NEXTGEN BENEFITS | NETWORK

EXECUTIVE PRIMER

The Top Power Questions For Your Broker & Insurance Company

Designed Exclusively for C-Suite Executives to Take Control of the Health Care Spend

Questions to Ask Your Broker

“What strategies are you using to reduce the frequency & severity of claims in our health care plan?”

The only way to reduce the cost of health care is to reduce the:

Frequency (the number) of claims, by

- Eliminating medically unnecessary treatments and procedures
- Reducing the need for health care by intervening with employees who are either high utilizers of care or high-risk to become high utilizers

Severity (the cost) of claims, by

- Encouraging employees to use the highest quality doctors and facilities;
- Managing the cost of care proactively.

If your broker does provide you with some strategies designed to reduce the frequency & severity of claims, you might question their **efficacy** unless you’ve been getting annual *reductions* in your health insurance rates.

“What are you doing to prevent the 20 percent of overspend in our health care plan due to waste, fraud and abuse?”

According to the Coalition Against Insurance Fraud, fully a fifth of health care spending is due to waste, fraud and abuse.

Examples include:

- Negotiated discounts that are not applied to the claim charges;
- Billing for more expensive services or procedures than were actually provided or performed, commonly known as "upcoding;
- Unbundling—billing for each step of a procedure as if they are separate procedures.

Your plan should be paying only for appropriate and allowed medical charges. A proactive *Payment Integrity* strategy can identify disallowed and fraudulent claims over the past 24 months. *Most important*, the process can recover all or most of your annual overspend – usually 7-10 percent of your annual health care spend – for those two years and put that capital back on your balance sheet.

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“Why do we get charged more every year for the same or even a lesser health care plan?”

What other product or service, other than health care, costs more every year while you and your employees get – at best – the same plan or, too often, higher out-of-pocket expenses and lesser coverage? Yet every year your broker brings you a renewal increase.

Would you accept this from your office manager, purchasing agent, or supply chain manager on any other purchase?

Questions to Ask Your Broker

BONUS QUESTION

(If your broker is paid a percentage of your annual premium as commission)

“Since your compensation goes up when my premiums increase, what is your financial incentive to work to lower my cost of health care?”

Since executives delegate to their broker responsibility for managing their health care spend, CEOs and CFOs are shocked to discover the misaligned and perverse incentives built into the **health insurance model**.

Can you expect your broker to work hard on your behalf to lower the cost of health care when doing so also would lower the broker’s personal and company income? Is it any wonder that your health care costs and premiums go up every year?

By contrast, **NextGen Benefits Advisers** not only refuse to take commissions but also put their fees at risk to guarantee you **bottom-line cost savings**.

Questions to Ask Your Insurance Company

“How do you ensure that our employees use only the highest quality health care providers and avoid the bad ones?”

Not all doctors and not all hospitals are created equal. But how do you and your employees know which surgeon produces the highest quality outcomes and which surgeon is facing three malpractice lawsuits?

Or which hospital has a nearly zero infection rate and which one infects seven percent of patients with MERSA? The insurance companies have ready access to provider quality scores and metrics; why do they allow your employees to make what could be a life-or-death decision without the right information? How can employees be smart consumers with their health care when they don’t know provider quality?

Questions to Ask Your Insurance Company

“We know the price of a meal or a car before we buy it. Why can’t we know the cost of health care before we get the bill from the doctor and/or hospital?”

Imagine buying a steak dinner and a glass of wine from a menu with no prices; three weeks later you get a bill for $1,045. Who would tolerate such a thing? Yet insurance companies allow doctors and hospitals to do exactly that with health care services.

It’s impossible to learn the price before a procedure or treatment. Why do the insurance companies not demand price transparency from hospitals and physicians so that employees can compare prices in order to be smart consumers – and save your plan money?

“Are you requiring a second medical opinion on all high-cost procedures and treatments to avoid inappropriate care and unnecessary cost to the plan?”

20 percent of medical diagnoses reviewed by physicians at the Mayo Clinic are *100 percent wrong* and only 12 percent of diagnoses are fully accurate, according to a **published study from Mayo**.

