Healthcare's **Big Lie**

How Healthcare's Middlemen Have Deceived America's C-Suites and **Fleeced U.S. Business of Billions**

Nelson Griswold

In C-Suites across America, a quiet revolution is exposing healthcare's Big Lie and overthrowing the unsustainable Status Quo in employee benefits and healthcare, providing a real and permanent solution to the healthcare cost problem.

After years of enduring steep annual increases in the cost of benefits, in 2017 the leadership of Garden State Engineering Surveying and Planning (GSESP) in Maywood, NJ, reclaimed control of its benefits spend and in 12 months lowered its year-over-year healthcare costs by an eye-opening 26 percent.

In the second year of its new healthcare plan, GSESP used part of its cost savings to eliminate totally the $5,750 family deductible while keeping the same affordable weekly premium contribution, producing a healthcare plan that employees can afford with no risk of large out-of-pocket expenses to keep them up at night or prevent them from accessing the healthcare they need.

"We now have a phenomenal retention, recruiting, and employee satisfaction tool with savings on top of it!" said Gary Bender, GSESP's Executive Vice President and CFO.

GSESP began to reverse what widely is considered an immutable fact of business life when John Sbrocco of Questige Consulting, a NextGen Benefits Adviser, engaged Bender in a financial conversation about his company's benefits budget and strategy.

A CFO's Epiphany

"In talking to John, it became obvious that what was missing from my benefits process was me, as CFO," said Bender. He now works closely on benefits strategy with Sbrocco, who manages the firm's Healthcare Value Chain for Bender to improve outcomes and lower costs. Active in the organization, CFO Solution, Bender has openly shared his eureka moment and bottom-line success with other CFOs, many of whom are adopting the same set of "next" practices and are seeing very similar results.

Despite Bender's evangelical efforts, however, he and his converts remain rare exceptions. In the ongoing national battle to control the cost of health care, America's C-Suite has been conspicuously absent. And Bender is not the only C-Suite veteran to recognize that executives have been AWOL from the benefits discussion.

"I would make a class-action apology for all CEOs. We allowed the mess on the economic side of health care to happen," asserts John Torinus Jr., the now-retired CEO of Wisconsin-based manufacturer Serigraph, Inc., in his influential book, *The Company that Solved Health Care*. "CEOs should be embarrassed at how they have allowed health costs to run wild. They would not allow that to happen in any other part of their businesses."

> Healthcare's **BIG Lie**
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> *"As a business executive, you have no control over the cost of healthcare. Healthcare costs – and your health insurance rates – will increase annually and there's nothing you can do about it."*

But why has the C-Suite not been engaged in benefits management? What could have convinced otherwise savvy executives to ignore – and continue to ignore – what has metastasized into most companies' second or third largest P&L expense?

The BIG Lie

Healthcare's middlemen – the health insurance companies (carriers) and their insurance broker accomplices – have been telling a Big Lie to the C-Suite for decades:

"As a business executive, you have no control over the cost of healthcare. Healthcare costs – and your health insurance rates – will increase annually and there's nothing you can do about it."

NOTE: *This White Paper is adapted from the Amazon Bestseller, NextGeneration Healthcare: Proven Secrets of Managing the Healthcare Value Chain to Improve Outcomes and Reduce Costs.*

This Big Lie is responsible for the most egregious, mass lapse of corporate fiduciary responsibility in the history of American business.

It may be surprising that almost every executive and business owner in America has fallen for the Big Lie that the buyer/payor has no ability to influence the cost of healthcare goods and services…when they ruthlessly manage their sourcing in every other part of their business. But as history has proven, a Big Lie repeated often enough and with conviction becomes accepted as Truth.

This Big Lie is responsible for the most egregious, mass lapse of corporate fiduciary responsibility in the history of American business.

Believing the Big Lie that they had no control over their healthcare costs, the C-Suite understandably tagged their benefits spend an OpEx, stuck it in SG&A, and promptly ignored it in favor of items they could manage. Believing it was unmanageable from a cost perspective, executives delegated operational management of the benefits plan to a Human Resources line manager with no P&L responsibility.

And, by default, executives delegated the manage- ment of healthcare purchasing to their insurance carrier, mostly the big five known collectively as the BUCAHs (Blue Cross, UnitedHealthcare, Cigna, Aetna, Humana).

