PRACTICE GROUP:

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A CONVERSATION WITH KAREN WREN ON THE CURRENT STATE OF EMPLOYEE BENEFITS

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When you meet someone in your field who causes you to reconsider your thoughts in an entirely new way, you take note. I had just that experience at the National Employer Summit held in Seattle in March of 2018, where I had the chance to hear and meet Karen Wren, Director of Benefits at the business consulting firm Point B Solutions. Karen has managed the benefits of Point B for 11 years, and in that time has evolved the health plan from an individual-based reimbursement arrangement, to one supporting nearly 1,000 employees. Additionally, she is active in the benefits community through her work as a member of both the health economics and the purchaser's committees with the Washington Health Alliance. While Karen's resume is impressive enough to warrant her inclusion on a panel about driving affordability in healthcare, her insight, candor, and commitment are what make her so compelling. I had an opportunity to connect with Karen, and what follows is a summary of some of the questions we considered. The conversation was rich, and the results interesting for anyone looking to pursue a cost and quality conversation within their organization.

How did employee benefits get where it is today?

The system as we know it was never formally designed. The "system" is in fact a disparate mix of employee consumers, employer purchasers, hospital and doctor providers of care, and insurance company payers, each operating independently but relying upon the other entities to support them. The system was not built to support employee health, but rather to respond to an employee's illness. As a result, the incentives are not aligned and there aren't any reward for doctors, who are running a business like any other, to prevent people from using healthcare.

Society in general hasn't had enough direction yet either. "My doctor said I need," is still enough to send us down a track of healthcare that may not be appropriate (i.e. supported by evidence-based best practices). The lack of information is unfair and, feeling uninformed, we defer to the single person that we rely on – our doctor.

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There are some bright spots:

Even though the United States has higher infant mortality rates and lower life expectancy than nearly all developing nations, people are still coming here for certain treatments and procedures. Healthcare in the U.S. can be outstanding, truly world class, but the quality of care is not consistent and inordinately expensive.

On why the CEOs and CFOs haven't tackled the issue of increasing healthcare costs in a more significant manner:

They just haven't gotten angry enough. The challenge of recruiting and retaining employees in this job market is extremely difficult. As a result, many HR and benefits directors are being told to control the cost increases year over year, but avoid disrupting the workforce. When the data clearly shows there are providers of healthcare that charge more than their peers with worse outcomes (e.g. higher rates of infection, lower success rates, higher readmission rates), but the employees want the ability to choose those particular doctors and still have the same coverage, it is very difficult to control cost and allow this unfettered access.

> The easy way out is to pay more and accept the status quo, but we should all be pushing for a more effective healthcare system.

What is the broker's role in this?

Brokers have not taken thought leadership on this issue, but consumers share fault for not asking brokers to be more proactive and explore options for our populations that may be troublesome to implement, but lead to much better outcomes. The easy way out is to pay more and accept the status quo, but we should all be pushing for a more effective healthcare system.

So now is the time to ask and to challenge. Ask for data that will support employees making educated decisions about their healthcare, i.e. where to get information about the cost of knee surgery, the quality of the surgeon and the facility, and what questions to ask prior to going under the knife. This is an important resource that Point B employees have access to through Compass Health. Compass isn't perfect, the quality piece is still a work in progress, but it is going the right direction.

Whose problem is this to fix:

This is not a political issue. Healthcare developing party lines is an unfortunate outgrowth of these challenges. The expectation that healthcare should be affordable and deliver consistent, high quality outcomes is not partisan. Pose the question of, "What do you want your kids to have covered in 10 years?" This is a really interesting question and should cut through the politics to address what's important.

Individuals need to ask for more information about cost, the expected results, the alternatives, and they should be rewarded for being intelligent and informed consumers. Employers need to challenge their brokers to provide a mechanism, whether Compass, Castlight, Health Care Blue Book, or an insurance carrier based tool, that delivers cost and quality information in such a way that everyone can understand it. Doctors also need to be comfortable with providing data about cost and quality, and potentially being judged by it.

What are you doing:

Create a grassroots demand for quality. Do this in any forum you have an opportunity, whether with your brokers, your C-suite, your employees, or through community organizations like the WHA; demand it. Anyone controlling the healthcare spend of a business is acutely aware of the cost, impact on the budget,

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potential for volatility in the annual spend, and effect on employees' total compensation; this awareness needs to lead to action. Knowing how the healthcare system works is the first step, and demanding better results is the next.

As the benefits director, Karen has taken a number of steps over time, because they reflect the values as an organization. Their culture is key to the business, and having a health plan that represents their value leads directly to supporting that culture:

They have a much broader definition of preventive care than the ACA requires, even before the ACA was passed.

They provide the Compass pricing transparency tool to employees and encourage its use through lower out of pocket maximums for those who choose high quality providers.

They have had an HSA plan for several years and, while cost shifting isn't the answer to improving outcomes, they do fund the deductible, enabling people who don't use the whole deductible - about 80 percent don't - to save money over time.

They provide a lot of information to employees regarding how to select a doctor, what to look for, questions to ask, how to use the HSA, the list goes on and on.

They have bucked the trend of restricting, reducing, and removing benefits. This is the wrong approach and one that does not fit in their culture.

Any other ideas:

Participate in industry groups and promote the concept of demanding better outcomes at a lower cost. You are not alone and you are not helpless. The Washington Health Alliance is actively looking for employers to participate in the conversation, the LeapFrog Group, a consortium of large employers, have been working to rate hospitals for quality for 20 years, and there are many buying groups and captives all demanding the market provide better quality healthcare.

Challenge your broker to bring you information about ideas and trends. What innovation is taking place, and how can we incorporate it into our plan?

Pay primary doctors by the minute so the more time they spend with a patient, the more they get paid. Incentivizing doctors to push people through as quickly as possible is counter-productive and does not support a holistic approach to care.

Wellness is something that every organization needs to evaluate. If a program is going to be prescriptive, restrictive, or invasive, then it must be consistent with company culture. Some other considerations are time; will there be staff to support a strong wellness initiative? Privacy is also a concern; will we be able to maintain total anonymity in the plan? If the answer is, "yes, wellness fits in our culture, we have the capacity from a staff perspective, and we can assure privacy," then trust the benefit managers to implement it.

To put it plainly, if you have responsibility for a benefits program, or of funding a benefits program, strongly consider asking your vendors for more transparency around cost and quality. This is an emerging conversation, but the stakes are enormous and it will take employers, the ones who are truly funding the current system, to disrupt the status quo.