INOVENTIVE BENEFITS CONSULTING
THE FUEL THAT POWERS EMPLOYER HEALTH BENEFITS

The Definitive Guide to Health and Benefit Plans for Manufacturing Companies

Control Costs by Managing Your Healthcare Supply Chain

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INTRODUCTION

A vital factor in operating a profitable manufacturing company is properly managing each element of your businesses' supply chain. Why shouldn't the same hold true for your company's healthcare plan? Right now, manufacturers continue to accept rising premiums on subpar plans that are increasingly passing the buck to employees as a cost of doing business. There is a better way, and it starts with understanding that the vast majority of healthcare expenses are variable — and therefore controllable.

By learning the four areas where a manufacturing company can have the biggest impact on plan costs, what it takes to offer competitive benefits, and why you should never accept that "the claims are the claims," you will have a better understanding of how you can move beyond annual rate hikes and into real, cost-effective benefit plan management.

Stop Buying Insurance Plans Based on Price

As independent actuaries, healthcare consulting firm Milliman doesn't care who the insurance company is, what provider network an employer is using or how a health plan is designed. In its Milliman Medical Index, the firm looked at how companies spend money under any form of benefit plan. What they found was, 20% of the plan cost is a fixed expense, such as administration fees or stop loss premiums, and 80% is variable, depending on the procedures and claims accumulated.

Far too often, brokers working on behalf of employers — manufacturers included — focus on negotiating the 20%. They tout a discount on admin fees or stop loss premium. But who cares if you squeeze a few nickels out of the 20%, if 80% is going totally unmanaged?

Inoventive Benefits Consulting always starts with the 80%.

THE FOUR COST VERTICALS

Milliman finds that of the 80% of claims costs that are variable, 96% come from only four verticals in the healthcare supply chain:

1. Inpatient (31%),
2. Professional Services (29%),
3. Outpatient (19%),
4. and Pharmacy (17%).

Here is an example of spending allocation for a manufacturing firm with 150 employees, using a mathematically-friendly cost of $10,000 per employee, per year (slightly below the $13,000 average found by the Kaiser Family Foundation) and adding up to nearly $1.5 million in annual health claims expenses:

- $465,000 from claims in an inpatient setting,
- $450,000 from physician and specialist visits,
- $285,000 from outpatient or ambulatory surgery,
- and $255,000 from prescription drug costs.

If your broker is not managing how your dollars are being spent in those four verticals, everything else is a waste of time.

Source of the Problem

A key problem facing manufacturing firms is the uncontrollable and unsustainable rise of healthcare costs. If insurance was the source of this problem, we could fix it with insurance. You've tried to do that at your manufacturing company for 20, 30, 40 years. We're here to tell you that insurance is not the problem and it's not the solution.

When we ask manufacturers what they're doing to control the 80% of their health plan costs that are coming from four key verticals in the healthcare supply chain — Inpatient, Professional Services, Outpatient and Pharmacy — they do not have an answer. Their existing broker is instead focused on acquiring small discounts from the 20% of fixed costs, such as carrier admin fees and plan premiums. As the expression goes, brokers are tripping over a dollar to pick up a dime, and doing nothing for long-term cost containment.

To save money and disrupt the least amount of people, manufacturers need to address the four verticals in this order:

1. Pharmacy,
2. Inpatient,
3. Outpatient,
4. and Professional Services.

Pharmacy

Saving on prescription drugs does not necessarily require your employees to change what drugs they take or where they get them filled. With no disruption to your workforce, a simple starting point is to begin by redirecting prescription drug rebates away from the insurance carrier and returning them to you, the employer.

Essentially, prescription drug rebates are a kick-back to the distribution channel. Drug manufacturers want their drugs higher on the formulary than their competitor's, so they issue rebates to sweeten the deal. Let's look at a couple of case studies.

A 130-person self-insured manufacturer's prior broker said the insurance carrier would provide a $9 per employee, per month credit to the plan's admin fee, if the employer let the insurance carrier keep the rebates. Sounds like a good deal. But, Inoventive Benefits Consulting re-priced the group's pharmacy claims. The plan cost was $164,000, with $23,328 in rebates. Or $14.95 per employee, per month. By only negotiating the fixed cost, the prior broker actually cost the client $5.95 per employee, per month on the back end.

