The Grassroots Health Care Revolution

How Companies Across America Are Dramatically Cutting Their Health Care Costs While Improving Care

John Torinus Jr.

Author of *The Company That Solved Health Care*

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The march is on to a new business model for the delivery of health care in America. Actually, it is a race. This book is dedicated to the innovators, most of whom are in the private sector, who are putting the pieces into place for that disruptive model. Health costs are the biggest economic issue facing the country. So these innovators—many are featured in this book—are doing patriotic work. They are fixing a broken, unsustainable model.

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Introduction

TWO ENTIRELY DIFFERENT mind-sets are at work in the world of U.S. health care. The public and private sectors, which roughly split the nation's nearly $3 trillion medical bill, see different challenges. Government leaders think reform means more access for more people through better insurance, subsidies, and expanded tax revenues; private companies see out-of-control costs as the main issue and improved work force health as a major solution. The health care law that was signed into law in 2010 and has begun taking effect (with the full effect hitting companies in 2015) is all about access and insurance reform, but it leaves largely unaddressed the pivotal issue of costs, which have been spiraling upward for decades. The costs have about doubled every eight years.

In my first book, *The Company That Solved Health Care*, I described what my mid-size manufacturing company, Wisconsin-based Serigraph Inc., did to loosen the cost noose that kept tightening around our neck. Since then, I have had the rewarding experience of traveling the country

to interact with hundreds, even thousands, of business people who were also grappling with that huge issue. I got more than I gave. It was a learning journey.

Growing up in the newspaper and manufacturing businesses, with a grandfather in each, I always had one foot in journalism and the other in commerce. Curiosity and questioning are the requisites for a newsman, and benchmarking on best practices at other companies is an invaluable tool for running a company. Both skills helped as I engaged in a cross-country dialogue with smart people who are passionate about finding a cure for the chaos in health care economics.

As I spoke with businessmen and -women across the country, it became clear that I am far from the only one who sees that the business side of health care is badly broken. I imparted what we had learned at Serigraph, as we improved workforce health sharply and kept our costs about 40 percent below the national average. But the more interactions I had, the more I realized something profound was taking shape across the land. Collectively, these innovators were hammering out a new business model for the delivery of care.

I, with help from a seasoned business reporter, interviewed many of these change agents, these disrupters, and their insights are spread throughout the book.

The payer revolt has been growing from the ground up, just the opposite of what happened in 2010 when President Obama and Congress imposed insurance reform from the top down. ObamaCare, love it or hate it, was fashioned

cerebrally by wonks and pols from inside the Beltway and inside the health care industry. It was anything but empirical, as its troubled launch demonstrated.

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What I was touching and seeing across America is the "real reform" that has been going on in the private sector at the grassroots level. The innovators have been dealing with the elephant in the room—the bloated cost structure of the industry. They also have been dealing with the health of employees, because you can't manage health costs without managing health. Duh! That basic truth became perfectly obvious in my many conversations.

It should come as no surprise that most of the innovators I encountered were in the private sector. Government payers move very slowly, except to devise new revenue schemes to cover the soaring medical costs. Conversely, innovation is at the heart of survival and competitiveness in the private economy. And corporate executives move fast once they engage a strategic issue and understand that it has to be solved. We in business are a community of problem solvers. We thrive on innovation. And we're

motivated to innovate in health care, since we're directly footing roughly half of the bill in this country.

Business leaders can push their reforms with the knowledge that we possess lots of leverage. As Jeff Thompson, CEO of Gundersen Health System in Wisconsin, put it: "All of the margin in health care comes from private payers."

Further, innovators in the private sector are more pragmatic than wonky. They are empirical. They get an idea for improvement, try it, keep it if it works, and dump it if it doesn't. When their proven initiatives and pilots are stitched together, they add up to a new model. It is a mosaic. In contrast, ObamaCare avoids, for the most part, the over-riding issue of costs. So no one really knows if ObamaCare is going to work without busting the bank. And it may not even resolve the access issue. We'll know in five to ten years.

