CHAPTER 2

PERFORMANCE BASED HEALTH PLANS™: A Business Strategy for Healthcare

BY CRAIG LACK

Napoleon Hill, in his renowned book, *Think and Grow Rich*, reinforced the message that people, and businesses, become trapped by their habits – either by lack of ambition, lack of specialized knowledge or lack of imagination. The proof of Napoleon Hill's message can be seen repeatedly in businesses everywhere today.

Take for example, the massive shift throughout the world from analog to digital solutions. There is hardly an industry or product that hasn't been transformed from analog to digital. Think of the music, movie, telephone or banking industries and see how everything has changed.

One of the most ironic examples of a business becoming trapped by its habits and success is the story of Eastman Kodak. Kodak was a very successful and profitable company for decades. They dominated the film industry and the portable camera market. Their financial success came from selling an inexpensive

camera and then selling consumers all the film to use inside. Of course, they also processed the film to provide consumers the photographs that they would place in their albums. Every click of every camera meant money for Eastman Kodak.

The story becomes almost unbelievable, but in hindsight everything seems so obvious. Kodak invented digital photography. Unfortunately they were trapped by their past successes and were locked into their entrenched habits and lack of ambition. No one could overcome groupthink and the mantra of historical best practices. Internally, the dialog inside the company was that nearly all profits came from film, so why waste profits on developing digital. We all know how that story ended.

Despite today's tsunami of change to the digital world, there are still two remaining enormous industries in the United States that are resisting and fighting the inevitable: Our public education system and our healthcare system. The healthcare system in America is a $2.8 trillion industry and is inherently and systemically inflationary. Despite twenty-five years of Managed Care (Costs) we are no closer to controlling costs than before PPOs, HMOs and Rx cards were created.

We have now reached a point in time where government intervention has created laws making health insurance a regulated industry and a mandate for its citizens under the threat of taxation. Nowhere is the HealthCare Reform impact felt more than in the middle market companies throughout America.

Middle market companies are stuck with out-of-control trend increases in their healthcare spend (cost). At first you make your habits, and then your habits make you. A perfect example of this can be seen in how middle market companies purchase their healthcare. Think of it as the trap of experience. Lacking specialized knowledge, executives rely on their developed habits over years of repeating the same buying strategies and tactics.

There is a behavioral economic theory called the rule of first

knowledge which states that most people have a difficult time unlearning the very first thing they learned about any particular subject, or process. More importantly, people find it very hard to change. This is evident in the repeated status-quo process of middle market companies purchasing and renewing their healthcare.

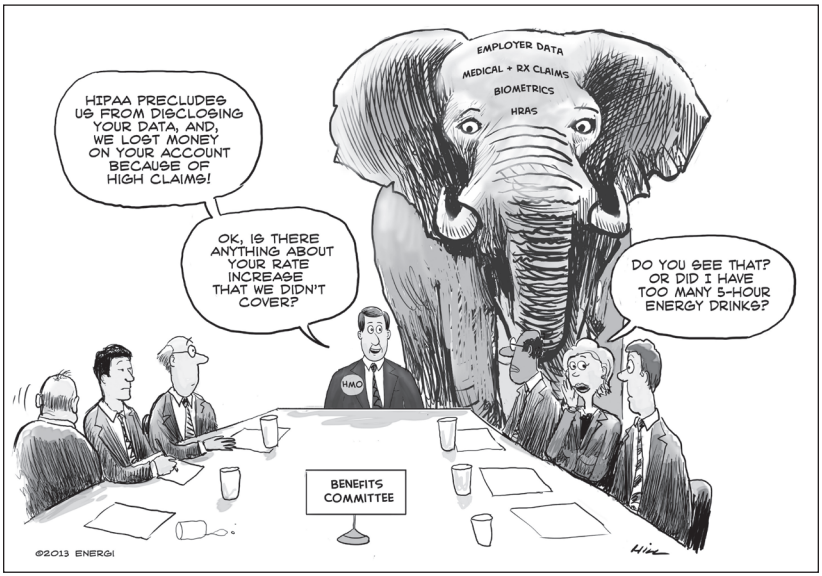
Napoleon Hill references habits and a lack of specialized knowledge as being two roadblocks to successfully making the change that you need in order to have success. Our experience with over 1,000 healthcare renewals leads us to the following conclusions. The vast majority of middle market companies look at their healthcare as a liability. Liability thinking is extremely limiting and diminishes the results and the outcomes that a company can expect to achieve. The majority of time is spent attempting to manage and control costs because, after all, healthcare is a liability.