Additionally, by taking the plan to an independent pharmacy benefit manager, that plan's cost would drop to $112,305 — a $52,305 savings. If this company operates on a 10% profit margin, they would have to do $523,050 in new business sales to add that kind of money to their bottom line.

A different self-insured employers administrative services agreement said that the insurance carrier keeps all the rebates. They didn't even provide an admin credit. The pharmacy costs for the group were $1.6 million with rebates of $332,052. In this case, if this company operates on 10% margin, they would have to do over $3.3 million in new business sales to generate that amount of free cash flow.

Inpatient

In the next bucket, inpatient claims, a typical plan will only see about 6 to 10 out of 100 people submit a claim in this category each year. However, these big-ticket claims — surgeries, transplants, etc. — account for nearly one-third (31%) of annual plan costs. The good news is, making costeffective changes will only impact a handful of people.

Start with the precertification process. If the carrier is doing it for you, they approve everything that is medically necessary and in-network. Employees going to a $100,000 facility when there is a $20,000 option available? It doesn't matter to the insurance carrier, they're spending your money, not theirs!

If your employee has the option of 10 facilities where they can have a procedure done, and one costs $100,000 and one costs $20,000, it would benefit you to make it free for the employee to go to the $20,000 facility by waiving their deductible and any out-of-pocket expenses. Why? Even if the plan has a $5,000 deductible, if you, the employer, can save $80,000 in the process, it is much more economical for you to cover that deductible for your employee.

Outpatient

There are more claims in the outpatient sector, but these still come from a small subset of plan participants. Even so, there are moves your manufacturing firm can make to control costs here as well, such as incentivizing employees to schedule a knee surgery in a less costly and more efficient outpatient facility versus a traditional inpatient hospital.

Professional Services

Professional services are somewhat unique in that they comprise a large chunk of expenses (29%), but consist of relatively low-dollar claims. Even in an emergency room setting, a claim of a few thousand dollars pales in comparison to a $45,000 hip replacement.

Out of a group of 100, at least half are going to go in for an office visit throughout the year. If you're doing a good job of promoting the fact that annual physicals are, for the most part, free to plan participants, you'd love to see everyone go in at least once a year. That said, there are a lot of options to control costs. One is to institute direct primary care, where you carve certain services out of the medical plan entirely and then pay a flat fee to the doctor to perform an unlimited number of those services.

Hospitals are buying primary care physicians because they are the front line for referrals to high cost procedures in inpatient and outpatient facilities. By taking control of the supply chain at the primary care level, your company, not the hospitals or insurers, will manage the healthcare supply chain in favor of your employees.

BUILDING A COMPETITIVE BENEFIT PLAN

For manufacturers who know to examine these four verticals in the healthcare supply chain, they are able to maximize the benefits budget to build a competitive benefit plan to attract and retain the best employees. But first, you want to know, are our benefits competitive enough to fill our open positions with qualified workers? Are we paying the right percentage of the premium?

We are often asked, "What's everyone else doing?"

The average employer/employee health plan cost share for a manufacturer in the Midwest is roughly 75/25. Breaking it down, the U.S. Bureau of Labor Statistics reports the cost of wages per hour worked has grown by an average of $4.51 in the last eight years.

Year	Wages Per Hour	Benefits Cost Per Hour	Employee Benefits Cost Per Hour
2010	$21.33	$11.03	$4.85
2011	$21.50	$11.40	$5.02
2012	$21.85	$11.38	$5.01
2013	$22.45	$11.73	$5.16
2014	$23.44	$12.56	$5.53
2015	$24.36	$13.03	$5.73
2016	$25.44	$13.67	$6.01
2017	$25.84	$13.80	$6.07

Further, BLS reports the total benefits cost per hour worked — including both employer and employee contributions — has grown by an average of $2.77 since 2010.

