L, often ranking in the top two or three. However, few business leaders give it any more time and attention than they do, say travel or entertainment expenses. Furthermore, some still leave benefits decisions up to the HR department, a seemingly well-intentioned strategy. However, taking an HR-knows-best approach is contrary to the organization's (and often employees') best interests. While HR is critical when it comes to rolling out, administering, and the required employee social counseling of your health plan, financial decisions are best left to officers with an innate ability to negotiate the highly complex.

HR professionals typically fall into one of three categories: coordinator (admin), generalist (social worker), manager

(expert). Ruling out the first two as negotiators, expecting your HR manager to deftly navigate a financial win while simultaneously managing recruiting, compliance, compensation, and the entire HRIS system, is akin to finding a unicorn in your driveway tonight. If your broker works closely with HR, and takes your CFO golfing twice a year, he or she is likely paying for the trip with a $50,000 carrier incentive.

Knowing how to select a benefits advisor or consultant* who has the right skill sets and integrity in an industry that is often deliberately opaque can make all the difference in delivering true value to your employees. If you'd like an example of client-first consulting, see the Appendix I "Decoding a fully insured renewal", written by Wes Spencer, an advisor from Michigan.

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 carriers to differentiate their networks 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 and employer size) on paying medical claims would prevent them from being overly profitable and would help control costs. It hasn't turned out this way for sev-

eral reasons. First, after paying medical claims, broker commissions, and normal administrative costs, carriers 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 rising costs, so long as their costs don't rise any faster than those of their competitors. This certainly existed before 2010, but the ACA turbcharged the dynamic. The common impression that insurance carriers' large networks and client pools give 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), drug manufacturers, pharmacy benefits managers, and, of course, brokers. [1]

A Broken Process

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

Around 60 days prior to the contract renewal date, your broker gets a renewal offer from the current carrier that has VERY lit-

tle 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. 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 proactive 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 loses them money every year.

Let's assume you are in that minority of money-losing clients. Your carrier has to make you a renewal offer by law. So why wouldn't they just make that offer astronomically high? Because an offer with too large an increase scares off all the other carriers, making it less likely they can get rid of you as a customer, and brings 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 delta, 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 six percent spread, so they offer a 12 percent increase over your current rates.

If your broker is loyal to your current carrier—and they usually are, because the more clients they have with one car- rier, the bigger their bonus income—he or she will share that 12 percent offer with them. Naturally, that carrier doesn't have to try as hard because they already have your business, so maybe they match the new offer or come in at one percent above or below it.

Some brokers stop right there. They've shown their "value" by reducing the renewal rate by six 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 matching offer back to the other carrier, pitting the two 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 while keeping the customers they want. Note that, in the unlikely event your broker was able to save you 20 percent on your premiums, he or she would also take a 20 percent haircut.

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 offer alternative options 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 (not to mention often leaving the employee in a catastrophic financial situation).

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 percent paid for the same business to a less loyal broker.

Unless your organization has fewer than 20 people in your health plan, you'd more than likely get great benefits from being self-insured. If your broker/consultant doesn't have that expertise, you are being steered to a plan that benefits the carrier and broker more than you. Many advisors do have that expertise, so be careful about being a guinea pig if the broker has little experience to draw upon.

The No Shop Offer

"David Contorno, because you are such a great partner, we have an amazing offer for our mutual client! If you renew this client without shopping the market, we will come in with an amazingly low renewal AND you will qualify for a $2,500 early renewal bonus! Is this something you would be interested in receiving?"

This is an actual email I, as a benefits consultant, received from a large, well known carrier. It's a tempting offer...I feel like I am in an infomercial of fast talk and supposed deals where all I have to do is act quick and I will get a better deal for me and my client! In my head, I hear the ShamWow guy yelling "If you order in the next 24 hours, we will give you the best deal of your life! But wait, there's more! Act NOW, and we will double your order to include an embedded wellness program, and free telemedicine! But that's not all! We will pay you an additional $2,500! But you must act now!"

Please allow me to translate above... "We at carrier ABC are making so much money on this case, we don't want anyone else possibly exposing that or stealing this nugget of gold from our membership base. Since your expectations of renewals are so low, we don't actually have to price this fairly, all we

have to do is come out with a better than expected increase and everyone wins!"

I have to admit, I was seduced by this offer for a long time. I can recall one case, where I was working with my "preferred" carrier at the time, on an existing client. The carrier came to me about 75 days before renewal with a no shop conversation. I asked them where they would be at, absolute bottom line best number, if I agreed to not shop it. They said 5% increase. That seemed extremely reasonable in light of the increases I was getting right around the time when the ACA was being rolled out. When I committed, on my client's behalf (without talking to them) to the offer, I was unaware that the client was already talking to another broker and that broker was out shopping the market. So, I had to backtrack on my "no-shop" promise. The carrier did not like this. The sales manager, to this day, still appears to hold animosity towards me over this case. But here was the outcome...when I was backed into a corner, and had to shop it, the "preferred" carrier of the other broker was coming in exactly in line with the pre-renewal rates. So, I had to push back on the current carrier, completely usurping my promise not to shop it. At the end of the day, we kept the cur- rent carrier and plans, but instead of a 5% increase, we wound up at a 5% decrease... what a great no-shop offer!

Now, if any of you reading this know me, you know this is not a good approach to managing healthcare costs. This is what we as an industry have been doing for decades, and I think the trend speaks for itself. Is a 5% decrease better than a 5% increase? Absolutely.... but when we got this client into a proper self-insured plan about 2 years ago, their costs went down by 41%! And at the same time we reduced out of pocket exposure for most procedures and services to zero for the employee!

The Self-Insured Market

How does this translate to the self-insured market? Most consultants (although not all) who 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 life- time 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 tai- lor 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 specifica- tions you set up and the supporting plan documents
- The network (usually "rented" from a large carrier) that pro- vides "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 pursue an employee to try to get additional payment. A proper plan pro- tects employees against this; in extreme cases, it 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 maybe 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 *Are Workplace Wellness Programs Hazardous to Your Health?* 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 enthu- siasm over data access and your fancy new workplace wellness program quickly dies. Seventy-two percent of companies have these programs and, I assure you, Seventy-two 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 price and use of overtreatment, which harms employees financially and potentially medically. The plan is built on a proven approach to lowering the actual cost of care for ALL employees, whether they are healthy or not, and 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 open networks/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: selecting a consultant at the same time you select your plans and other benefits for the upcoming year. A forward-looking 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. Your consultant 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. (Fees are usually a small percentage, in the low single digits, of your total health care spend, which doesn't speak to their true value.) 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 more based on money actually saved! Now that's aligning incentives.

While no one expects an organization leader 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. Pick your benefits advisor with greater care than you would pick a 401-k advisor. After all, not only is there the same ERISA fiduciary liability as 401-k plans, a status quo plan can subject your employees to unnecessary medical harm. One way you can judge a consultant's skill, integrity, and expertise is whether they're certified by the Health Rosetta. Certification requires transparency, expertise in key areas and strategies, and adherence to valid cost and outcome measure- ment models. Many seasoned, high integrity professionals have already received this qualification. Learn more at healthrosetta.org/employers.

David Contorno is a nationally recognized speaker, author and founder of E Powered Benefits which helps employers and brokers to lower costs and improve outcomes.

Key Takeaways

- If your health care costs have increased over the course of the last 5 years, there is a good chance you need a new advisor.
- Separate the annual benefits process from the benefits advisor decision by as much time as possible.
- Beware of brokers unwilling to align your financial interests with theirs. At the same time, value counts more than fees, so avoid being penny wise and pound foolish.