Hill speaks about getting into a rut – which means that we accept our fate because we form the habits of daily routine. With respect to managing the healthcare spend, executives at middle market companies have become habituated and fear change, and typically prefer to hold onto the status quo liability thinking. Mistakenly, they rely on broker/consultants who mirror the same 'stuck' thinking. Excessive rate increases are costing middle market companies millions of dollars in lost profits. Employers are trapped using historical best practices that result in shifting costs to the employees, reducing benefits or limiting access to care.

Lack of ambition is described in *Think And Grow Rich* as a universal weakness. It's noted that lack of ambition was especially prevalent with salaried employees, and in our experience there are common parallels with many of the executives in charge of the healthcare budget at middle market companies today. The executives tend to manage healthcare as a liability and therefore focus their buying criteria on the price of insurance, much like a purchasing manager. The purchasing manager mentality is ex-

hibited throughout the middle market, which results in companies being forced to react to their renewals each year. If managed correctly, EBITDA can be created from the current healthcare spend by reducing trend!

Because the insurance carriers and HMOs play hide and seek with the key utilization data, companies rely on their broker/consultants to go shopping for sales on insurance every twelve months. We fondly refer to the process as the Ground Hog Day renewal process. As Peter Drucker once said, "If you can't measure it, you can't manage it." Therein lies the biggest problems for the middle market who are fully insured. The annual benefits renewal meeting looks and feels an awful lot like this cartoon.



For those middle market companies who are self-funded, most are operating on old maps that don't provide the directions they need moving forward. Quite simply, your outcomes are a function of your design. And, your design is representative of the knowledge and understanding of your internal staff and your outside broker/consultant. Since 99% of those professionals manage healthcare as a liability then you can be assured of con-

tinued unmanaged excessive trend increases. When you are lost in the woods, you have to stop looking for signs that confirm you know where you are – just admit that you are lost.

Here's a story about being open to learning and changing your perspective, despite your illusions of expertise, which evolved over time, primarily because you have been involved with a health care purchasing process for your company twenty times over twenty years.

A karate master came to Bruce Lee and asked Bruce if he would teach him everything he knew about karate. Bruce Lee filled two cups of water and handed one to the karate master.

Bruce Lee said, pointing to his cup, "This represents everything I know about karate." And then he pointed to the eager master's cup, and said, "This represents everything you know about karate. If you are to learn anything from me, you must first empty your cup to make space for what comes from mine."

One thing that we've learned after 25 years of managed care is that we can't control the supply-chain side of the healthcare equation. Lack of ambition is particularly common in the healthcare renewal scenario because of the competing demands that often face executives who are charged with the management of the healthcare spend. For example, competing demands include making the boss happy, other job responsibilities that have to be borne by limited staff, keeping a lid on costs or just trying to keep everything as close to the *status quo* as possible!

Since nearly everyone involved in managing the healthcare spend believes it is a liability, there are also common errors made. Too often there is a reliance on the mythology of national brands and the perpetual launch of another outdated best practices initiative from other liability thinkers, who are often the consultants that are being paid to provide tactics on controlling costs.

The primary expectations of the middle market are just to have their broker/consultant at least negotiate a renewal that's below national published trend and below the first carrier/HMO renewal offer. The whole process has lead to the normalization of pain for middle market companies. In today's world, healthcare rate increases are a foregone conclusion and a "less bad" renewal is the new good renewal.

All the while for the last decade, the premium increases and cost shifting to the employees in most middle market companies has exceeded the rate of pay increases, so that the net result, is employees are working for less money than they did five years ago. The renewal experience usually results in cost shifting to employees' paychecks like the cartoon on the next page.

The problem to solve is not on the supply side, but in fact, the demand side. If we reduce the demand for services we will incur

lower claims. If we incur lower claims we will have lower rates. It doesn't matter whether we're fully insured or self-funded or partially self-funded - the formula works.

One of the biggest problems we have today is the American idle. Nearly 69 percent of adults in the U.S. are overweight with nearly 40 percent considered obese. The question the middle market companies have to ask themselves is - do you want to eliminate disease, or do you want to promote health? Think of it the same way as in the financial world - do you want to eliminate poverty, or do want to promote wealth?

The future is going to be about the redistribution of health, not wealth. It's not about controlling the health premiums! Success in the future is about maintaining the health of the employee!