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2010	$21.33	$11.03	$4.85
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Employee Costs

Let's couple these government statistics with data from Milliman. The actuarial firm finds employees contribute to the cost of their benefits with an average of 27% of their wages in payroll deductions. Using this data, the chart below shows the approximate benefits cost manufacturing employees pay per hour worked. This does not include the additional 17% in outof-pocket expenses employees are also forking over.

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While these numbers provide some benchmarking perspective, as a manufacturer looking to ensure your benefits are competitive in order to ease the pain point of having positions remain empty, you need to take a look at how well you're managing your healthcare supply chain. Lowering the overall cost of your benefits means you will be able to pay a higher percentage of employee benefit costs. Or increase wages. Or both.

COMMON BROKER EXCUSES

Don't Accept Regular Cost Increases When informing manufacturing clients of yet another annual premium increase, brokers will commonly reference industry "trend," or the average percentage by which health plan costs are rising each year, as a benchmark to validate their performance. The problem is, health insurance trend is a fake number.

Everyone does it, from small boutique firms to national consulting houses. The latter will then reference their internal surveys, which — surprise, surprise — tend to show the employer's annual cost increases are just below the national average. "Thank goodness you're working with us, we have you performing better than the market," they say. "You're below trend."

Another common broker line is, "The claims are the claims. We can't do anything about the claims."

You've probably been told this for years. The typical broker mindset is that as long as your costs don't go up as much as the average "trend," then they've done a great job for you. That sets a low bar to satisfy the broker, not to do what's best for your company.

Effective Cost Management Intelligent employers don't care that everyone else's costs went up an average 12% and theirs went up 6% or 8% or 10%. They know what the real goal is: How do I manage my own costs in the most effective way I can? That's the way we operate.

So, what should your expense be? According to the Kaiser Family Foundation's 2017 Employer Health Benefits Survey, the average employer's premium cost per employee is $13,050, with employees paying an additional $5,714. Inoventive Benefits Consulting has a history of lowering these costs by at least 20% and has a book of business average of $9,048 per employee. Inoventive Benefits Consultings' book of business average for self-funded groups is even lower at $6,880 per employee.

Even a group with a "bad claims year" can effectively navigate the supply chain. Don't accept less bad renewals, start to demand results. Start to demand your trend be negative, or at least flat. Quit accepting the industry spiel that the claims are claims and the trend is trend and you should just be happy that your broker negotiated your renewal down by a few percentage points. That is not acceptable.

MISALIGNED INCENTIVES

We've established that 80% of healthcare costs are variable and thus within your manufacturing firm's control. So why are your rates continuing to increase?