We private payers, on the other hand, know beyond a doubt that the emerging business model in the private sector works, because it is being rolled out successfully in thousands of results-oriented companies.

The emerging business model in the private sector works… it is being rolled out successfully in thousands of results-oriented companies.

Corporate purchasers also understand basic business concepts, like the rock-hard fact that they and their employees are the customers.

Medical providers, who often think they are at the center of their universe, have a hard time with the concept of customer. I often have to explain to them that the customer is the one who writes the check.

Corporate purchasers see the world through supply chains, with the payer at the top and the doctors, hospitals, clinics, and insurers as vendors down the chain. With that mentality, proper relationships start falling into place.

In my learning expeditions, I encountered a mountain of frustration, even anger, at the existing system for delivering care. Most of the ire is on the economic side of the equation, though there is plenty of room for improvement on the medical side.

The American people are fully aware that unchecked health costs—almost twice per capita of anywhere else in the world—are crowding out advances in education, research and development, wage increases, public safety, environmental improvement, even defense. They see the hits to their personal finances. Health costs have become the leading cause of personal bankruptcy in the country. The citizenry wants it fixed.

Fortunately, there is a grassroots revolution surging across the country, company by company, and it offers hope and change. In that light, this is an optimistic book.

The rate of inflation in health care premiums has dropped from double-digit increases a decade ago to mid-single

digits. The wonks are puzzled by that unprecedented drop. How did it happen? Look no further than the Grassroots Revolution led by private payers. They are demanding change, and they are making it happen.

This book lays out the initiatives that many companies have launched and the platforms they have built for a restructured health system.

Unlike the current system that revolves around specialist doctors, hospitals, and insurers, the new model centers on the employee, the consumer. The new delivery model listens first to the voice of the customer. It is patient-centric.

That's the heart of what I learned from the innovators at the ramparts of real health care reform, and it's at the heart of this solutions-oriented management book.

1

Go or No-Go Under ObamaCare?

WITH MAJOR CHUNKS of the new health care law taking effect in 2014 and 2015, companies across the country have been faced with a decision on whether to continue their health benefit—or to begin coverage if they don't currently cover employees.

On its face, this may not seem like a very involved decision. After all, if companies have been offering health care to employees, why wouldn't they continue to do so? Yet, the new law offers an escape hatch of sorts. It might look like it's cheaper for a company to pay the new fines than provide insurance for each employee. But there's a lot more to the decision.

The new law, above all else, is complicated, and those complications spill over to private companies. Even with the new law, though, the real issue remains the underlying costs, which is why the name of the legislation—the Affordable Care Act—is so ironic. Health care has been many things, but affordable is not among them, and everyone agrees that the new law will not change that reality, that ACC will actually add costs. The only debate is over how much.

The escalating costs are the primary reason companies are faced with the go or no-go decision under ObamaCare. If costs were low, like they were after World War II when companies first got into offering a health care benefit, the decision would be less difficult. No economist is predicting that general cost escalation will lessen in the future.

So, should businesses they default to the government exchanges created under ACA to avoid the financial burden of health benefits, or should they stay in the health care game?

This book focuses on ways companies across the country have innovated to reduce health care costs so they can maintain the benefit. It profiles innovators—company by company at the ground level—to describe a rapidly emerging business model for health care. It is a disruptive new model that will force radical change in the way providers and health insurers operate.

Even deeper, at the very root of the national problem, is necessary behavior change by individual employees, as they become engaged consumers. The new model is based on individual responsibility.

Yet while costs and improved health are at the center of the reform in the private sector, no company can ignore the impact of the Patient Protection and Affordable Care Act, also known as ObamaCare or ACA. The decision on whether or not to offer health care for employees is made difficult by the complex, unclear, and still developing rules to flesh out the law. Businesses got a one-year reprieve when the Obama administration moved the effective date of the mandate on employers to provide care or face a penalty from Jan. 1, 2014 to Jan. 1, 2015. But that doesn't change the need to make a fundamental decision on whether to offer health care as a benefit.

