CHAPTER 10

# CREATING A COMMUNITY-OWNED, PARENT-APPROVED HEALTH PLAN

The word "local" takes on multiple meanings in this book. In the last chapter, LOCAL was used as an acronym to walk leaders through the steps they need to take to reduce their annual health care spend. In this chapter, the term will be used to explain what should be at the heart of every health plan: the local community.

## Understanding COHPs

Unfortunately, as it stands today, many community health care systems are controlled by out-of-town owned health systems and health plans. That can mean that over 50% of so-called "healthcare dollars" are extracted out of local economies. Yet, the health care system only drives less than 20% of health outcomes.

Often, the dollars being extracted out of local economies are dollars that were previously being spent on education, human services, public health, public safety, mental health, and local aid, aka the "social determinants of health" that drive approximately 80+% of health outcomes.

It is quite clear that status quo health plans have it all back-

wards – taking money away from the things that would actually improve healthcare and wastefully dumping substantial sums into things that only aim to address symptoms of underlying issues. High-performing, "community-owned" health plans (COHP) do the opposite, focusing on the unique needs of the local community and working to address them before they balloon into bigger, more expensive problems.

Leaders who have done the initial work of going through the LOCAL steps described in the last chapter should head in this direction next – for both financial and moral purposes. COHPs eliminate shareholder profits and/or extravagant executive salaries – common in so-called "non-profit" health plans/systems – as the central guiding principles and mission of the healthcare system, and as a result, produce lower costs and improved levels of care. COHPs prioritize the totality of health – not just institutional healthcare – and provide better working conditions and motivation for caregivers.

They do this by having leaders – be they consumer cooperatives, employers, unions, local governments, or any other entity that manages the health plan – shift from a health plan "renter" mindset to a health plan "owner" mindset. As "member-owners," organizations are incentivized to tailor their health plan to meet their unique needs, or in other words, the needs of their beneficiaries.

The best way for member-owners to meet the needs of their beneficiaries is to connect them with a strong, local, and properly resourced primary care team. This team can help beneficiaries organize and interface with other facets of medical care (e.g., specialty care) when it is needed, and mitigate the impacts of the social determinants of health that could be present in their community.

Primary care providers in COHPs need just four things to be successful:

1. A clear area of responsibility
2. Clear service and quality markers to monitor

3. Freedom to innovate in how to address their population's needs e.g., home care, office visit, phone care, virtual visit, etc.
4. Flat monthly payment that is age and sex-adjusted (in industry parlance, "global capitation" like in Medicare Advantage programs).

This stands in stark contrast to traditional health plans, in which the administrative hassle is maintained by insurance payers to justify their control, independent of medical necessity. Similarly, the primary success metric of traditional health plans with disinterested and distant shareholders is the profit/volume of healthcare services – not, as it should be, the well-being of its members.

## The Impact of COHPs

We are seeing dramatically better value from health plans, like COHPs, that focus on the well-being of its members.

The Southcentral Foundation of Alaska's Nuka System of Care is an excellent example. In it, the health care system is built by and around the local community. Its success is defined by the positive outcomes of its plan members, meaning that the local physicians do everything they can to address social determinants of health and empower patients to lead healthier lives.

As a result of The Southcentral Foundation embracing this community-owned approach, from January 2000 to 2017, they saw a 40% decrease in ER visits, as well as a 36% decrease in hospital stays. They also saw overall health care spending dramatically slow: Between 2004 and 2009, annual per capita spending on hospital services grew by only 7% while primary care spending remained below the national index.

Two other great examples can be found in Pacific Steel & Recycling and Rosen Hotels & Resorts. Through a combination of reference-based pricing and paying attention to the quality of care they were paying for, Pacific Steel & Recycling reduced its healthcare spending by over 50%, savings that translated into

working class employees retiring with 7-figure retirement nest eggs due to the company's ESOP. And at Rosen Hotels & Resorts – despite having a significant disease burden in their workforce (e.g., 56% of their pregnancies are categorized as high risk) – there's still money left over to invest in the surrounding community. The result is not only better health, it's minuscule amounts of opioid addiction issues, less crime (a reduction of over 60%), and doubled high school graduation rates.

