CHAPTER 11

THE 7 HABITS OF HIGHLY EFFECTIVE BENEFITS PROFESSIONALS

In previous chapters, I've highlighted tricks the status quo health care industry uses to redistribute profits from companies to their coffers. Here I will outline some basic antidotes that the most effective benefits leaders use to ensure their organizations don't needlessly overspend on health benefits.

Collectively, the approaches outlined below have enabled employers to sustainably save 20 percent or more on health benefits over the status quo.

Habit #1: Insist on Value-Based Primary Care

This is the bedrock of the highest-functioning health systems. Primary care providers own the patient relationship, are highly trusted by patients, and when properly incentivized, can be the first line of defense against downstream costs. Some of the characteristics of value-based primary care providers are the following.

- Are always available in one form or another
- Welcome and immediately address complaints
- Practice shared decision making with patients

- Adequately inform patients of the risks, costs, and invasiveness of all relevant treatment options
- Refer to specialists as a last resort and only to high value ones
- Integrates behavioral health and physical therapy into comprehensive primary care
- Close the loop when patients are seen by specialists or are admitted to inpatient care
- Are supported by nurse practitioners and physician assistants
- Offer care in convenient locations
- Offer direct contracted care arrangements that align their economic incentives with lowering costs and improving health outcomes

Habit #2: Proactively Manage Pharmacy Benefits

Successful Rx management has been described as playing whack-a-mole. Many pharmacy benefits management (PBM) firms are well known for hidden fees, shell game pricing, and taking drug manufacturers' money to promote specific drugs. You need to stay ahead of all of these tricks.

There are three pillars to effectively managing drug cost and quality.

1. Review PBM arrangements to determine the "spread" (PBM profit) and whether more favorable terms are available
2. Make formulary changes that have a large financial impact with next to no disruption
3. Carefully manage specialty drug purchase costs by shopping around

Habit #3: Have Specific Plans for Uncommon (But Predictable) Gargantuan Claims

You need a defined program for each common category of uncommon claims. It's not unusual for 6 percent of employees to

account for 80 percent of total annual claim costs. They usually fall into these areas.

- **Dialysis** – With the rise of diabetes, this is inevitable. The best dialysis cost containment vendors offer multiple solutions aimed at setting the optimal price before treatment starts. They provide the most flexibility for choosing approaches that are appropriate to your specific situation.
- **Organ transplants, cancer, and complex surgery** – Sending beneficiaries to high-performance centers of excellence like Mayo Clinic and Virginia Mason Hospital & Medical Center will reduce unnecessary complications and procedures, saving enormous money despite travel costs.
- **Premature babies** – A comprehensive and closely monitored prenatal program is always worth it, especially if your employees have risk factors like advanced maternal age, diabetes, hypertension, and HIV.

Habit #4: Deploy Evidence-based Musculoskeletal (MSK) Management Programs

Given that MSK issues frequently account for 20 percent of claim costs and that over 50 percent of procedures are not evidence-based,[101] this is a tremendous opportunity to slash costs and ill-advised overtreatment. As we saw in Chapter 5, one manufacturer increased its earnings by 1.7 percent by getting just a third of employees' MSK cases into an evidence-based management program. The impact on the company's market cap was tens of millions of dollars.

Evidence-based approaches build on clinical knowledge with modern quality management techniques and data analytics. The results, validated in many settings, demonstrate far superior health outcomes.

Habit #5: Refuse to Sign Blank Checks to the Health Care Industry

Pricing failure is the most vexing problem in health care. True price transparency is the answer, e.g., bundled payments for the complete continuum of care for things like hip and knee replacements. You should demand nothing less. Virtually every area of the health care industry has high-integrity and high-quality providers that are happy to provide transparency. Find them and work with them. The Health Rosetta Institute will even help.

Habit #6: Protect Employees by Sending Them to Providers With First-rate Safety Records

In his book *Unaccountable*, Dr. Marty Makary, professor of surgery at Johns Hopkins, pointed out in devastating detail how flawed the safety culture is—and how hidden the failures are—in too many hospitals. No corporate travel department would allow an employee to fly on an airline that suppressed its safety records (even if the FAA allowed it). In the same way, it's unconscionable to blindly send an employee to a hospital with little or no information on its safety record. If the hospital suppresses that information, go elsewhere and tell your employees why.

Habit #7: Avoid Reckless Plan Document Language that Costs Millions

As mundane as ERISA plan language can sound, the most effective benefits leaders go over it with a fine-toothed comb. This is such an important topic that we've included sample document language in the Health Rosetta. You can read all about it in Chapter 18.

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All your moves to implement these habits should be properly documented for two reasons. First, you want your entire team (not to mention your successor) on the same page. Second, not doing so can leave you and your company vulnerable to litigation related to health plan design and administration.