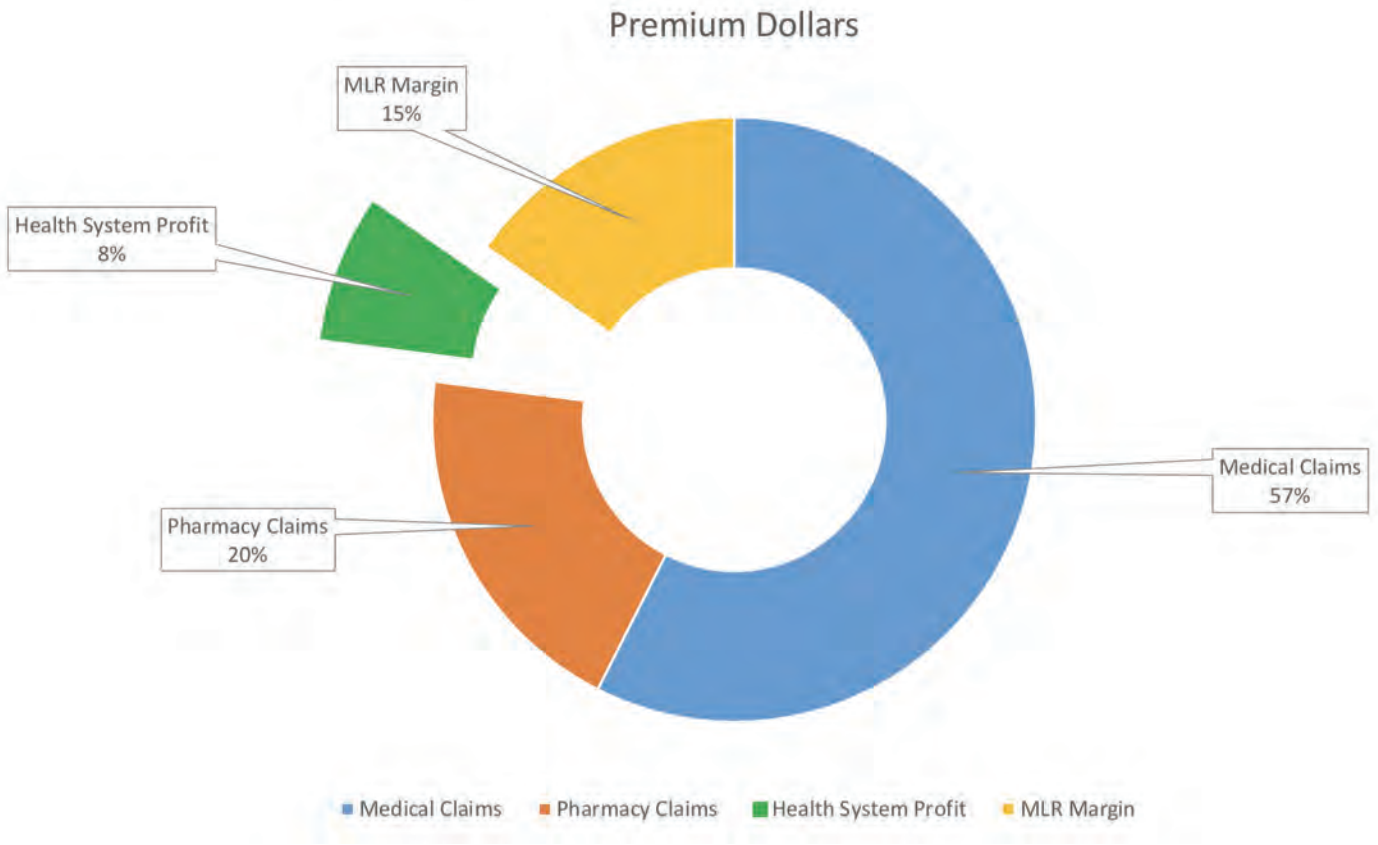
You're trusting the insurance carriers to manage the supply chain, and they have no incentive to reduce healthcare or health insurance costs. Whether your health plan is fully insured or selffunded, they're charging you a specific dollar amount in premium. As long as the insurance carrier meets their obligations to their shareholders, what business incentives do they have to reduce your claims cost?

Not only do insurance carriers have no incentive to reduce insurance costs, the Affordable Care Act (ACA), also known as Obamacare, almost guarantees that fully insured premiums will increase. The Medical Loss Ratio (MLR) established by the ACA, requires insurance carriers to pay 80% to 85% of all premium dollars (depending on group size) to claims and activities that improve the quality of care. If the insurance carrier pays out less than required in a given market segment, they have to reimburse employers the difference. All the insurance carriers want to do is make their profit margin and not lose money.

You, as the employer, are the one left to figure out how to do something different to stop the annual 5%, 10%, 15% rate increases.

Let's explore further why it's not in the interest of insurance companies to reverse trend on healthcare costs, using a real-life example. At the end of March 2018, a major health insurance carrier announced in its annual earnings statement for a midwest market that the carrier increased revenue over expenses by $1 billion over the prior year. The carrier said it was driven by "the continued strengthened performance in their commercial and government segments." This is industry speak for the employer-sponsored market.

This large national carrier also bought a local hospital system, saying consumers are benefiting from "increased access to high quality community-based healthcare." Maybe. But think about it: If your insurance company buys a hospital and you call that insurance company asking where you should go for a medical procedure, where do you think they're going to send you? Their own hospital.