## Securing "Parent-Approval"

Health and wellness, crime, education – these are the kinds of things that parents worry about. And seeing as they all, indeed, connect, one could make the case that the best health plans are not only the ones that are community-owned, but ones that would be "parent-approved."

Creating a parent-approved health plan means always searching for ways to get more value; to see better health outcomes, as well as more savings that can be used for higher and better purposes. To do that, it helps for leaders and their advisers to keep Health Rosetta's core tenets – HEALTH (for short) – in mind:

- ***H*ealth professionals are incredibly compassionate people who are well trained and want to do good.** But just like patients, health professionals want to see and be seen. Just like patients, they want to hear, and be heard. And just like patients, they want to feel, and be felt. In other words, health professionals desire to be unleashed from a system that does not allow them to love their patients to health, freely and fully. This means they do their best work independent of stifling administrators and bureaucracy in an environment that loves and respects their work. Aligned professionals keep their patients out of harm's way including overtreatment or low value care and institutions. When they have time, they can lay out all the care options.

Health plan implications: Health Rosetta actively seeks out and supports independent, empowered medical practices and hospitals. The "magic" of patient-caregiver partnership returns when administration goes away or moves into the background where it belongs. Technology should be at the service of the patient rather than a tool for profiteering.

- ***E*-Patients are smart but frustrated they cannot be healthier.** [Note: "E-patients" are a large patient movement that defines the "e" as equipped, enabled, empowered, and engaged in their health and health care decisions.] Everyday living presents many obstacles that can be overcome when caregivers are aware of them, which is why individuals need the health system to be fully engaged with them on a regular basis – not just during visits. Achieving full health is always the overarching goal. That is why communication is the most important medical instrument out there. It drives action and builds trusted relationships, and given the tools that are now available, the good news is that communication has never been easier. Individuals and their dedicated, committed caregivers are the greatest untapped sources of information, knowledge, and motivation, and empowering them to work together will optimize care. However, the full benefits of this will only be realized when there is already a strong foundation, that is, when patients can understand the health risks that come along with their health choices.

  Health plan implications: Health Rosetta plans and systems are designed so individuals can stay healthy, taking as few drugs and having as few procedures as possible. Maintaining and optimizing health, rather than maximizing profit and revenue, is always the priority. We recognize that many times, the best place for interaction between the clinician and an individual isn't at the clinic but in the comfort of an individual's home via phone, email, and other digital tools, or even in a social setting

such as schools, churches, or other community organizations. Plan design must support this, including using Health Rosetta Dividend money for things outside of the traditional health care system. Health plans should enable a health "ownership" versus a "renter" mentality run by "slum lord" absentee owners (i.e., profiteering carriers and health systems).

- ***Avoid waste.*** Approximately 50% of the $3.5 trillion health care industry is waste. The more health money that's spent upstream and outside the expensive, wasteful, unnecessary, and redundant health care system, the more money is freed up for maintaining and optimizing health by investing in what actually drives 80% of health outcomes – social determinants like housing, education, food scarcity, etc. Previously squandered money will be there to address the truly catastrophic events, whether a serious medical condition or the need to have caregiver help. This concept can also be applied to individual treatment; when it comes to health care, often less is more, and in many cases, no treatment is much better than any treatment.

  Health plan implications: Avoiding waste allows Health Rosetta to make investments in long-term health. Every health plan should include a Health Rosetta Dividend plan with a dashboard comparing actual spending versus company and overall industry trends. Develop a Health P&L, in which profits include proven non-care health investments, increased pay / bonuses, and reduced cost sharing, while losses reflect increased spending on health care.
- ***Local health starts at home.*** Local health starts at home and moves out in concentric circles, and the closer health investments are made to home, the higher the yield. It makes sense: Communities are best suited to understand and address their own problems, and when health dollars are re-localized, there's sufficient funding to address

those items requiring investment in education, mental health, social services, public health, and more.

Health plan implications: Plan design should always optimize care that can be delivered close to or in the home, whether this means supporting local, independent medical practices or providing tools for self-care, family caregivers, and professional home care. Local public entities (towns, counties, school districts) can and must become market accelerators and bully pulpits for re-localization, because health care costs are intimately linked with all of these vital entities.