Over the past several decades, as putative stewards of companies' benefits spend, the BUCAHs "proved" the Big Lie that it is impossible to restrain the rising cost of healthcare.

Medical Trend

Despite frequent and regular announcements that they are working hard to control and reduce the cost of healthcare, the BUCAHs have failed dismally to stem the growth of healthcare costs, benignly referred to as "medical trend" – which trend every year is always upward.

Healthcare costs have risen every year since 1960. (Source: "National Health Expenditures Summary Including Share of GDP, CY 1960-2016," Centers for Medicare and Medicaid Services.). In just the years 1999 - 2016, U.S. healthcare spending grew a remarkable 261 percent. (See Figure 1.)

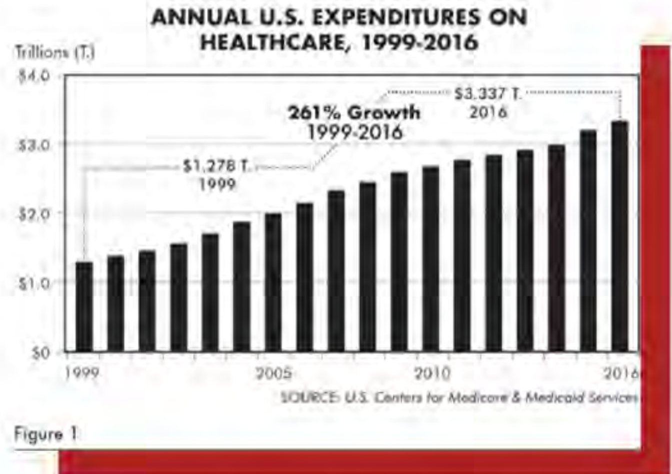

Figure 1

While many factors contributed – e.g., the aging of the Baby Boomer generation, increasingly advanced (and expensive) medical treatments & technology, and the growth in the number of costly specialty drugs – abusive and arbitrary unchecked price hikes by healthcare provid- ers, especially hospitals, have been a key driver of health- care inflation. This health- care inflation is reflected in the dramatic growth in the cost of health insurance, which increased by 213 percent over the same time period. (see Figure 2) Note, too, how the growth of health insurance premiums largely track the rise in healthcare costs.

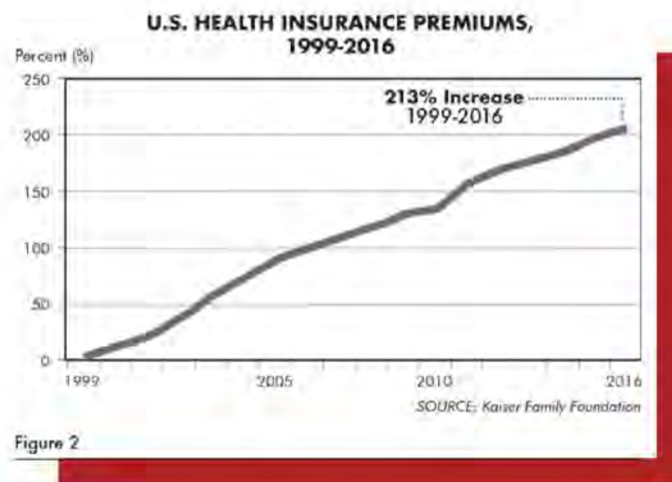

Figure 2

Asleep at the Switch

Healthcare prices are out of control, pricing abuse is rampant, quality can be hit-or-miss, and there is no transparency in healthcare pricing. Yet the BUCAHs seem oblivious…and asleep at the switch, allowing the dysfunction of the healthcare Status Quo to continue.

For example, a recent Consumer Reports survey of U.S. pharmacies found that a basket of five popular generic prescription drugs ranged in price from just $66 for all five medications at online mail-order pharmacy healthwarehouse.com to $928 for the same five drugs at CVS/Target. That's a price difference of over 1,300 percent…for the exact same drugs. (See Figure 3.). Yet, no BUCAH alerts health plan members to these price differences and guides them to fill their prescriptions at lower-cost pharmacies.

