NEXTGEN BENEFITS

MAC CONSULTING

C-Suite Survival Guide
RECESSION EDITION

Accessing Your Company's Hidden Cash Reserves

Making Health Care a Controllable Cost to Eliminate Overspend

NELSON GRISWOLD

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> We have to get inflation behind us. I wish there was a painless way to do that. **There isn't**.[1]
>
> **– Jerome Powell, Chairman, Federal Reserve**

In response to the Federal Reserve's aggressive strategy of interest rate hikes to fight high inflation, financial experts are nearly unanimous in predicting a recession for the U.S. economy, likely in 2023, or early 2024 at the latest.[2]

Moreover, businesses should prepare for a severe economic downturn, according to a growing chorus of top economists. Expect a "whopper of a recession," warns respected economist Steve Hanke of Johns Hopkins University.[3] Nouriel Roubini, the economist who predicted the 2008 financial crisis, now predicts a "long and ugly" U.S. recession.[4] Economists at Deutsche Bank have upgraded their recession forecast from "mild" to "major."[5]

Eyeing the impending recession, Conference Board president and former Office Depot CEO Steve Odland advises, "As a CEO, if you are going into a recession, what you want to do is… batten down the hatches."[6]

CONSERVING CASH

American C-Suites are taking the warnings seriously. In a survey of CEOs, 98% report they are preparing for a recession in the next 12-18 months.[7] Moving to "batten down the hatches," executives have begun taking swift and immediate action on numerous fronts, including cutting costs to conserve cash.

Confronted with a highly probable and deep recession, as a CEO or CFO you likely are under tremendous pressure to cut all controllable costs. **Yet your second or third-highest operating expense is health care, a massive cost that you believe is out of your control**.

Conventional wisdom holds that your health care spend presents a binary choice: Accept the cost of offering health care OR stop offering health care. Eliminating health care as an employee benefit is unimaginable for most companies…until it becomes an existential issue.

But, before events force you and your company to that point, you should know something about the conventional wisdom that health care is an uncontrollable cost.

Conventional wisdom is **dead wrong**.

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[1] Colby Smith, "Jay Powell warns of interest rates pain as US recession risks rise," Financial Times, Sept. 21, 2022, https://www.barrons.com/news/no-painless-way-to-defeat-high-inflation-fed-s-powell-01663788307

[2] Josh Wingrove, "Forecast for US Recession Within Year Hits 100% in Blow to Biden," Bloomberg, October 17, 2022, https://www.bloomberg.com/news/articles/2022-10-17/forecast-for-us-recession-within-year-hits-100-in-blow-to-biden

[3] Isabel Wang, "'Economist Predicts a 'Whopper' of Recession in 2023—and That's Not Necessarily Due to Higher Interest Rates," Barron's, Aug. 31, 2022, https://www.barrons.com/articles/recession-2023-economy-interest-rates-51661979731

[4] Natalia Kniazhevich, "'Dr. Doom' Roubini Expects a 'Long, Ugly' Recession and Stocks Sinking 40%," Bloomberg, September 20, 2022, https://www.bloomberg.com/news/articles/2022-09-20/roubini-sees-stocks-sinking-40-us-in-a-long-ugly-recession

[5] Matt Egan, "A major recession is coming, Deutsche Bank warns,"CNN Business, April 26, 2022, https://www.cnn.com/2022/04/26/economy/inflation-recession-economy-deutsche-bank/index.html

[6] David Gura, "It's almost impossible to find a CEO who isn't bracing for a recession," NPR, Sept. 14, 2022, https://www.npr.org/2022/10/14/1128832571

[7] The Conference Board, "CEO Confidence Deteriorated Further Heading Into Q4," US CEO Confidence, Sept. 13, 2022, https://www.conference-board.org/topics/CEO-Confidence/press/CEO-confidence-Q4-2022

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HEALTH CARE'S BIG LIE

Why would savvy executives, who ruthlessly manage every other cost in their company, believe that they can't control health care costs, that health care costs are somehow uniquely exempt from market discipline and supply chain management? The answer is CEOs and CFOs have been duped into this false belief.

America's C-Suites are the unwitting victims of what propagandists call a "big lie," when a known falsehood is stated, repeated, and treated as if it is self-evidently true. When bold enough and repeated often enough, a big lie eventually becomes accepted unquestionably as truth.

In this case, health care's middlemen – the insurance companies and benefits brokers – for decades have been spreading health care's Big Lie in company C-Suites: **You have no control over the cost of healthcare. Healthcare costs – and your health insurance rates – will increase annually… and there's nothing that can be done about it.**

> **HEALTH CARE'S BIG LIE**
>
> **You have no control over the cost of health care**. Health care costs – and your health insurance rates – will increase annually… and there's nothing that can be done about it.

After hearing that deceptive refrain over and over from credible and reputable industry "experts," CEOs and CFOs eventually accepted this Big Lie as gospel.

Being smart executives, once convinced they had no control over health care costs, they promptly turned their attention to items they ***could*** control and delegated operational control to a line manager in HR. Which is how a middle manager with no P&L responsibility came to run what has become one of the company's biggest operating expenses and largest business units…***the health care business unit***.