The Changing Landscape of Health Care

The percentage of employers that provide a health plan has been dropping steadily over the last several decades. Hyperinflation (a justifiable term) of medical costs has driven 40 percent of U.S. companies, mostly smaller firms, out of coverage. That's down nine points since 2000. No one really knows how many more employers will drop coverage because of soaring medical expenses or because of the new law. But some will, because they haven't figured out how to manage or afford ever-higher premiums.

If a company with 50 or more employees decides to offer health care coverage, it will use either a self-insured plan or a plan sold by an insurance company that meets

two ACA tests: 1) it can't cost more than 9.5 percent of an employee's pay, and 2) the employer coverage must pay at least 60 percent of the employee's health care bill.

There are many insurance plans with medium to high deductibles, offset by personal health accounts, that can meet those hurdles. However, for those crunching the numbers, it's a little like shooting in the dark, because no one really knows how much premiums will jump in the years following enactment of the new law. If you can't fix a premium cost, you can't do the percentages.

Most analysts agree, though, that the addition of people with highly expensive pre-existing conditions and other mandates can only drive premium costs upward.

The Obama administration had already pushed back the website startup for small businesses to purchase insurance on the new public exchanges from 2014 policies to 2015. That was a broken promise to those employers that have seen the biggest premium hikes in recent years and were hoping the exchanges might give them some relief. Many extended the small group policies as 2013 came to a close. That bought them a 12-month reprieve to see how prices will shake out for 2015.

SMALL COMPANIES WILL GAME THE RULES

Congress gave small companies a break in the new law. Businesses with fewer than 50 full-time equivalent employees escape the ACA penalties for not providing coverage. That means many small companies will game the rules to stay below 50. They will:

- Choose not to grow
- Adopt labor-saving methods like automation
- Outsource work
- Buy rather than make components
- Split a company into separate corporations to get below the maximum
- Keep part-time employee hours under thirty 30 hours per week so they can't be counted in the full-time equivalent totals.

They are already taking those steps in anticipation of the activation of the new law.

Some financially strapped companies with more than 50 employees will be relieved to pay the ACA penalty of only $2,000 per employee as they retreat from a benefit plan that includes health care. The penalty is a slap on the wrist compared to health benefit costs.

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Those Saying 'Go' to Health Care: Mostly Medium and Large Companies

My guesstimate is that at least half of the employers in America will make a decision to stay in the health care business, down from 60 percent that offered a health benefit in 2013. Polls confirm that most large and medium

UNINTENDED CONSEQUENCES LOOMING UNDER OBAMACARE

Premium Hikes—Most states will see premium increases, ranging from low to high, with different impacts on different subsets of people. Political spin on the level of the increases will confuse Americans.

Some Employers Will Drop Plans—At penalties of only $2,000 per full-time worker, firms with high employee turnover will pay the penalty and send their workers to Medicaid or the exchanges.

50-Employee Max—Small firms will do somersaults to stay under the 50-employee limit and avoid ACA penalties.

30-Hour Employees—Companies are managing part-time hours aggressively to avoid the health care mandate that kicks in at 30 hours per week.

Young Healthies Will Fly Naked—Young adults will pay the small penalty and sign up for guaranteed health insurance only when they get sick.

Insurers Won't Play—Major health insurers have decided not to offer individual policies on some state exchanges. That spells limited choices of carriers, often duopolies or oligopolies.

Many available health plans on the exchanges will offer narrow networks, which means some hospitals, clinics, and doctors won't be accessible.

Reduced Benefits—Many plans will cut back to avoid the 40 percent Cadillac tax.

Doctor Shortages—Workforce experts predict huge shortages of physicians by 2020 because of the increased demand.

employers will continue coverage, and brokers that each represent hundreds of companies, medium and large, also report that almost all of their clients intend to stay the course in offering a health care benefit.