Seeing how much CVS charges for drugs, however, it's easier to understand how a pharmacy chain can buy a health insurance company, Aetna, for $69 billion.

Inpatient Surgery

In addition to prescription drugs, the lack of health- care price transparency and abusive pricing can be seen in hospital quality/cost comparisons that can be found in most any city in the U.S. (See Figure 4.).

In New York City, you can have cardiovascular surgery performed at Mount Sinai Hospital, with the highest quality rating, for $64,336. Or you can go 12 miles away to NYU Hospital Center, with a lower quality rating for that procedure, for $212,707. If this information was common knowledge, would anyone choose the lower quality hospital charging over three times more for the exact same procedure?

In Dallas, TX, you can choose to have your orthopedic back or neck surgery done at University of Texas Southwestern Hospital, boasting a top quality rating, for $20,952. Or, less than 19 miles away, you can have your back or neck procedure performed at the Medical Center of Plano, rated lower quality for this procedure, for $81,114. Who, if made aware of the choice, would select a lower-quality facility with the attendant health and infection risks and pay 287 percent more?

These glaring price and quality differentials are common throughout the country. Plus, I haven't mentioned the option of high-quality outpatient surgery centers that bundle all surgical costs – facility fee, surgeon, anesthesia, appliance, etc. – into a single cash price that usually is a fraction of the cost of the same procedure at even the lowest-cost hospital.

RETAILER	Pioglitazone (Actos)	Celecoxib (Celebrex)	Duloxetine (Cymbalta)	Atorvastatin (Lipitor)	Clopidogrel (Plavix)	TOTAL PRICE
HealthWarehouse.com	$12	$22	$13	$10	$10	$66
Costco	$16	$26	$35	$13	$16	$105
Independents	$19 ($10-$493)	$34 ($11-$295)	$31 ($20-$267)	$15 ($8-$197)	$15 ($8-$260)	$107 ($69-$1,357)
Sam's Club	$20	$38	$31	$20	$45	$153
Walmart	$132	$203	$123	$30	$30	$518
Kmart	$160	$185	$120	$35	$35	$535
Grocery Stores	$113 ($10-$349)	$189 ($46-$250)	$170 ($13-$223)	$32 ($11-$71)	$36 ($7-$224)	$565 ($88-$1,112)
Walgreens	$167	$204	$251	$65	$65	$752
Rite Aid	$255	$194	$170	$128	$119	$866
CVS/Target	$270	$187	$195	$135	$141	$928

SOURCE: Consumer Reports, Shop Around for Lower Drug Prices, April 5, 2018. https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/

Figure 3

HOSPITAL PRICING DISPARITIES

Cardiovascular (Heart) Surgery
New York, NY • Hospital Facility Fees Only

Facility	Quality Rating for Procedure	Price	Change
Mount Sinai Hospital	High	$64,336	230%
NYU Hospital Center	Moderately High	$212,707	
Price Difference		$148,371	

Back or Neck Surgery
Dallas, TX • Hospital Facility Fees Only

Facility	Quality Rating for Procedure	Price	Change
UT Southwestern Hospital	High	$20,952	287%
Medical Center of Plano	Moderately High	$81,114	
Price Difference		$60,162	

SOURCE: Surgerate Database (surgerate.com); 2018 Data

Figure 4

Whether it is an inpatient or outpatient procedure, no BUCAH informs plan members of these gross quality and price disparities, leaving every member at risk of choosing a lower-quality, higher-price facility, potentially putting the member's health in greater jeopardy and certainly costing both employee and employer an unnecessary and unwarranted greater expense.

Imaging Tests

Diagnostic imaging testing provides a final example of the extreme pricing disparity and lack of price transparency in healthcare. Not only does the cost for tests such as CT scans and MRIs vary widely from city to city, the cost for one of these diagnostic tests can vary within a city by as much as a factor of 10 or more. (See Figure 5.).

PRICE DISPARITY IN DIAGNOSTIC TESTS

Head/Brain CT Scan
Variations in price across and within major U.S. cities

City	Price Range	Swing
Tampa, FL	$224 - $2,804	1,152%
Buffalo, NY	$197 - $1,105	460%

Lower-Back MRI
Variations in price across and within major U.S. cities

City	Price Range	Swing
Fresno, CA	$859 - $4,395	411%
Nashville, TN	$453 - $2,552	463%

SOURCE: Castlight; 2018 Data.