> Our premiums today are less than they were in 2014 when we completely insured the [health] plan. We expect this to remain the same in 2022, with no cost increases and a reduction in [medical] claims.
>
> **– Azam Mirza, Co-Founder & President | Akorbi, Inc., Dallas, TX**

MISALIGNED INCENTIVES

Fair-minded executives might question the claim that health insurance companies ("carriers") and benefits brokers have been pushing a lie – and a whopper, at that – on the C-Suite. Why, you ask, would they lie like that? Well, "follow the money" is always a smart strategy when looking for motive.

Misaligned carrier incentives

The 2010 Affordable Care Act (ACA) limits health insurance carriers' gross profit margin to 15 percent on large (over 100 employees) employer clients and 20 percent on small employers. After cutting expenses following the implementation of the ACA, the carriers' net margins have settled at 4.5 to 5.5 percent. With a relatively fixed margin, the only way to increase EBITDA is to increase revenues.

Premiums are insurance companies' revenue. It's been said that health insurance is expensive because health care is expensive. Rising health care costs drive up the cost of insurance premiums. So, higher premiums mean more carrier revenue and higher profits, too, since a profit margin on a bigger number is...well, a bigger number. In other words, when health care costs force premiums higher, the insurance company earnings are higher.

The carrier's financial incentives are completely misaligned with yours as a company. The insurance company is rewarded when health care costs continue to rise every year, while you want health care costs to go down and stabilize.

If you and your company were to take control of your health care spend and successfully control and lower the cost of health care, that would negatively impact the carrier's finances. Of course, the insurance company never will act on its own to lower the cost of health care, since that would be counter to their financial interests. So, it's obvious why companies with fully insured health plans managed by the insurance company receive annual rate increases every year – regardless of their employees' actual claims – and will never see their premiums go down. Without any downward pressure from the insurance companies, rising health care costs – known as "medical trend" – provide the carrier's rationale for higher premiums. Convenient...and profitable.

Over the past 10 years, insurance company share values have skyrocketed, with Cigna shares up over 400 percent and UnitedHealth Group shares up an eye-popping 924 percent. *(See Figure 1)*