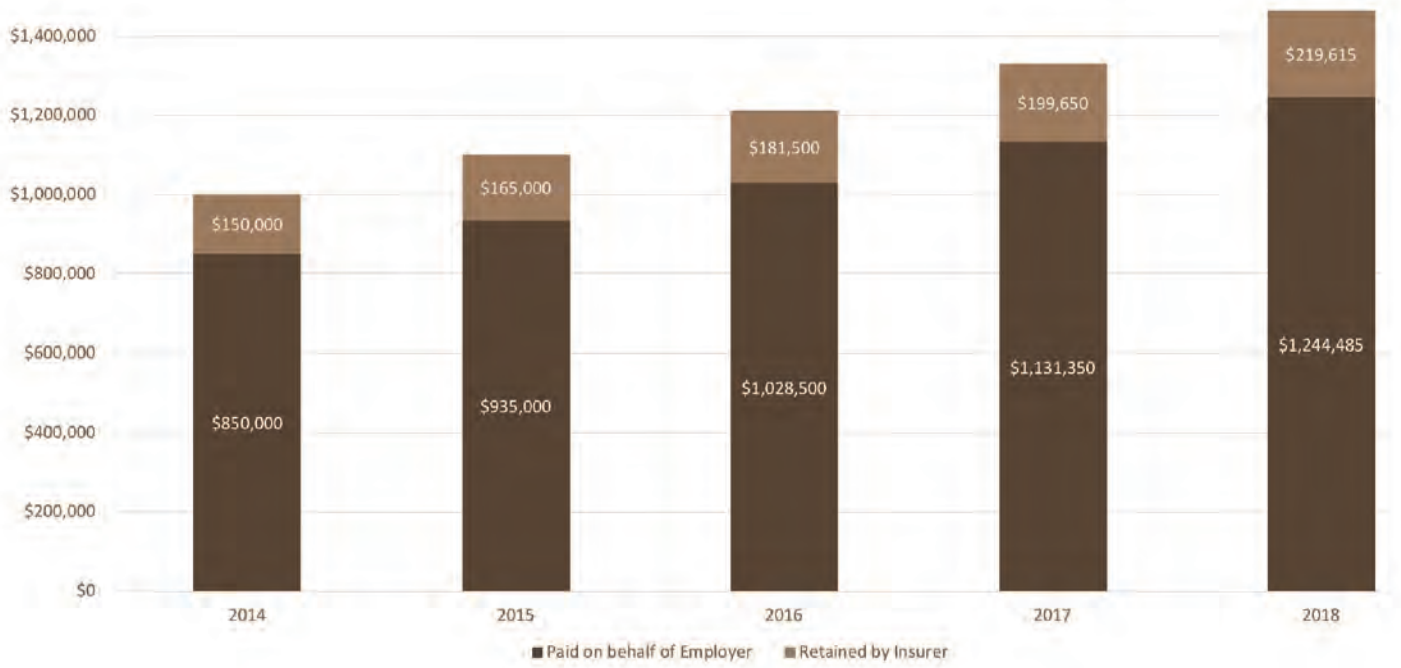
The same rationale applies to pharmacy benefit managers. A lot of insurance companies have bought PBMs, one of the four verticals in the healthcare supply chain. Why would they get into the pharmacy business? Once again, if your margin is capped at 15%, you can only keep 15 cents on every dollar. But, if you vertically integrate a piece of the healthcare supply chain, you get to turn the claims expense required by the MLR into a profit center.

It is no different than if a business owner buys a warehouse and then their manufacturing firm leases it. They were going to pay rent, anyway. They might as well pay it to a company they own. That's exactly what these insurance companies are doing. And that's how they're generating high returns for shareholders and massive increases to their share prices.