Figure 5

In Tampa, FL, a head/brain CT scan ranges from a low of $224 to a high of $2,804, a more than 1,150 percent swing in price. In Buffalo, NY, the same head/brain CT scan is available for as little as $197 but at a nearby facility can cost as much as $1,105, a 460 percent cost difference. Similarly, you can get a lower-back MRI in Fresno, CA, for $859 or you can travel a couple of miles to pay as much as $4,395 for the exact same test. In Nashville, TN, that same lower-back MRI costs just $453 at one facility but balloons to $2,552 across town.

> *"The BUCAHs force employees seeking healthcare to play Russian Roulette with their employer's money and their own health."*

Despite these absurd price disparities, just as with the wide cost differences in pharmacy prices and hospital fees, the BUCAHs provide plan members with no guidance is shopping for diagnostic tests, regardless of the impact on the member's and employer's wallet.

Amazingly, massive price variations such as these for imaging and in-patient surgical facilities can be found within a carrier's provider network, so that both the lowest- and highest-priced are approved, in-network providers. Sometimes paying a cash price to an out-of- network testing facility or surgery center often can be far less expensive than going to an in-network provider.

In all these examples, by not directing employees to high-quality/low-cost healthcare, the BUCAHs force employees seeking healthcare to play Russian Roulette with their employer's money and their own health

Misaligned Incentives

Why have the BUCAHs, multi-billion-dollar organizations with the best talent and resources available, failed to stem the growth of healthcare costs or even address the dysfunctional pricing in the system? It's not that they are incapable of reducing the cost of healthcare; the carriers certainly know how to bring down healthcare costs. Their spectacular failure points to THE foundational problem in our healthcare system: *grossly misaligned incentives*.

The health insurance companies lack any financial incentive to reduce healthcare costs and healthcare spending. In fact, the two middlemen in healthcare, the insurance carriers and the insurance brokers, financially benefit from rising healthcare costs.

Carrier revenue is largely the health insurance premium dollars paid by employers and individual policyholders. Rising healthcare costs force carriers to increase the premiums they charge to reflect the higher cost of goods and services. As medical trend drives premiums higher, the higher premiums boost carrier revenue. A carrier's profit margin on a higher revenue number is…more profit.
So the simple financial equation for the BUCAHs and other carriers looks like this:

Positive Medical Trend X Insurance Premiums = Higher Premiums = Increased Carrier Revenue X Carrier Profit Margin = Higher Carrier Income

As healthcare costs have steadily increased, so have therevenue and income of the BUCAHs. In fact, their stock value growth over the past five years has been nothing less than spectacular, averaging 257 percent growth.

FIVE-YEAR BUCAH STOCK VALUE GROWTH & NET REVENUE IN U.S. DOLLAR BILLIONS, AS OF AUGUST 2018

	5-Year Stock Growth	Net Income (August 2018)
Anthem (Blue Cross)	230%	$3.2
UnitedHealthcare	326%	$10.7
Cigna	146%	$2.8
Aetna	315%	$3.6
Humana	269%	$1.5

SOURCE: Morningstar, FactSet, Financial Times, 2018.

Figure 6

The BUCAH's earnings shown in Figure 6 include billions of dollars in higher premiums paid by employers due to increases in healthcare costs that the carriers easily could have prevented. But their financial incentives lead health insurance carriers to welcome – not work to avoid – higher healthcare costs.

Misaligned Brokers

Likewise, health insurance brokers have terribly misaligned incentives. Brokers usually are paid a commission on the premium dollars for the health insurance they place with employers. When rising healthcare costs push premiums higher, the broker receives an automatic raise. For example, when her employer client receives a 10 percent increase in its health insurance premium at renewal, a broker who is paid commission on the healthcare premium just got a 10 percent increase in her compensation… even as her client was being charged more for the same insurance coverage. (Brokers compensated with a per-member-per-month fee instead of commission still have zero financial incentive to do the additional work to control and reduce their client's healthcare costs.)