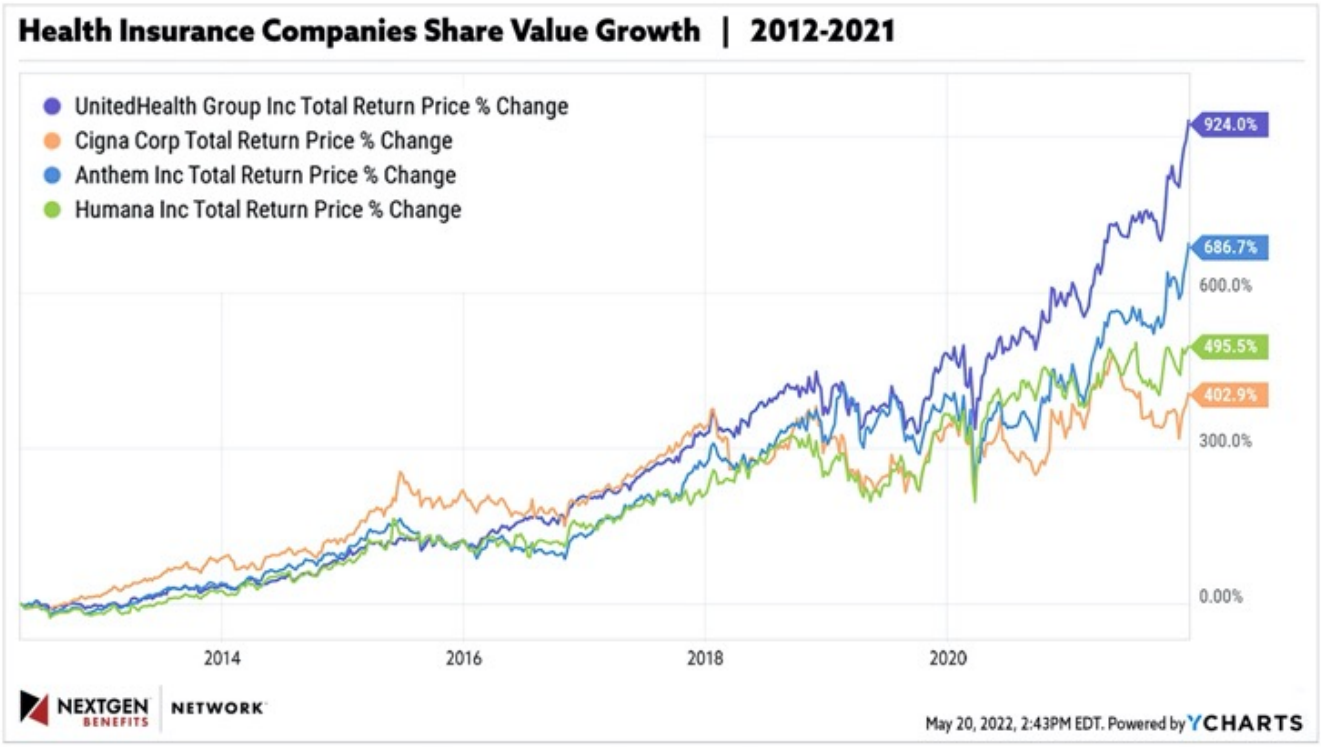

Figure 1 Health Insurers Share Value Growth, 2012-2021

Misaligned broker incentives

In addition, health brokers' financial incentives are misaligned with yours. Most brokers are paid a commission – usually 3-7% of your premium – by the insurance company. So, when rising health care costs cause your premiums to increase by, let's say, 10 percent, your broker gets a 10 percent raise. The broker fails to keep your costs down, yet he gets paid more. You can see why your broker doesn't want you and your company working to control and lower your health care costs. And his misaligned incentives disincentivize him from working on your behalf to lower your cost of health care.

The result is that brokerages have seen revenues and profits soar much like the carriers. Over the past 10 years, the share value for Willis Towers Watson, now known as WTW, is up over 200 percent while Aon shares are up a remarkable 627 percent. *(See Figure 2)*

Both the broker and the insurance company have an unquestionable incentive to keep you from working to lower your health care costs. Thus, health care's Big Lie, which over the past decade has cost American Businesses billions of dollars in profits, which instead flowed to the bottom line of the carriers and brokers.

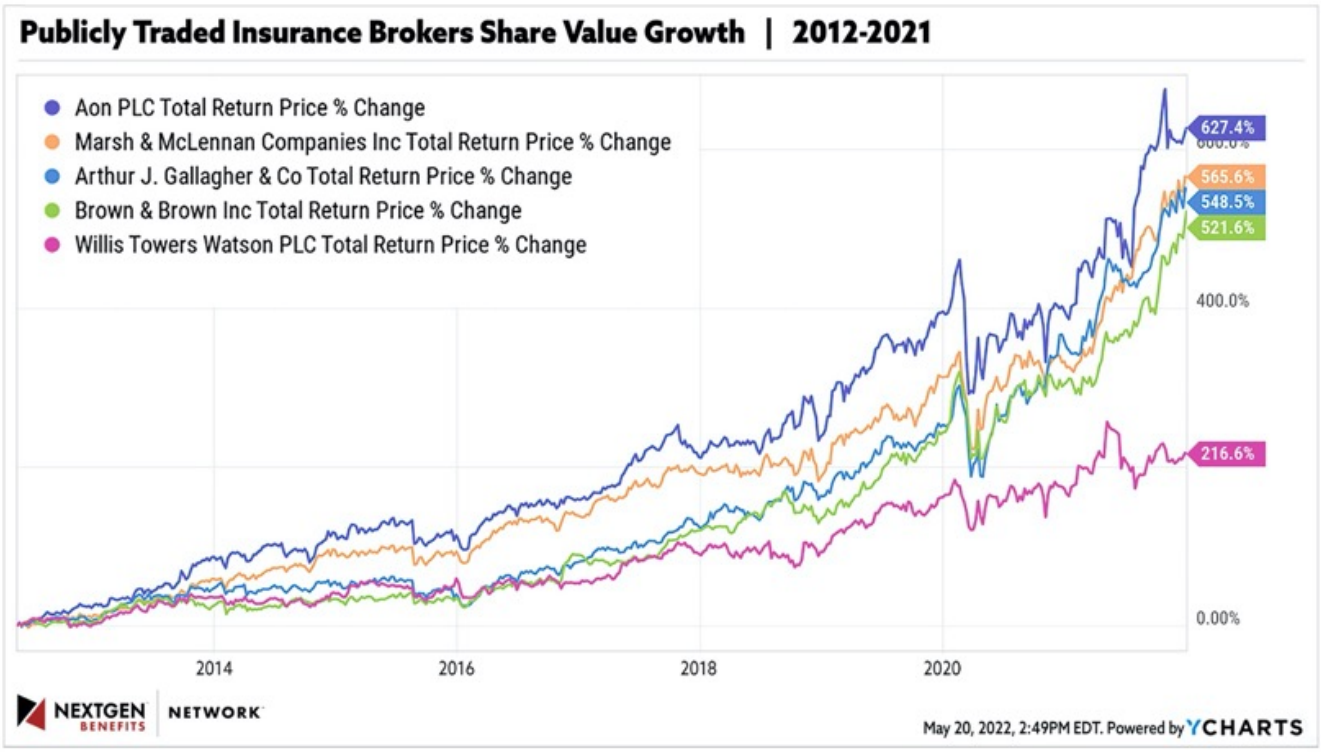

Figure 2 Brokerage Share Value Growth, 2012-2021

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INSURANCE COMPANY MONEY GRAB

Dissuaded by their financial incentives from working to control and lower your health care costs, the health insurance companies obviously cannot be your partner in your fight to make health care a controllable cost. Their fully insured health plans allow you zero control over your health care costs, dictating the vendors that are used and refusing to implement effective cost-containment strategies. Moreover, in most years they force you to overspend for your health care by charging you far more than your employees actually spend on health care. Your overspend goes to carrier profit or to offset excessive spending by other companies' plans.