WHY FULLY INSURED PREMIUMS ALWAYS INCREASE

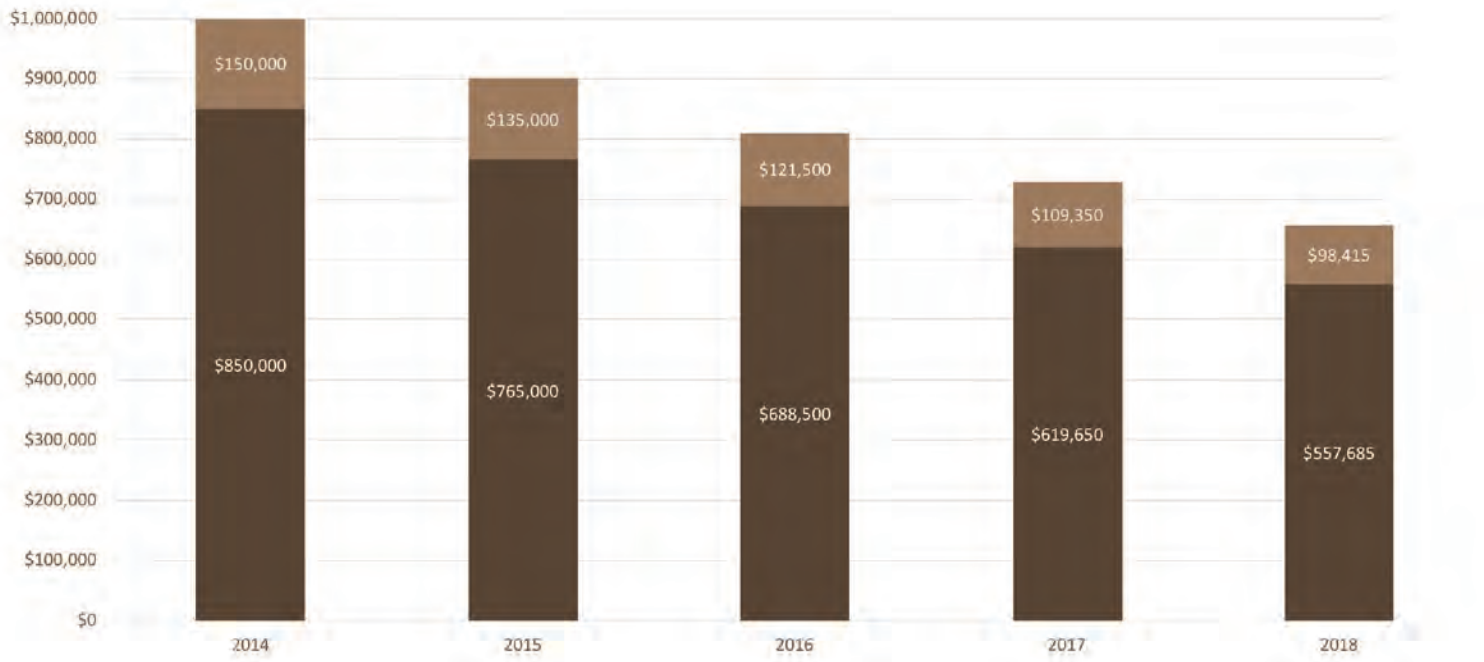
A Legislative Disincentive to Reduce Costs

Looking at a 10% rate increase with a 15% MLR, as the premiums go up, so does the amount the insurance company gets to run their business and offset their administrative overhead. For example, an insurance company paying out $850,000 on behalf of an employer in 2014 would be able to retain $150,000. By 2018, assuming that 10% annual rate increase, the insurance carrier is paying out $1.24 million and retaining nearly $220,000.



Would an Insurance Company Accept Margin Compression?

If the insurance carrier reduces your fully insured premium, they're going to cause margin compression on their own business. A $150,000 profit on a 15% MLR plan would be reduced to $98,415 by 2018 if premiums went down 10% each year. No CEO of a publicly traded company could survive long producing the returns in the chart below.



NO TRANSPARENCY

The University of Pittsburgh Medical Center in Allegheny County, PA, is the big local hospital system in the Pittsburgh region. If you need a knee replacement, the cost of that procedure ranges from $45,000 to $95,000 in the UPMC system of five facilities.
If the facility is in-network and the procedure is approved, the insurance company doesn't care which one you choose to perform your surgery. As the employer, if you keep letting people go into that world where there's only two criteria — medical necessity and network qualification — your rates are going to keep going up.

In contrast, here's the experience of an adviser who needed a hernia surgery and knew how to manage the supply chain. He called four hospitals in his home state, asking about their quality metrics and surgery fees. None of the providers could give him any of the information. One of them even said, "How much it costs depends on what insurance you have."