Furthermore, regardless of whether their compen- sation is commission or a per-member-per-month fee, the broker is being paid by the insurance company. Since everyone works for whomever signs their pay- checks, clearly brokers can't be working for their employer client, no matter how much they claim they are. Unless they are being compensated with fees paid by the employer, brokers work for the carrier. Period.

As a consequence, brokers, too, are incentivized to keep their employer clients ignorant of healthcare pricing and data such as employee healthcare utilization. In his Foreword to the Amazon bestseller, *BREAKING THROUGH THE STATUS QUO: How Innovative Companies Are Changing the Benefits Game to Help Their Employees and Boost Their Bottom Line,* GSESP's CFO Bender described his treatment by health insurance brokers:

[S]tatus quo brokers, which is most of them, have treated CFOs and CEOs like mushrooms... they've kept us in the dark and fed us a steady diet of manure.

So both of healthcare's middlemen – carriers and brokers – have financial incentives totally misaligned with the employer that is paying the healthcare bills for its employees.

It should now be easy to understand why healthcare costs continue to increase unabated every year.

The C-Suite delegates to the insurance company and their broker responsibility for managing the cost of healthcare, while the carrier and the broker do nothing to lower healthcare costs, turning a blind eye to the dysfunction and abuses in the healthcare system that drive healthcare prices – and their revenue – ever higher.

> *The middlemen in healthcare – carriers and brokers – have financial incentives that are totally misaligned with the employer.*

And it should now be easy to understand why the insurance carriers and their broker partners feel compelled to keep company executives out of the healthcare discussion. The result of the Big Lie is the continued upward trend in the cost of healthcare, by ensuring that employers, as the healthcare payors, never apply to healthcare the purchasing strategies and market discipline they apply to every other aspect of their businesses.

Healthcare's middlemen are best served if employers never attempt to manage the healthcare supply chain and begin to negotiate price and quality with the providers of healthcare.

Benefits Revolution

However, a growing insurrection in employee benefits is exposing healthcare's Big Lie and challenging the passivity of America's C-Suite in the face of unsustainable healthcare cost increases.

A veritable Benefits Revolution, led by a vanguard of innovative NextGen Benefits Advisers operating across the U.S., is changing the way companies purchase and manage their healthcare.

As Bender describes it, NextGen Benefits Advisers "are working with the CFO to ensure fiduciary oversight, shifting the strategic decision-making on the benefits budget from HR to the C-Suite to engage executive management, and providing supply chain management to the employees' healthcare to promote appropriate utilization of medical services and plan resources."

Having transformed from a Status Quo transactional broker to a consultative adviser, these NextGen Advisers are engaging the C-Suite with strategic financial conversations about the benefits spend.

These advisers are eschewing commission compensation in favor of employer-paid fees, which provide transparency. But even more important than the compensation transparency of fees, they then are putting part of their fee at risk to guarantee bottomline results ... specifically real, year-over-year reductions in the cost of healthcare. This is the most essential innovation of the Benefits Revolution, aligning the adviser's incentives with the employer client.

The 2017 Employee Benefit Adviser of the Year, Mick Rodgers of Boston's Axial Benefits Group, explains in the bestselling book, *BREAKING THROUGH THE STATUS QUO* why performance-based fees are such an important development in employee benefits:

In the new fee-for-performance employee benefits purchasing structure, advisers are paid more when an employer's benefits program performs better. Not only does this help build trust, it also motivates advisers to continually improve program options and seek new ways to optimize performance.

By putting their fees at risk, NextGen Advisers are moving their chair around the table to sit next to the employer, unheard of in employee benefits. This alignment incentivizes the adviser to do the hard work necessary to improve the benefits and lower the employer's healthcare costs. While the move to performance-based fees is essential, a new role for the benefits adviser is the most important change in how employee benefits are bought in the NextGen Benefits model.

Supply Change Management

In the most high-impact innovation of the Benefits Revolution and the reason they can guarantee cost savings, Next-Gen Advisers are taking on the role of managing the healthcare

supply chain to improve medical outcomes and enhance benefits while controlling and lowering healthcare costs.

Again, CFO Bender: "[T]he real problem with employee benefits is that we in the C-Suite simply have not treated our benefits like we do every other key part of our business. ...Supply chain management? Of course, for every single business unit in the company... except benefits.... And, just as I don't personally do supply chain management for my other business units, I don't have to with benefits. That's what my NextGen Benefits Adviser does."