Let's say you pay an annual premium of $1 million on your fully insured plan. With a typical 20 percent fixed cost, in this case, $200,000, for plan administration and carrier profit, your plan would have an $800,000 claims fund to pay your employees' medical and drug costs. But what if your employees use only $650,000 worth of health care, leaving your plan with a surplus of $150,000? You get back none of your overspend; the carrier keeps it. **But whose money is it?** Then, to add insult to injury, you almost certainly will get a renewal premium increase for next year, despite grossly overpaying this year.

Level-funded Plans

Even with so-called "level-funded" plans that do return unspent claims dollars to the employer, the insurance companies play more games. When there is a year-end surplus, most carriers return only half of your overspend to you, keeping the other half as additional profit. **But whose money is it?** Shouldn't any unspent plan funds remain with the employer?

Alternative funding

To make your health care a controllable cost, it's necessary to move from a fully insured health plan to an alternative funding arrangement that has two major benefits:

1) You pay only for the health care your employees actually purchase during the year; and
2) You gain total control over your health care spend and all aspects of your health plan.

Moving to a properly designed alternative funding arrangement for your health plan has no more risk than a fully insured carrier plan. Your maximum liability can be the same as under the fully insured plan. But, where your fully insured premium represents both your worst-case and best-case scenario, your maximum liability under your alternative funding plan is only your worst case but your best case can be a much lower cost figure. In other words, with alternative funding, you'll pay no more than your maximum liability, but your health care spend could be much less.

Once you have actual control of your health plan, you can begin to implement the same business strategies that you use to control costs in every part your company except for – until now – health care.

Important Note: Alternative funding alone does not give you operational control of your health plan. It's necessary that your benefits adviser engage an independent and "unbundled" Third-Party Administrator (TPA) to administer your plan, one that allows your adviser to utilize vendors – e.g., the Pharmacy Benefit Manager and Medical Utilization Management company – of his or her choosing. If you use an insurance carrier's Administrative Services Only (ASO) arrangement to administer your plan, the carrier ASO will prevent you from controlling health care costs, just as in their fully insured plans.

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MANAGING YOUR HEALTH CARE SUPPLY CHAIN

To maximize their revenue and profits, insurance companies and brokers had to convince you and your C-Suite colleagues to ignore the health care supply chain. After all, when you already negotiate the price of paperclips down to one-tenth of one cent, there is simply no reason you couldn't manage the quality and cost of the health care that your employees purchase. Health care is not exempt from the rules of economics.

Health plan administration is a fixed cost in the 20 percent range. Medical and pharmacy claims are variable costs that represent about 80 percent of the plan costs. Therefore, meaningful cost reduction must address the frequency and severity of claims. According to the actuarial consulting firm, Milliman, there are four major components driving health care costs. *(See Figure 3)*

Health care supply chain management focuses on managing the quality and cost of these cost drivers.

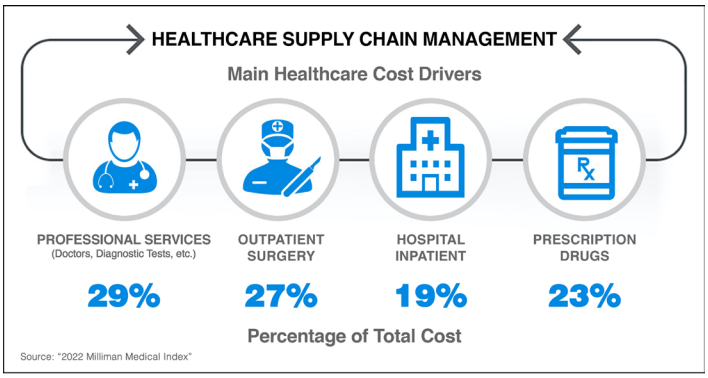

Figure 3 Healthcare cost drivers & percentage of total cost

10-20% reduction in year-over-year spend

Waste accounts for approximately 25% of total health care spending, according to a recent peer-reviewed research study in the ***Journal of the American Medical Association***.[8]

So, it should not be surprising that forward-thinking CEOs and CFOs who apply standard supply chain management techniques to health care are reducing their company's year-over-year health care spend by 10 to 20 percent or more in the first year alone. By year four, savings can reach 40-50 percent of the original health care spend. For example, a company with a $1 million annual health care spend in 2022 could be down to an annual health care spend of $600,000 or even $500,000 by the end of 2023.

The March-April 2020 issue of ***Chief Executive*** magazine profiles three innovative CEOs who have taken control of their health care spend and are managing their health care supply chain with impressive results.[9] (See the following Case Study on Akorbi CEO Azam Mirza, one of the CEOs featured in the ***Chief Executive*** article.)