Creating measurable data points around the health status of the employee population will have the largest impact on future rates.

Middle market companies who can create Performance Based Health Plans™ based upon data, employee participation and engagement in health promotion will be the winners – whether fully insured or self-funded.

When the Centers for Disease Control says that 50% to 70% of all claims are preventable and modifiable, because they're based on lifestyle and behavior choices, then we can see that there are big changes afoot. Additionally, the Institute of Medicine recently released a report that said 30% of the money spent in the US healthcare system is fraud, waste, bureaucracy and unnecessary care.

One can see the coming attractions in healthcare by studying the Affordable Care Act. Starting in 2014, employers are allowed to charge a 30% healthcare premium differential to employees based on participation or performance in health promotion, and smokers can be charged up to a 50% difference. Currently HIPAA allows for a 20% healthcare premium differential based on participation or performance in health promotion.

The majority of middle market companies have yet to build a healthcare business strategy around the future direction of healthcare, and that is a costly mistake. Whereas, most of the largest and smartest companies in America have been implementing health promotion for many years, and in some cases for decades. The proven results have been published extensively in academic, medical and business journals.

The obvious parallels can be seen in all other insurances. Non-smokers pay less for life insurance and good drivers pay less for auto insurance. As a matter of fact, the newest innovation in auto insurance is the offer to attach a computer-monitoring device that records your driving habits and performance in exchange for the lowest possible rates.

Middle market companies have been practicing for years many of the same health care culture changes that we are espousing, but they have instituted these changes in the management of

their workers' compensation program. Think of your workplace safety program and the reasons you created a focus on preventing workplace injuries. What about your IT, Capital Asset, Auto or Fleet maintenance programs?

Are you starting to see the enormous blind spot in seeing healthcare as a liability? Now ask yourself why you don't have a similar prevention program for your employees. The time is now for middle market companies to align incentives, engagement and responsibility in their health care program! The solution is called Performance Based Health Plans™.

More data equals greater transparency and greater correlation to measuring future risk. The same equation holds true for healthcare claims. With more data points measured over time and supported by a health promotion program, insurance carriers can deliver better rates and for longer than twelve months.

Conventional wisdom surrounding the healthcare spend at middle market companies is outdated. It's a classic analog solution in a modern digital world. We operate a 19th century medical system with 20th century physicians and 21st century employees.

The future of healthcare in America is undergoing a major transformation from B2B to B2C. The primary focus is no longer about the providers of medicine. Instead, the future of medicine is about the patients, their health and their outcomes.

When insurance carriers/HMOs are receiving over one thousand RFPs per month, why exactly will they view your company as a preferred risk? Successful middle market companies have to partner with professionals who can position their risk profile to a prospective insurance carrier/HMO in a way that reduces the perceived risk. The carriers/HMOs are mostly for-profit and their primary objective is to earn an underwriting profit off of your premiums.

If companies continue with their current design and current tactics, they will continue to receive excessive trend renewals. Risk

management, or lack thereof, makes most employers look like every other employer. If you are fully insured then you're not doing anything except transferring the risk to the insurance company/HMO. They control all the data and they set the pricing. Is it any wonder that employers feel trapped by the uncertainty and total lack of predictability?

Remember, the insurance companies/HMOs have some data based on a clinical intervention or ongoing prescriptions for your employees that have been diagnosed with a mild, chronic, critical or degenerative disease. For an average group that means around 25%-40% of the employees. Here's a little news, most health plans ignore the 60%-75% of the employee population because they are not symptomatic and they get paid to treat sickness.

So when your broker/consultant tells you in your quarterly claims review meeting that their predictive analytics software has correlated what happened last year to 25%-40% of your population, into a forecast of next year's estimated utilization, don't be surprised later. Take a look at your 401(k) disclosures from the mutual funds – past performance is no guarantee of future performance. Those claims reviews tell you what already happened but provide little actionable intelligence for management to use. Even though the analytics reports are three inches thick that doesn't make them useful.

The digital solution is to measure your emerging risk to see what's coming around the corner, or over the horizon. By focusing on the ignored 60%-75% of the employees we can impact future claims dramatically. For example, the CDC states that 59% of next year's high claims will come from this year's low claims. That means you never see it coming and the carrier never sees it coming, because you're not measuring the emerging risks. Proper design can stratify future risks up to three years in advance.