Unlike the easily disintermediated broker middleman, the NextGen Adviser plays an integral role in the benefits process. As both financial strategist and manager of the Healthcare Value Chain, the adviser contributes to both the operational and financial goals of the company and provides the valuable alternative to the Status Quo broker that is needed to begin fixing healthcare.

But, first, before employers and their NextGen Benefits Advisers can begin to manage the health care supply chain, employers have to take back control of their health plan from the BUCAHs.

Disintermediating the Middlemen

Disintermediation of any long-serving intermediary should not be done arbitrarily and without due consideration. A supply chain management best practice is a three-step exercise to evaluate whether disintermediation would be advantageous or not. After analyzing if the intermediary supports a company's Financial and Operational objectives, the process then considers and compares available alternatives to the intermediary.

Applied to health insurance companies, the BUCAHs, this exercise quickly leads to the unavoidable conclusion that disintermediation of the insurance carrier would be a tremendous benefit to the healthcare supply chain.

While the financial implications of disintermediation are profound, the operational considerations are much more to the point, since it's not possible for the NextGen Benefits Adviser to manage the supply chain as long as a BUCAH is running the employer's health plan.

Once the BUCAH is disintermediated, the employer and its adviser have unfettered access to claims data for predictive analytics and can implement any number of highly effective cost-containment and supply chain management strategies.

Managing the Healthcare Value Chain

With control of the health plan, NextGen Benefits Advisers employ supply chain management techniques to manage and improve the Healthcare Value Chain. Value chain is defined as a process that enhances the value of a good or service to provide a superior outcome. In the case of healthcare, managing the value chain is ensuring that "the right patients are getting the right care, at the right time, in the right place, at the right price," as formulated by Deborah L. Ault, RN, MBA, president of Ault International Medical Management, a leading provider of medical management services.

"This disintermediation exercise quickly leads to the unavoidable conclusion that disintermediation of the insurance carrier would be a tremendous benefit to the healthcare supply chain."

Healthcare Value Chain management employs strategies & techniques including medical management, data mining and predictive analytics, reference-based pricing, direct contracting with healthcare providers, claims audit, domestic andd international medical travel, telemedicine, bundled-price surgery centers, Direct Primary Care, expert medical opinion, cost-transparency tools, fiduciary pharmacy benefit management, specialty drug cost-mitigation, and population health management.

As the Benefits Revolution grows and expands, NextGen Benefits Advisers are discovering – and the market is developing – new strategies and tools to improve healthcare outcomes and lower the cost of healthcare.

NextGen Benefits Case Studies

Conventional wisdom in the Status Quo benefits industry is that healthcare costs are on an immutable upward trajectory and that annual increases in premiums are unavoidable. Yet NextGen Benefits Advisers are producing bottom-line, year over-year cost savings for employers across the US by managing the Healthcare Value Chain.

In the case studies below, all advisers are disintermediating the health insurance company and moving the client to an alternative funding strategy that allows greater control of the benefits plan and budget. While the specific strategies vary, all advisers are implementing NextGen supply chain manage- ment strategies to manage the Value Chain. Just these few real-world case studies prove that the strategies work in any market with any size group and produce remarkable results: better benefits for employees at a much lower cost for the employers.

39%
Year-Over-Year Savings

In Massachusetts, the CEO of ProMedical (65 employees) engaged Benefit Adviser of the Year Mick Rodgers of Axial Benefits Group to manage the benefits spend. Putting the firm into a Healthcare Purchasing Coalition and introducing supply chain management strategies, Rodgers reduced ProMedical's year-over- year benefits spend by 39 percent in just one year, saving the company $363,773. And while Rodgers was lowering the cost of healthcare, in year one he also reduced the employees' deductible by $500.

$1.03 Million
in Savings

In California, NextGen Adviser Craig Lack of ENERGI was retained by a large School District Joint Powers Authority (JPA) to reduce their benefits spend. Using just a single Next-Gen Benefits strategy, by the end of 12 months the JPA had saved over $1 million in plan costs while saving employees hundreds of thousands of dollars in out- of-pocket expenses.