- ***T*rust is built through transparency and openness.** Transformation is dramatically accelerated through openness – sharing ideas, and the transparent open flow of information – as transparency quickly builds a sense of trust.

  Health plan implications: We will be open with the Health Rosetta blueprint, sharing results (good and bad) and our business relationships. We will expect and demand full transparency (well beyond pricing) from providers of care and administrative services.
- ***H*uman-centered health plans restore health, hope, and well-being.** Humane health plans are built on humility, integrity, and generosity. Humility is thinking of others, recognizing that caregivers and individuals together deliver the best outcomes. Integrity includes making individuals aware of all options and the accompanying tradeoffs. When individuals are given full and unconflicted information, they typically choose the least invasive option; when they do not, a humane health plan allows them to make that choice with as few constraints as possible (given resource limitations). A person may have diabetes, but they still want to live their best life possible.

  Health plan implications: Whatever the business or clinical challenge, we will seek out what's best, not necessarily what sounds best or what generates the most revenue.

Often, following these tenets will lead advisors to implement these fundamental health plan components:

- Transparent advisor relationships. All direct and indirect revenue sources/benefits that advisors receive are disclosed to their clients.
- Active ERISA plan management. Employers deeply manage budgets in every other area of spending. Why not health benefits? Internal fiduciary oversight is critical.
- Value-based primary care. Properly conceptualized and incentivized primary care is the frontline of defense against downstream costs.
- Individual stewardship. Navigating health care is complex, even for those of us in the industry. Employees need access to trusted, aligned resources.
- Transparent open networks. 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 when addressing high-cost outlier claims that make up most of the spending.
- Transparent pharmacy benefits. Purchasers need true transparency of data to control decision making.
- Investment in high-value alternatives (e.g., centers of excellence) rather than low-value plan parts (e.g., workplace wellness programs).

## Low-value vs. High-value components

### Workplace Wellness Programs

One area of widespread spending that typically has little benefit – and no cost savings – is workplace wellness programs. Promotion of wellness programs has been a particularly deft move by health insurance companies to distract from their economic incentive to raise health care costs. For someone not paying attention, it seems plausible that the fattening of America is a

primary driver of increased health care spending (it is not). There are numerous other, much bigger cost-inflation drivers, even if the so-called wellness programs were effective (few are).

To start, they are usually sold on mathematically impossible ROIs and undisclosed commission models that enormously benefit brokers. This has caused Al Lewis, former workplace wellness industry proponent turned leading critic, to offer a $3 million reward to anyone who can prove that the industry has reduced employers' medical claims costs enough to cover its $8 billion annual cost. So far, his money is safe.

By way of background, Lewis was a workplace wellness industry insider, called one of the founding fathers of disease management. Now, he is CEO of Quizzify, a provider of employee health literacy programs, and author of several best-selling books on measuring the outcomes of employee health-improvement programs, especially workplace wellness programs. (Check out *Surviving Workplace Wellness and Why Nobody Believes the Numbers*.)

Promoters place workplace wellness programs among the most important advances in medical history, equivalent in impact to vaccines and antibiotics (their words). Detractors call it a "scam." An entire website, www.theysaidwhat.net, is devoted to exposing its many alleged lies and misdeeds.

Obviously, it cannot be both a significant advance and a total scam. It's critical to know which though, because there is a very specific distinction between workplace wellness programs and everything else in this book. Whereas everything else is an unfortunate byproduct of insuring your employees in today's status quo market, these programs are a totally optional undertaking.

Workplace wellness program fees typically cost employers $100 to $150 per employee per year: plus a similar amount in employee incentives to encourage usage; plus lost work time to participate in screening programs and complete health risk assessments; plus, administrative time to ensure compliance with relevant laws and regulations. Add these up and you start to see that the total costs are much more than just vendor fees. All this

to generate great employee dissatisfaction, judging by the fact that a 2016 *Slate* article entitled "Workplace Wellness programs are a Sham" generated more shares than any other Slate article on either health care or the workplace that year.