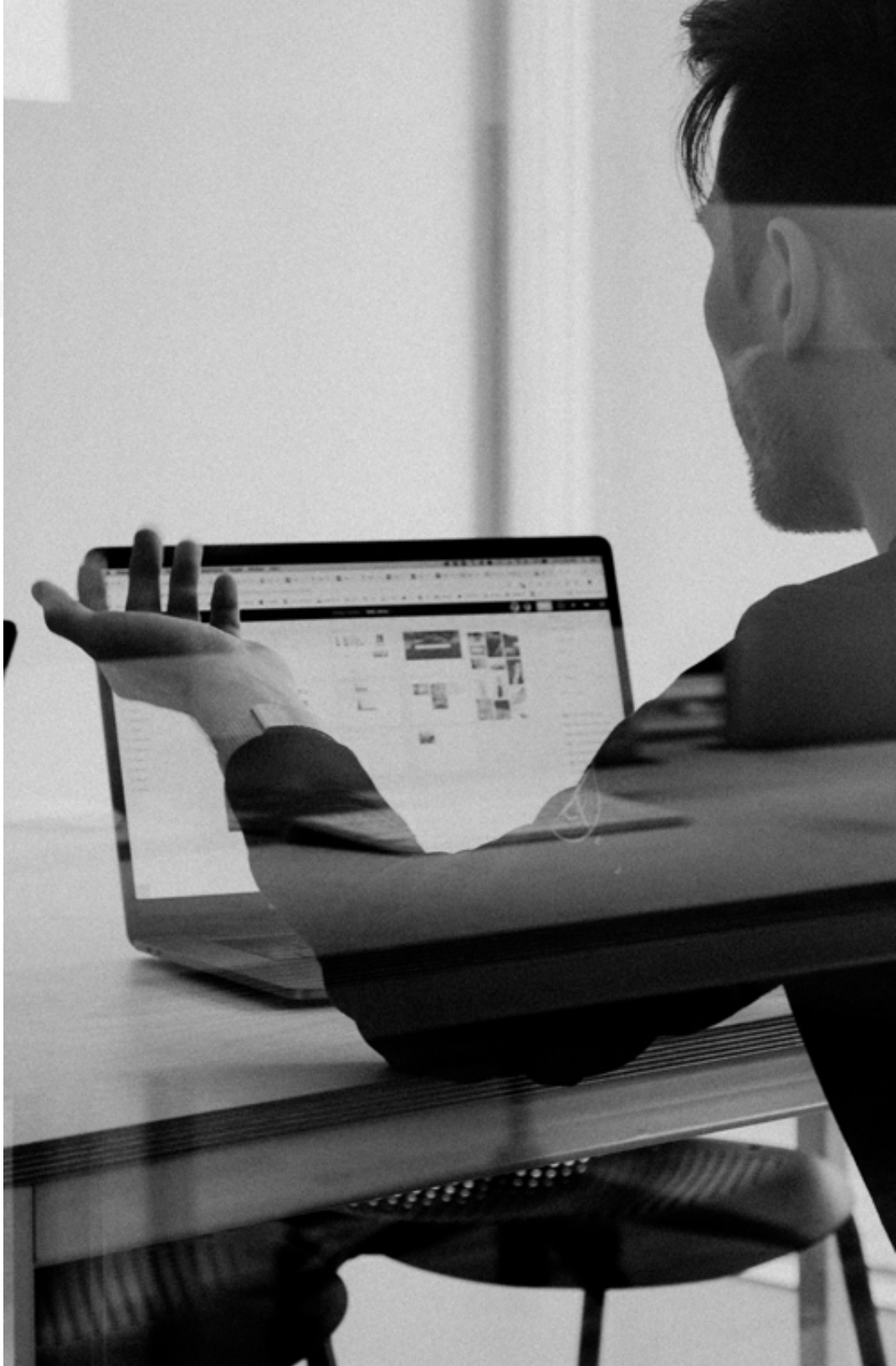
Yet no insurance companies require a second opinion from an independent third-party physician. With one in five diagnoses completely wrong, why is nothing done to protect your employees and your plan from inappropriate care and unnecessary costs?

“How much did the drug companies pay in rebates on our plan and how much of that money did our company actually receive?”

A drug rebate is the return of part of the purchase price by the pharmaceutical manufacturer to help offset the drug’s high retail price to the payer. Prescription drug rebates are generally paid by the manufacturer to the pharmacy benefit manager (PBM), which then shares a portion with the health insurer or the self-funded employer.

But sometimes the self-funded employer sees none or very little of the rebate, despite being the payer. Why are you, the payer, not getting all of the rebates, since you – not the PBM – are paying for the drugs?

Questions to Ask Your Insurance Company



“Our company manages the sourcing for everything we purchase to ensure high quality and low cost. Why can’t you do that with health care? More to the point, why can’t we?”

Health care costs have risen every year since 1960 and, **according to the Kaiser Family Foundation**, insurance premiums have increased 173.8 percent since 1999, adjusted for inflation. Executives ruthlessly manage their sourcing in every part of their business... except for health care, which they delegate to the insurance company.

Why can’t the insurance company do a better job managing the quality and cost of health care?

Could it be time for you to take control of your health care spend and begin to manage the health care supply chain?

BONUS QUESTION

(if you have a fully insured plan)

"Can we get our claims report from last year to see how much we spent in actual claims versus how much we spent in premium?"

If you are like most companies with a fully insured health care plan, you overspend on your health care. Your claims report will show your amount of overspend. Your health insurance premium dollars go into one of two buckets:

- *Administration*, which is a fixed amount (usually around 20 percent);
- *Claims*, which is the balance, to pay for medical and other health care expenses.

Questions to Ask Your Insurance Company

But how much you actually spend on claims is a variable amount, depending on how much health care your employees purchase that year. **Did your employees spend all of the funds in your claims bucket?** Or how much less (or more) did they spend?

You need your total claims report from last year so you can compare the actual amount you spent on health care with the premium in your claims bucket. **The insurance company keeps your overspend** – as much as 20-30 percent of your premiums...then gives you a rate increase, regardless.

If you currently are fully insured, you have the option of an **alternative funding strategy** that lets you pay only for the health care your employees purchase; you, not the insurance company, keep any unspent funds left in the claims bucket at year end.

ABOUT NEXTGEN BENEFITS

The **NextGen Benefits Network** is comprised of innovative leaders from the top independent employee benefits firms acrossthe U.S., working with C-level executives to manage the health care supply chain.

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

Working with NextGen Benefits Advisers to deploy standard business practices to manage health care costs, companies reduce their year-over-year health care spend by 10 to 20% or more – *in the first year alone*.

FIND A NEXTGEN ADVISER

Located throughout the country, NextGen Benefits Firms lower your costs while improving access and quality of care for your employees, by making healt hcare a controllable cost.

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