37%
Year-Over-Year Savings

In Indiana, NextGen Adviser Jeff Fox of H.J. Spier implemented a key NextGen strategy in 2017 with Washington Township in Hendricks County (61 employees), which had a per- employee-per-year (PEPY) health-care spend of $21,230. Jeff moved the Township to a direct contract with healthcare provider Hendricks Regional Health (HRH), which, in addition to lower healthcare costs, provided the Township employees with access to near-site clinics and a concierge service to help them navigate the healthcare system. After a year, the HRH Network helped reduce the Township's PEPY to just $13,328, a 37.2 percent drop that allowed the Township to accumulate a reserve fund with over $500,000 in unused claims dollars.

$1.3 Million
in RX Savings

In Georgia, the Board of Commissioners of Cherokee County, GA (1,300 employees) brought in NextGen Adviser Spencer Allen of IOA in Atlanta to address their out-of-control drug spend. Using NextGen cost-containment strategies, at the end of 2017 Allen had reduced the total prescription drug spend by 38 percent, saving the county $1.3 million.

45%
Year-Over-Year Savings

In Montana, the owner of Ace Hardware Great Falls (32 employees) engaged NextGen Adviser Dawn Sheue of Summit Insurance Services to manage the company's benefits spend. Moving the company from a fully- insured to a level-funded health plan with NextGen cost-containment strategies, after just the first 12 months Sheue had reduced the company's year- over-year benefits spend by over 45 percent, without increasing the deductible or co-insurance. And because in this funding arrangement any claims dollars that don't get spent go to the employer instead of the insurance company, Sheue presented the owner with a $45,621 refund check for unused claims dollars.

36%
Year-Over-Year Savings

In New Jersey, the CEO of New Jersey Door Works (52 employees) hired John Sbrocco, Gary Bender's NextGen Benefits Adviser, in 2016 to manage their benefits spend. Implementing an alternative funding strategy, Sbrocco then deployed several NextGen cost-containment strategies that, by the end of year one, reduced the healthcare spend by 36 percent, saving the company over $200,000 over the previous year without any new cost-shifting to employees. By the end of 2017, Sbrocco reduced the annual spend by an additional two percent and presented the CEO with a refund check for $162,250 in unused claims dollars.

Advancing the Revolution

The Benefits Revolution is waking up the C-Suite to the Big Lie of the BUCAHs and their broker agents that executives are powerless in the face of increasing healthcare costs. As the revolution spreads and disrupts the Status Quo, CEOs and CFOs across the country are engaging and changing the way they purchase and manage their healthcare.

Partnering with NextGen Benefits Advisers whose incentives are aligned with their own, employers are seizing control of their benefits spend by disintermediating the BUCAH and broker middlemen.

Working closely with the C-Suite on financial strategy around the benefits spend, NextGen Advisers are managing the Healthcare Value Chain on behalf of the CEO and CFO. As their supply chain strategies take effect, medical outcomes are improving for employees and the cost of healthcare is coming down, making healthcare affordable again for both employees and employers.

As NextGen Benefits Advisers debunk healthcare's Big Lie across the country, as more and more employers join the Benefits Revolution, more and more C-Suites are taking control of their healthcare spend to make healthcare affordable again.

Vive la revolution!

About the Author

Author and speaker Nelson Griswold is a consultant to many of the leading benefits advisers in the country, including three who have been honored as "Employee Benefit Adviser of the Year." A monthly columnist for *Employee Benefit Adviser* magazine, Griswold is a leading architect of the NextGen Benefits movement that is revolutionizing employee benefits and lowering the cost of healthcare by 20-40 percent for companies across the U.S. He is a contributing author to the two Amazon #1 Bestsellers, *Breaking Through the Status Quo* and *NextGeneration Healthcare*.

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Powering C-Suite Executives & Business Owners with Healthcare Cost Solutions in New Economic Climate

Reducing Controllable Costs

Your second largest expense after payroll is healthcare.

The **NextGen Network** is made up of innovative leaders from the top independent employee benefits firms across the U.S., working with C-level executives to manage the healthcare supply chain.

NextGen Advisers have one single goal:
to improve the quality of care & lower health care costs for both employers & employees.

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Professionals

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Practices

Strategies
that move healthcare costs from OpEx to CapEx

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costs for budgeting & planning

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