Lewis advocates a much simpler approach to preventive care: regular screenings based on well-established clinical guidelines developed by the U.S. Preventive Services Task Force (USPSTF), an independent, volunteer panel of national experts in prevention and evidence-based medicine. To balance the harms of over-screening, misdiagnosis, and overtreatment against the benefits of early detection, the USPSTF guidelines recommend far fewer blood screenings, far less frequently than most vendors advocate. These guidelines are easily accessible through the Choosing Wisely initiative, a partnership between the American Board of Internal Medicine Foundation and *Consumer Reports* that seeks to advance a national dialogue on avoiding wasteful or unnecessary medical tests, treatments, and procedures.

## Centers of Excellence

Connecting employees who need care to the best-possible places is just as important as making efforts to keep them healthy. After all, sometimes potentially expensive surgeries and procedures are necessary no matter how hard you try to prevent them.

Wise leaders and benefits advisors plan for this in much the same way they plan out their primary care foundation; they seek out the hospitals and surgery centers that boast the best results at the lowest total cost. But they don't stop there and for good reason.

Tom Emerick, a consultant on health care benefits administration, founder of Edison Health, and coauthor of *Cracking Health Costs* and *An Illustrated Guide to Personal Health*, compiled 30 years' worth of data from various sources and found the following serious health conditions and their typical misdiagnosis rates:

- New cancer cases – 20%
- Spine surgery – 67%
- Orthopedic surgery – up to 30%
- Bypass surgery – 60%
- Stents – 50% in some parts of the United States
- Solid organ transplants – 40%

If accurate and poorly managed, cases in any of these areas could easily cost employers tens of thousands of dollars. And even if the hospitals they select for their beneficiaries are pretty darn good, looking elsewhere, toward what is called a center of excellence, could make a gigantic difference.

Centers of excellence are medical centers that specialize in certain high-risk and usually high-cost areas like cancer, organ transplants, heart surgery, etc. Care isn't "one-and-done" so to speak but managed from start to finish. As Emerick puts it:

"A center of excellence typically offers the complete continuum of care for a chronic disease or acute condition such as diabetes or breast cancer, from diagnosis to treatment to rehabilitation, at lower costs than less capable providers. These centers are fundamentally focused on patient care more so than on research or education, although they likely do both. They practice medicine using a team-based, data-driven, and accountable model. They perform high volumes of complex surgeries with great outcomes, yet they are more likely to recommend nonsurgical treatment plans whenever appropriate."

Within a center of excellence, a patient will see and frequently interact with a multidisciplinary team of specialists, receiving not only more thorough care but a wide variety of honest, unbiased opinions about different options, surgical and nonsurgical, in large part because bundled payments replace fee-for-service payments.

Leaders interested in engaging with centers of excellence should start by looking at Health City Cayman Islands, Mayo Clinic in Minnesota, Virginia Mason in Washington, Mercy Hospital in Missouri, Intermountain Healthcare in Utah, Kaiser

Permanente in California, Geisinger Health in Pennsylvania, and Baptist Health in Arkansas. However, it is imperative to remember that excellence is not absolute: Centers of excellence should only be used for the procedures and specialties they're best known for, not anything and everything.

## Conclusion

Healthcare is not one size fits all. Each individual person has unique health needs, and the only way those unique needs will be met is if leaders design their health plans to be community-owned and parent-approved.

Once that plan is designed, the next step is for leaders to make sure their organization uses it through effective change management. The next chapter breaks that process down into concrete steps.

## Key Takeaways and Things to Think About:

- Health starts at home. The best health plans are those that are rooted in the community and that serve the community, mitigating social determinants of health, improving outcomes, and freeing up previously squandered healthcare dollars.
- Investing in local primary care practices/physicians is critical. There is no high-function health care system in the world not built on it, and U.S. primary care must be rebuilt from the ground up.
- Leaders should look at their health plan from a parent perspective, as health, public safety, education, and other issues are inherently linked. By improving one, leaders can improve others.
- Wellness programs are optional, and money is better spent on what truly drives health and well-being, such as value-based primary care.

- There are extraordinary rates of misdiagnosis and over-treatment that put patients in harm's way. The savings from avoiding complications, misdiagnosis, and over-treatment more than pay for the extra cost of travel to world-class centers.
- The highest quality centers have a team-based model that allows for more accurate diagnoses and more appropriate treatment plans.