> [I can see] where every penny goes in paying for employee healthcare, helping us forecast where best to allocate capital to grow the business and price our products and services.
>
> **– Jim Eickhoff, CEO | Creative Dining, Grand Rapids, MI**

[8] William H. Shrank, MD, MSHS et al, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA, Oct. 7, 2019, https://jamanetwork.com/journals/jama/article-abstract/2752664

[9] Russ Banham, "The Cure for Healthcare Costs," Chief Executive, March-April 2020, https://chiefexecutive.net/the-cure-for-healthcare-costs

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ELIMINATING YOUR EMPLOYEES' OUT-OF-POCKET COSTS

Because reducing health care costs and, thus, your premium would be detrimental to your broker's financial interests, most of your cost savings in your health care plan over the past 10 years have been the result of shifting costs onto your employees. Increasing the employee's share of the premium, raising the deductible, charging higher co-payments, increasing the co-insurance… all shift the cost of health care from the company to the employee. Sadly, so-called "consumerism" – giving employees "skin in the game" to encourage smart health care decisions – has been used as a fig leaf for shifting costs to your employees.

"Underinsured" employees

Tragically, deductibles now have increased so much that many employees now pay expensive premiums for insurance they can't afford to use until they require catastrophic care, i.e., for severe illnesses such as cancer and real emergencies where they have no choice, like heart attacks, strokes, and serious accidents. With just 44 percent of Americans able to cover a $1,000 emergency expense with savings,[10] for many employees a $1,500, $3,000, or $5,000 health care deductible can be an insurmountable barrier to accessing needed care. 25 percent of employees with employer health coverage are "underinsured" due to high out-of-pocket costs that constitute an unmanageable financial burden.[11]

When circumstances force an employee to seek care, serious conditions or injuries can leave your employees facing an out-of-pocket expense of up to $9,100 for an individual or $18,200 for a family.[12] For many employees, this can be financially devastating. A joint study from Harvard Medical School and Harvard Law School found that over half of U.S. bankruptcies involve unpaid medical bills. Of those who filed because of medical debt, 75 percent had insurance when they became ill or injured.[13]

But while the status quo practice to reduce employer costs is to shift more health care costs onto employees, companies that take control of their health care spend to manage the quality and cost can provide health care to their employees with lower or ***even zero*** out-of-pocket expenses. The health care cost savings often allow these companies to eliminate the deductible and co-insurance. Imagine your company's competitive advantage in recruiting and retaining talent with low insurance premiums and "free health care"…no deductible or co-insurance.

Results of the C-Suite's managing their health care supply chain: A more affordable and sustainable health care spend for the company; higher-quality health care and lower or zero out-of-pocket costs for the employees; and a real ROI measurable in:

- **Easier recruiting**
- **Higher retention**
- **Greater productivity**

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[10] Carmen Reinicke, "56% of Americans can't cover a $1,000 emergency expense with savings," CNBC, Jan. 19, 2022, https://www.cnbc.com/2022/01/19/56percent-of-americans-cant-cover-a-1000-emergency-expense-with-savings.html

[11] Sara R. Collins et al, "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability," The Commonwealth Fund, Aug. 19, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial

[12] "Out-of-pocket maximum/limit," HealthCare.gov, 2020, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit

[13] David U. Himmelstein et al, "Illness And Injury As Contributors To Bankruptcy," Health Affairs, 2005 https://www.healthaffairs.org/doVfull/10.1377

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MAKING HEALTH CARE A CONTROLLABLE COST

The secret to making health care a controllable cost and lowering that cost is as simple as:

1) **move to alternative funding to take control of your health care spend and health plan; and**
2) **provide oversight of the health care spend by an executive with P&L responsibility;**
3) **treat your health care spend as a capital allocation* that you manage; and**
4) **manage your health care supply chain to reduce the frequency and severity of claims.**

** No, accounting never will treat health care as a CapEx, but you should and can **manage** it like a CapEx.*

Frankly, managing health care costs is, in concept, no different from managing the quality and cost of raw materials or office supplies. Although, to be fair, managing the quality and cost of health care in practice is much more complex than that of managing steel or paper clips. But, fortunately, you can retain consultants who specialize in managing the health care supply chain.

The bottom line is that, despite what your broker and insurance company rep repeatedly tell you, you *can* and, as a plan fiduciary, you ***must*** manage your health care costs, especially in times of economic crisis that require conserving as much cash as possible.

So, let's take a look at the high-impact action steps you can take in your company to make your health care spend a controllable cost and how you can begin to control and reduce that cost.

ACTION STEPS TO MAKE HEALTH CARE A CONTROLLABLE COST

» *If your health plan is FULLY INSURED FROM AN INSURANCE COMPANY*

As long as your health care financing arrangement is a fully insured plan from an insurance company (usually a Blue Cross affiliate, UnitedHealthcare, Cigna, Aetna, or Humana), you have few real options to control costs due to the insurance company's total control and misaligned incentives.

Moreover, as mentioned above, you likely are overspending for your health care with a fully insured plan.

Would you like to see how much money you are being overcharged each year by your insurance company? Obtain a full report on your total annual medical and pharmacy (Rx) claims (the amount your employees actually spent on health care).

Ask your current broker to obtain a full medical and Rx claims report from your insurance company for your previous plan year. Keep in mind that this is your data, on your health plan, without which data you cannot possibly fulfill your fiduciary responsibility under the federal ERISA law.

NOTE: In all candor, you are highly unlikely to get such a report since the insurance company doesn't want to reveal your overspend. Expect stalling, delays, and incomplete data. Additionally, while most brokers are happy to request and provide the data, your broker may resist obtaining the data for you if he or she has something to hide.