The adviser then called the Surgery Center of Oklahoma. The facility reported:

- the specific number of operations its doctors have performed in the last 12 months,
- the complication rate,
- and a cash price — which included the surgeon, anesthesiologist and all of the charges.

In the PPO world, this kind of information simply isn't available. All the insurance company says is, "Do you need it? Is the doctor you're going to in our network?" This is why rates keep going up. All they're asking the employees to do is go somewhere in-network, not knowing that within the network there is huge price variance. It's 80% of your cost, and no one knows what's going on behind the scenes.

A LESSER PLAN DOES NOT LOWER COSTS

Here's a familiar conversation. A manufacturer says, "We need to keep our costs down." Their broker responds, "No problem, we can do that. Let's bring in a high-deductible plan." That's not a health insurance strategy. It's a cheap parlor trick.

Putting in a Health Savings Account alongside a PPO may reduce an employer's costs in the short term, as premiums are cheaper when the plan doesn't cover as much, but every year those costs will keep going up. Instituting a high-deductible plan is a one-year bandage, not a sustainable strategy. Rather than continuing to increase your employees' contribution, it's time for your manufacturing firm to change your approach to rising health insurance premiums.

Stop looking at which carrier is offering the lowest premium. Anyone can lower a premium. Just offer a worse benefit and charge more for it. Ultimately, chasing the lowest acquisition cost is not the right strategy. By managing the supply chain, the 80% of variable plan costs within employers' control, Inoventive Benefits Consulting can reduce the health plan cost. Your manufacturing firm doesn't have to offer less benefits. In fact, the only way to do it is to offer better benefits.

So how can your manufacturing firm take control of costs in a healthcare system like this one? Start by creating a better plan and give your employees an incentive to make the right decision.

REDUCE COSTS WITH A 'FREE' EMPLOYEE OPTION

If you had a group of employees traveling on a business trip and you told them they'd only need to pay a $100 contribution toward the hotel room, what's to stop them from choosing a Ritz Carlton over a Days Inn? Both provide a decent night's sleep, but one will cost you, the employer, a significant amount more.

This is what manufacturing firms are doing now with their benefit plans. If a provider is inside your insurance carrier's network, you're giving the employee a free pass to choose any facility they'd like — regardless of cost and quality metrics. The employee doesn't know how much the plan is being charged on the back end, nor if they chose the best provider. Employees are just following the rules by staying in-network and paying their set co-pays and deductibles.

Wouldn't you want your employees going to the highest quality, lowest cost facility? It would reduce your cost while improving employee outcomes. And you can do it by offering free healthcare to plan participants. Talk about a win-win.

As the plan sponsor, it's in your best interest to ensure your employees are incentivized to utilize the least expensive, top-quality providers that you designate as Centers of Excellence. Do this by waiving deductibles and out-of-pocket maximums for these facilities, paying for 100% of the cost and making it free to them.

It can be make a massive financial difference if the employee goes to a costlier and often lower quality facility. The average American doesn't have enough money to cover a $500 emergency. A $2,000 deductible is going to put a lot of people in a financial hardship, or worse, leave them functionally uninsured (having insurance they can't afford to use). Imagine the relief they'll feel knowing the best option is free to them. This is how covering the deductible for employees to go to the low cost, high quality facility pays off.

Say your employee has 14 places to go for a joint replacement. What are you doing right now to make sure that they're making the right decision? The answer is likely nothing.

