finHealth | Simplify & Control Healthcare Costs

10 Healthcare Best Practices for Self-Insured Employers

As a self-insured employer, you owe a strict fiduciary duty to your employees and their families to act in their best interest in the management and oversight of your organization's health plan. Add to that the complexity of running a $10 million, $50 million or even $100 million "healthcare business" within the confines of your core business operations, and you get a sense of the daunting task faced by senior leaders in benefits. While you may have "help" via your broker / consultant, or even your payer, their financial interests are not always aligned with yours or your people. In order to help, we outline below 10 healthcare "best practices" that we see emerging among industry thought leaders and innovators among America's elite companies:

1. **Implement Real-Time Data Analytics** – In addition to being tasked as a responsible fiduciary for the company health plan, benefits leaders are tasked with running and overseeing substantial healthcare expenditures. Imagine how difficult it is to run a complex multi-million-dollar healthcare business with NO visibility to the results of your day-to-day operations. Per the Employee Benefits News survey issued in November 2018, only 7% of self-insured employers had ever seen their own claims data in-house. And in those few cases where data is retained internally, the data may not be extracted at the proper level of granularity to drive true informed decisions. Only by having real-time transparency to healthcare expenditures can the benefits executive make knowledgeable, evidence-based decisions to improve the quality of care and rein in escalating costs.

2. **Eliminate "Outliers"** – All of the major payers have "gaps" in their networks where they are routinely paying certain providers rates that are 3, 5 or even 10 times the level of competitive market prices. In total, we are finding that these outliers are responsible for as much as 10%-20% of your overall healthcare costs. Via such means as employee steerage, reference-based pricing, narrow networks, medical marketplaces, direct contracting or even just bringing it to your payer's attention, these control gaps can be plugged to save significant monies for your plan.

3. **Conduct Independent Audits of your Health Plan** - We suggest starting with an eligibility audit for dependents & spouses, add in a measure of targeted claim audits & don't forget hospital bill audits for those large complex cases. In one disturbing situation, an auditor noticed that their client had been billed over $1.2 million for a couple day stay in the hospital. This was a very tragic medical incident involving a baby born with congenital defects. For the 11 hours of "treatment", they were charged $1.2 million despite the mother's decision to hold her baby given that their physicians advised them that there was no chance for the infant to survive. Nearly $1 million of this money was refunded back to the organization due to a skilled hospital auditor who asked the right questions.

4. **Refine Your Plan Design Based Upon What's "Not Working"** – In reviewing millions of lines of paid medical bills, we find that plan selection (i.e. high deductible health plan) and plan design do NOT always promote the desired behavior for our plan participants. Surprisingly, we have found plan participants that have gone

to the emergency room over 50 times within the same plan year (almost once a week). Even worse, there was zero copayment, deductible or coinsurance. Simply by increasing the copayment to a higher level, some folks will stop visiting the ER for non-emergency issues. Another client was having issues with employees in the Midwest traveling 1,500 – 2,000 miles to substance abuse "resorts" in California and Florida during the winter time. By simply adopting a meaningful pre-certification process, they were able to save $1 million annually and more importantly, were able to ensure their folks were going to safe and effective treatment centers with licensed personnel.

5. **Evaluate Your Payers Contract** – There are likely terms embedded in your current payer contract today that adversely affect your ability to exercise your fiduciary duties to your employees and their families under your current health plan. We see ambiguities relative to who "owns" the organization's claim data, restrictions on performing a comprehensive and effective audit, undisclosed payer revenue sources that are impossible to measure or track, performance guarantees that are not independently vetted, and an overall lack of financial alignment between you and the company administering your plan. In order to tighten these up, use the "five asks" that should be part of every contract renewal for a self-insured health plan:

   https://www.finhealth.com/five-asks-for-upcoming-contract-negotiations-with-tpa/

6. **Promote Health Literacy for your "Peeps" & their Families** - Most of us are not confident consumers of healthcare goods and services, and gladly defer to our caregiver, health system or payer as to what treatment is appropriate. We are reluctant to ask about relative costs, the preferred medical setting, inherent risks and side effects or alternative treatment options, even though some choices may be far better suited to us based upon evidence of cost, quality or comparative outcomes. A company called Quizzify has done a phenomenal job of "game-ifying" health literacy for your members, with their knowledge base fully vetted by Harvard Medical School. Check out a quick quiz below:

   https://app.quizzify.com/questions/1514?quiz=1514

7. **Integrate Health Advocacy / Employee Shopping Tools** – We currently have better information to pick out a nice restaurant for dinner versus locating a skilled surgeon to treat us for a life-threatening disease. That is an incredibly scary proposition. Add the fact that only 7% of U.S. hospitals nationwide have achieved the Medicare's demanding five star quality rating, and that costs paid for common medical services range from 200% to 1,000% of what Medicare would pay for the very same service, and you quickly learn that knowledge matters in preserving both your health and your financial wellness. Solutions are available to help your people navigate the complex healthcare ecosystem, locate convenient, high quality providers for routine diagnostic procedures and identify highly skilled "centers of excellence" for those conditions where there may be only a few providers in the country that are truly experts in its treatment. Find a solution partner(s) that enables you and your members to identify "top notch care at a fair price".

8. **Create Relationships with Health Systems in your Top Geographies** – Most organizations have geographic pockets where they have at least 500 – 1,000 employees and/or members located. Their company names are well-known in the community, and they have negotiating leverage with the local health systems that is often not being exerted. Working with your payer and health systems jointly, you may be able to negotiate more aggressive rates for common healthcare treatments than by remaining silent. When companies exert their considerable financial muscle, they can often extract another 10%-20% discount, particularly on routine treatments such as medical imaging, common endoscopies and simple musculoskeletal procedures. Don't be afraid to flex your financial muscle to save money, gain better service for your members or increase the quality of care.

9. **Tap into Medical Expertise** - If you are lucky enough to be an organization that already has a chief medical officer, they can play an incredibly valuable role in ensuring that your folks receive "top notch care at a fair price". Even if you are not, consider the addition of "centers of excellence" and "second opinion" firms to your governance of health plans. Their most valuable role is ensuring that your folks are not receiving unneeded or inappropriate care. Per the Mayo Clinic, a disturbing 88% of initial diagnoses are altered when a patient chooses a "center of excellence" for care. Employees and their families also appreciate the comfort of having their employer advocate on their behalf through the use of a "second opinion firm" like Grand Rounds. Below is a recent Walmart article that describes how the patient was sent to the Geisinger "center of excellence" for a spinal surgery, yet was able to avoid that painful and unnecessary surgery:

   https://www.cnbc.com/2019/03/14/walmart-sends-employees-to-top-hospitals-out-of-state-for-treatment.html

10. **Network with Industry and/or Geographic Peers** – One of the best independent sources of information to help run your healthcare operations efficiently and effectively are your Benefits peers at other similar-sized organizations. Like you, they are tasked with overseeing substantial medical expenditures, and have likely developed innovative methods to ensure its effective operation. In particular, organizations sharing your same payer and/or in overlapping geographies makes for stronger "apples to apples" comparisons of administration costs, relative medical and pharmacy costs per employee, handling of high dollar claimants and working relationship with local health systems. This networking can be achieved via coalitions, healthcare conferences, trade groups and introductions from your benefits consultant or your payer.

This summarizes our list of top 10 healthcare best practices. It is clearly a "work in process", as every day innovative Benefits leaders like yourselves are developing new strategies to ensure that their employees and their families are receiving top-notch care at a fair price. We welcome your suggestions & insights to add to or replace our "top ten", so please feel free to reach out and let's chat further ☺!

Jim Arnold

jarnold@finhealth.com / 336-314-9955