Claims Analysis Report

When you are unable to get your complete claims report, visit the **NextGen Benefits Network** website (see the back page of this white paper) and request a NextGen Benefits Adviser contact you about a Claims Analysis Report to provide you with optics into your actual health care costs to see if and how much you are being overcharged by your insurance company.

» *If your health plan is SELF-INSURED*

There are multiple actions you can take to control your health care costs if you are self-insured or part of a self-insured health care coalition.

NOTE: As mentioned previously, if an insurance company ASO arrangement manages your self-funded plan, you will not be allowed to work on health care cost-containment. Moving to an independent and unbundled Third-Party Administrator makes it simple for a NextGen Benefits Adviser to effectively manage your health care costs.

Bolt-on cost-containment options

However, in a crisis situation when immediate cost savings are required, a number of these cost-containment strategies can be implemented as a bolt-on solution or by creating an overlay plan that bypasses parts of your existing health plan to generate immediate cost savings.

Ask your broker to get aggressive and take immediate action in the following areas:

PHARMACY (Rx)

Pharmacy represents some of the lowest-hanging fruit for cost containment. There is tremendous waste and abuse (and, sometimes, even fraud) in your pharmacy spend.

PHARMACY COST-CONTAINMENT. Implement a pharmacy cost-containment vendor that works with your traditional Pharmacy Benefits Manager (PBM) to ensure generic equivalents are used, employees are obtaining the lowest cost for their drugs, and dangerous drug interactions are avoided. This solution can be bolted onto your plan regardless of the PBM. **SAVINGS: 10-15 percent of your Rx spend over 12 months**.

TRANSPARENT, PASS-THROUGH PHARMACY BENEFIT MANAGER. Tell your broker to carve out pharmacy and install a transparent and pass-through PBM to manage your employees' prescriptions. The transparency will eliminate numerous abusive PBM practices, and the pass-through aspect will ensure you receive 100 percent of your drug rebates from the pharmaceutical manufacturer. **SAVINGS: 40-50 percent of your monthly pharmacy spend within 60-90 days**.

SPECIALTY-DRUG COST MITIGATION. Implement a specialty-drug cost-mitigation program to alternatively source high-cost specialty medications, including expensive maintenance drugs. While this solution can be bolted onto your plan regardless of PBM, using a transparent PBM will allow for greater plan savings and more employees to be helped. **SAVINGS: 70-100 percent of your specialty-drug spend within 60-90 days; 100 percent ($0 copay) for employees on high-cost medications**.

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HEALTH CARE ADVOCACY & TELEHEALTH

HEALTH CARE ADVOCACY/CONCIERGE. Install a health care advocacy/concierge service as the entry point to your health plan, requiring employees to contact the advocate to access the health care system. Top advocacy/ concierge programs provide employees a wide range of assistance, from giving information on the health plan, answering health questions, even offering access to a nurse for clinical questions. The health advocate/ concierge should serve as your health plan's gatekeeper, directing employees to your zero-dollar-copay telehealth service as a first step before employees engage more costly options, such as a physician's office, Urgent Care, or the emergency room. **SAVINGS: Will generate savings as employees are directed to the lowest-cost option that meets their health care needs. See savings estimate for $0-Copay Telehealth below**.

$0-COPAY TELEHEALTH. Implement a $0-copay telehealth service that makes physicians available to employees via smartphone, tablet or computer at half to a third less than the cost to your plan of a visit to a doctor's office. Telehealth also improves productivity by reducing absenteeism due to doctor office visits during work hours and sick days due to incidental infections from waiting room exposure to other patients.

Meaningful utilization of telehealth requires either mandating that employees access care through an advocate/ concierge and/or extensive and ongoing employee education around their telehealth service. **SAVINGS: Estimated savings average $472 per visit by keeping employees from unnecessary (and more costly) visits to the doctor's office, urgent care, or the emergency room**.[14]

MEDICAL CLAIMS

CLAIMS REPRICING. Engage a claims repricing vendor to negotiate excessive hospital charges. Hospital charges to employer-sponsored plans average 224 percent (but often are 300 to even 1,000 percent) above the price allowed by Medicare, which the government sets at cost plus a modest profit.[15] **SAVINGS: 30-50 percent, dependent on provider pricing and provider competition in a market.**

PAYMENT INTEGRITY. Implement a medical claims re-adjudication by a qualified forensic analytics vendor to ensure payment integrity by identifying and recovering funds based on improper and inaccurate provider charges. Fulfills CEO and CFO's fiduciary responsibility under the federal ERISA law. Two-year claims look-back is allowed in most states. **SAVINGS: 14-20 percent of annual spend (Two years at seven to 10 percent of annual spend.)**

[14] Terena Bell, "Can Telemedicine Be Both Cost Efficient and High Quality?" US News & World Report, Feb. 27, 2018, https://www.usnews.com/news/healthcare-of-tomorrow/articles/2018-02-27/can-telemedicine-be-both-cost-efficient-and-high-quality

[15] Christopher M Whaley et al, "Prices Paid to Hospitals by Private Health Plans," RAND Corporation, 2022, https://www.rand.org/pubs/research_reports/RRA1144-1.html

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MEDICAL UTILIZATION

MEDICAL SECOND OPINION. Even though over 20 percent of patients with a serious diagnosis are completely misdiagnosed, according to the Mayo Clinic,[16] not one insurance company employs second opinions in their health plans. Add to your plan document a requirement for an independent medical second opinion on every procedure above a certain dollar amount (e.g., $3,000 or $5,000). An option is a low-cost virtual second opinion service that utilizes top specialists across the country and requires no office visit by the employee. SAVINGS: Indefinable, but the most expensive claim is the one that never should have happened. The least costly claim is the one that never occurs.