NUMBERS: REAL AND FAKE

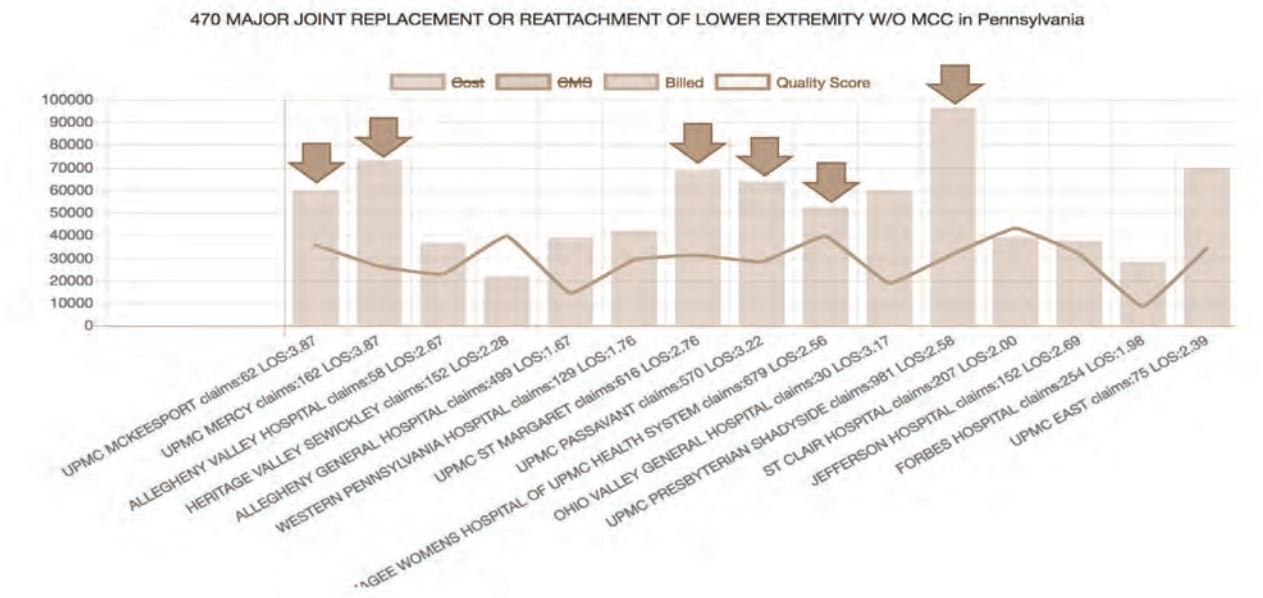
Insurance carriers will say their biggest value-add is their network discount. This is one of the biggest lies ever sold to the American public.

In healthcare, there are four numbers, two of them are real and two of them are fake:

- Provider Cost: Real Number - It costs a provider a certain dollar amount to perform procedures
- Medicare Reimbursement: Real Number - Medicare reimburses based on a fixed fee schedule
- Charge Master: Fake Number - What your doctor or hospital bills you for services
- Network Discount: Fake Number - A negotiated reduction off of the Charge Master

Providers have to bill Medicare the same way that they bill your private insurance. Diagnostic codes represent procedures, such as a major joint replacement, and the providers use those codes to bill insurance companies. Medicare also requires providers to submit their data on complications, infections, re-admission, length of stay, etc., which are then aggregated into a quality score that is put together by the Centers for Medicare and Medicaid Services.

The graph below illustrates real Medicare data from Pittsburgh, PA. The pink bars in the graph represent the amount that the facility would bill your private insurance for the procedure. The blue line is the quality score as established by CMS. The higher the blue line, the higher the quality. In our example, one hospital bills $22,000 for the joint replacement procedure. Another bills $97,000 for the same procedure. Although the first hospital has the highest quality score from CMS, most patients go to the more expensive, brand name facility. Why wouldn't you pay the employee's deductible and coinsurance to incentivize them to use the best provider and save $75K?



Even within the same health system, meaning hospitals that are owned by the same parent company, charges can vary by tens of thousands of dollars. It's for a variety of reasons, such as building a new facility at one location where they need to offset that capital expense, but the reality is it's all made up. If it wasn't, it would be standardized. Even a network discount of 90% is irrelevant if the provider can simply bill more for the services. If insurance carriers are negotiating better and better discounts each year, hospitals should be making less profit, right? This is why relying on the network discount is not an effective strategy. It's taking a fake discount off of a fake number.

A NEW DIRECTION

The bottom line is, if you're a manufacturer paying out X dollars in premium and you allow the insurance carrier to manage them, you're going to lose every one of those dollars.

At Inoventive Benefits Consulting, our fundamental job is to move your firm into a different arrangement that allows us, not your insurance company, to manage the healthcare supply chain.

It's time to take ownership of the 80% of plan costs that are within your control!