By identifying risk factors before employees become symptomatic and creating engaging incentives, employers can dramati-

cally influence currently unmanaged future claims. Health status is a continuum. Just like we get another year older each year, our health changes as well. If left unmanaged we slide along the natural continuum from asymptomatic to symptomatic to chronic to critical to expiration. Of course, there are varying degrees to all stages. …Who wouldn't want information on how their lifestyle and behavior choices were contributing to their own premature expiration date?

With more useful data that the employer can control it is possible to influence the reduction in the demand for services through a reduction in the number, size and frequency of claims. So, the natural conclusion is that we promote health not eliminate disease, and, therefore, over the long run, we prevent the preventable.

By reverse engineering the outcome that you want, one can design small incremental, repeatable, sustainable improvements to a multitude of areas and components in your healthcare program –whether it is fully insured or self-funded. The impact of those improvements will ultimately lead to lower utilization, lower healthcare rates, lower healthcare renewals and lower trend.

The natural consequences of a lower trend results in higher profits, lower workers' comp costs, lower absenteeism, greater employee productivity, less 401(k) hardship loans, less turnover and happier and healthier employees. By focusing on promoting health as an outcome and preventing the preventable, we end up with the outcome that we're looking for, because we've changed the perspective to investing in healthcare asset management versus attempting to manage by controlling the spend.

Performance Based Health Plans ™ identifies and measures the emerging healthcare risks of middle market companies – which improves the predictability and control over costs. The needs of the Company, employees and insurance carrier are aligned by promoting and incentivizing employee health responsibility. The results are higher earnings (EBITDA) by lowering the health care trend.

TOP 10 Questions To Assess Your Healthcare Management

1. Do you have a three-year healthcare business strategy in a blueprint to guide you in converting healthcare from a liability to an asset?
2. Explain how you currently identify your population's emerging health risks up to three years in advance?
3. Other than paid claims analysis, what else do you use to predict next year's healthcare spend?
4. Exactly what data does your insurance carrier really have, and is it the best data to determine your future risk?
5. Exactly what metrics do you use to manage your healthcare spend?
6. How much is adverse selection costing the company in unnecessary claims?
7. How much does your carrier provide you in financial incentives for your health promotion?
8. If you are a preferred risk company, what strategies are you currently using to design 5% to 20% fully insured premium reductions, or similar savings to the fixed and variable cost on your self funded plan?
9. Exactly what are you using to reduce the number, size and frequency of medical claims?
10. How would engaging 75% to 95% of your employee population improve your health care business strategy?

BONUS: How to calculate the new sales revenue necessary to replace lost profits from excessive trend increases:

$ Amount of Increase

Example:

$500,000 = $5M New Sales

Net Profit Margin (%) .10

About Craig

Craig Lack, the creator of Performance Based Health Plans™, will be featured in an *Inc. Magazine* spread entitled "The Next Big Thing" speaking about how Craig's exclusive program, Performance Based Health Plans™, is designing a business strategy around managing health care and building three year benefit strategies that reduce healthcare trend. Middle market companies around the country are looking for certainty and predictability to deal with the excessive trend increases they have suffered for nearly a decade.

Craig Lack is the Founder and President of Employer's National Expert Resource Group Inc., doing business as ENERGI and brings over 20 years of employee benefits insurance experience working with middle market companies nationwide. His experience includes well over a 1,000 group medical renewals that have generated millions of dollars in additional profits for clients.

The purpose of ENERGI is to fundamentally change the perspective of the middle market on Health Care. Instead of viewing healthcare as a liability, where treatment costs have to be controlled, healthcare is redesigned and reframed as an asset where investment in employee health promotion is measured and managed. ENERGI has named its strategy Performance Based Health Plans™. We are changing the narrative on how to manage healthcare.

ENERGI creates EBITDA from health care by converting unmanaged liabilities into performing assets. The company's focus is on providing companies a step-by-step road map on how to manage health care as an asset and deliver a lower trend. The exclusive program guarantees savings in advance for qualifying fully insured and self-funded middle market companies.

Craig Lack earned his MBA and Bachelor's degrees in Finance from Long Beach State University while playing basketball for Tex Winter. Married for over 27 years to his college sweetheart, Sandy, they have two sons, Ryan and Mark. He has served on the Board of the Boys and Girls Club and financially supports the Bike Foundation, the Eric Trump Foundation, Boy Scouts of America and the American Red Cross. He is currently sharing

company profits in support of the Second Harvest Food Bank by feeding 10,000 meals to neighbors in Orange County, CA.

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