MEDICAL UTILIZATION MANAGEMENT. Engage a medical utilization management company to enforce second opinions when indicated and to identify high-quality providers (based on the quality of their outcomes) for employees to use for their health care needs. High-quality surgeons have fewer complications and patient readmissions, saving the plan substantial expense. **SAVINGS: 50-70 percent or more on each procedure when the employee follows the medical team's recommendation of provider(s)**.

BUNDLED-PRICE SURGERY. Implement a bundled, cash-price surgery program to make these high-quality/ low-cost procedures available to your employees. The fixed cash price includes all costs – anesthesia, surgeon's professional fee, facility fee, any appliance as needed (e.g., hip or shoulder) – and usually covers any complications for 30 days or more following the procedure. **SAVINGS: 60-70+ percent on each procedure**.

DIAGNOSTIC IMAGING. Provide employees with low-cost diagnostic imaging center options for high-volume, low-cost tests such as an X-Ray or sonogram as well as for less common but expensive tests such as a CT Scan or MRI. **SAVINGS: 30-80+ percent on each diagnostic test**.

REDUCE OR WAIVE EMPLOYEE OUT-OF-POCKET COSTS. Once one or more of the above medical utilization plans are in place, incentivize your employees to make smart provider choices by creating a program to reduce or eliminate employee out-of-pocket (OOP) health care costs when they choose a high-quality health care provider or low-cost imaging center. **SAVINGS: See all above**.

[16] Monica Van Such et al, "Extent of diagnostic agreement among medical referrals," Journal of Evaluation in Clinical Practice, Apr. 4, 2017, https://onlinelibrary.wiley.com/doi/abs/10.1111/jep.12747

BEHAVIORAL HEALTH

EMPLOYEE ASSISTANCE PROGRAM. Implement a robust Employee Assistance Program (EAP), which provides employees access to counseling sessions with a professional therapist at no cost to the employee or your plan (three to five sessions, depending on the EAP). Counseling sessions are available over the phone, as well as in person with a local counselor. **SAVINGS: $100 to $1,000. Counseling sessions average $100 to $200 for a single session with patients averaging nine sessions. Employees needing counseling always should be directed to the EAP first to save your health plan the cost of 3-5 sessions**.

VIRTUAL BEHAVIORAL HEALTH. Engage a virtual behavioral health counseling service that increases access to effective mental health treatment by providing services via smartphone, tablet or computer. For use after an employee exhausts the EAP counseling benefit, these counseling sessions are available at low or no cost to the employee and at a dramatically reduced cost to your plan. **SAVINGS: Addresses an important employee need while controlling costs to save over current counseling options**.

NEXT STEPS

As an executive, implementing these Action Steps will require the assistance of a highly qualified benefits broker or adviser/consultant.

NOTE: If your broker insists that your plan already includes a specific strategy, ask to see the cost savings to your health plan from that strategy. Let me assure you that no insurance carrier health plan employs any of these strategies.

If your broker doesn't move quickly and enthusiastically to implement some of these action steps, don't hesitate to find a benefits adviser or consultant who knows these strategies and can implement them quickly.

In the fast-evolving world of health care, the most sophisticated and effective advisers and consultants are members of the NextGen Benefits Network, a national alliance of independent benefits advisory and consulting firms that specialize in working with C-level executives to make their health care spend a controllable cost.

For a list of these innovative health care consultants, visit **www.NextGenBenefits.Network** to locate one in your area. If there is not one in your immediate area, many NextGen advisory firms have a national footprint and consult with forward-thinking CEOs and CFOs across the U.S.

[17] Ryan Kilcullen, "Returning therapy clients: Determining prevalence rates and identifying predictive variables," Penn State Center for Collegiate Mental Health, Nov. 11, 2020, https://ccmh.psu.edu/index.php?option=com_dailyplanetblog&view=entry&year=2020&month=11&day=10&id=6:returning-therapy-clients-determining-prevalence-rates-and-identifying-predictive-variables

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CASE STUDY: A CEO's Success Leaning into Health Care

Company: Akorbi
Co-Founder & CEO: Azam A. Mirza
Headquarters: Plano, TX
Employees: 300 Full-Time

Akorbi provides companies including Fortune 100 and 500 firms with enterprise solutions including interpretation, multilingual and technical staffing, multilingual contact centers with business process outsourcing capabilities, learning, and localization services. They have employees in six countries and across the U.S.

In 2018, Akorbi CEO Azam Mirza, working with Daniel LaBroad, a NextGen Benefits Adviser with Ovation Health & Life Services in Plano, began planning a move to an alternative funding arrangement for the company's health care, a coalition health plan in which like-minded companies share risk and pay only for the health care their employees purchase. The company joined the coalition on May 1, 2019. The new funding arrangement led to a reduction in the cost of stop-loss insurance from $360,000 to $225,000. **RESULT: An immediate cost savings to Akorbi of $135,000**.

More importantly, this new arrangement gave Mirza and his consultant, LaBroad, total control over the company's health care spend and health plan. Taking advantage, Mirza had LaBroad engage a fiduciary Pharmacy Benefit Manager (PBM) to better manage the prescription drug supply chain. The PBM reduced generic and brand-name prescription drug costs by over 50 percent. Separate cost-mitigation strategies practically eliminated specialty drug costs for the company while employees are receiving their high-cost specialty drugs with zero co-pay. **RESULT: Akorbi's pharmacy spend has been cut by 75 percent with better drug benefits for employees**.

Akorbi recently instituted a new clinical initiative known as bundled-price surgery, using a high-quality surgeon and surgery center that bundles fees for the surgeon, anesthesiologist, and the facility plus the cost of any appliance into a single, pre-negotiated cash price. The first use of bundled-price surgery involved an Akorbi employee who needed a total knee replacement (TKR). While the previous TKR surgery cost quoted by a provider was $100,000, the bundled-price surgery was just $28,000. **RESULT: The bundled-price surgery arrangement saved Akorbi $72,000 on a single total knee replacement.**

Based on the success of the bundled-price surgery initiative, LaBroad plans to implement Medical Utilization Management to detect waste, fraud, and abuse in the health care system and to ensure that employees receive the right care, from the right provider, at the right time, in the right place, and for the right price. Employees will be provided with a nurse concierge to guide them to high-value providers, such as bundled-price surgery centers, that will provide better medical outcomes at lower cost to both Akorbi and the employees.

The most accurate measure of a company's health care costs is the Per-Employee-Per-Year (PEPY) cost. Under Mirza's bold leadership, guided by LaBroad's expertise and innovation, Akorbi is on track to reduce its PEPY to a remarkable $1,888 for the 2019-20 plan year, from the 2019 PEPY of $6,512. (Note: These numbers represent the PEPY cost of medical and pharmacy claims but do not include the plan's administrative costs.) **RESULT: Net year-over-year savings for the Akorbi health plan is on track to exceed $350,000 for the current plan year.**

The savings are so substantial that Mirza has decided to return some of the savings to their employees, electing to lower the employee contribution for this coming plan year, which is great timing considering the financial hardships many are facing in the wake of the COVID-19 crisis.

Although Mirza and the Akorbi leadership team are excited about the total cost savings, they are more excited that health care has become a controllable cost over the past six years since engaging LaBroad as their benefits adviser. "Our premiums today are less than they were in 2014 when we completely insured the [health] plan," said Mirza. "We expect this to remain the same in 2020, with no cost increases and a reduction in [medical] claims."

For Azam Mirza and Akorbi, taking control of the company's health care spend and managing the health care supply chain has been a huge success, turning health care into a controllable cost that is now a sustainable capital allocation.

If you could dramatically reduce your turnover and become an employer of choice, while generating a $2,000 per employee windfall to the company, how big of a competitive advantage would you have in your market?

NELSON GRISWOLD
Chairman, NextGen Benefits Network

About the Author

A disruptive & controversial visionary author, and in-demand keynote speaker, Nelson Griswold is recognized as the Chief Architect of the NextGen Benefits movement and Founder & Chairman of the NextGen Benefits Network, an influential national alliance of elite independent health care advisory & consulting firms.

NextGen Benefits recently was named "Most Influential Industry Organization" in an industry-wide vote. Its successes and strategies have been featured in prominent business publications including *Chief Executive, Employee Benefit Adviser, CFO,* and *Employee Benefit News*.

NextGen Benefits Vision Statement reads: "The highest quality health care accessible and affordable to all Americans, starting with the employees of our clients." The lead author of three Amazon #1 bestsellers on NextGen Benefits strategies, Nelson is frequently published industry and business magazines.

The Founder & Chairman of ASCEND, for multiple years Nelson has chaired the Benefits Adviser Leadership Track for the World Health Care Congress in Washington, D.C.

Before his career in benefits and health care, Nelson had a distinguished career as a nationally recognized public policy expert, which informs his leadership of the NextGen Benefits movement.

NEXTGEN BENEFITS

NEXTGEN BENEFITS NETWORK

The **NextGen Benefits Network** is comprised of the top independent health care advisory and consulting firms across the U.S., working with owners and C-level executives to make health care a controllable cost and to manage their health care supply chain.

The goal of NextGen Benefits is not to sell you insurance. The goal is to empower you to become smarter and more effective with your health care spend. If you're ready for a strategic, financial conversation about your second or third largest operating expense that will show you how to take control of and lower your health care spend, a NextGen Benefits Adviser is ready to meet with you.

FIND A NEXTGEN ADVISER

Located throughout the country, NextGen Benefits Firms improve access and quality of care for your employees while lowering your costs, by making health care a controllable cost.

Explore **NextGenBenefits.Network** for more info.