Some have decided, though, to retreat to a defined contribution, say $5,000 to $7,000, where employees will get a check and will be asked to go to the exchanges to buy individual health policies. How big that trend will be remains to be seen.

Typical are the quoted comments of Randy Baker, president of Joy Global's surface mining division: "It is certainly a large line item in our budget, but we are going to continue to offer health care at our company regardless of what the federal government wants to do, because our employees deserve that."

My company reached a similar conclusion. After a rigorous analysis, Serigraph Inc., which self-insures about 1,100 lives, made its decision in 2013 to keep its full health plan, mainly because we cannot afford to lose talented employees if we drop coverage. Some would surely look elsewhere for work at companies with full benefits. There are several such soft costs involved in dropping coverage, and they offset the hard costs of continuing coverage. The competitive reality, at least for now, is that providing coverage for employees is still considered the norm for mid-size and large corporations.

The Costs of Health Care

Companies that have done the best job of managing the health of their workforces and, therefore, of controlling medical costs, will be the ones most likely to keep their health care benefits. Best-practice employers in the private sector deliver health care for a total cost between $8,000 and $10,000 per employee. That has been and will continue to be a bearable level of expense for companies that want to attract and retain talented employees.

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Employers who haven't applied management disciplines to health care often pay more than $20,000 per year. At that level, the small penalties under ObamaCare for dropping coverage, $2,000 per employee, look like an easy way out. In short, the higher the costs of a plan, the more likely the company is to drop coverage and pay the penalties for not offering coverage.

The "Cadillac plans," those that cost more than $27,500 for a family, face a 40 percent surtax under ACA, effective 2018. Those bloated plans cover some executives, many union members, and some public employees. They

show how far out-of-control costs can climb if not managed. Assuming an 8 percent upward trend in premiums, more than 50 percent of plans could face the 40 percent tax within a decade.

Employers will only escape the penalty if they redesign their plans or Congress yields to pressures to raise the cap. Companies are already trimming back their plans in anticipation of 2018.

Soft Costs

The proposed rules are maddeningly complex, and thus the decision to stay with health care or drop coverage has been complicated. For openers, the soft costs are as vexing as the hard costs. For exempt smaller companies, among the soft costs are legal fees. They are hiring lawyers and benefits experts to make sure they are stay exempt at fewer than 50 employees. The new law has created an army of consultants.

For medium and large employers, the soft costs of discontinuing the health benefit go beyond turnover, but that is the biggest one. Another major one is the loss of influence over promoting health among employers.

If a company drops coverage and instead chooses to pay the modest ACA penalties, what's the cost of losing a top engineer who leaves for a position with a full-benefit employer? Turnover brings the steep expenses of recruiting a replacement, of training a successor, of slower technology advancement in the interim while there is a vacant position. Such transitions could easily cost $100,000 each. Further, recruiting an equivalent engineer to a company

not offering health care would be a challenge. The same can be said of other skilled positions, from press operator to programmer to executive.

As for losing positive leverage over the health of the workforce, companies in the vanguard of containing health costs do it by managing health. In the process, they enjoy improved productivity, higher morale, less absenteeism, and lower workers' compensation charges.

Companies in the vanguard of containing health costs do it by managing health. In the process, they are enjoying improved productivity, higher morale, less absenteeism, and lower workers' compensation charges.

Where health plans are well designed, including such amenities as on-site primary care, employees see their employer as making an investment in their families. That commitment creates a long-term bond. It acts much like tuition reimbursement and is appreciated by employees as a similar investment in their futures.

In contrast, dropping health care and telling people to go to the public exchanges for individual policies will inevitably be viewed as a step backward in a company's commitment to its workers. That will be true even if the employer gives the employees a raise or a "defined contribution" to help purchase the individual policies.

It will be especially true if the premiums for individual policies sold on private or public exchanges show a big hike over today's prices. Because of expensive ACA mandates on what a health insurance policy has to look like, some major insurers have decided not to offer policies in some states. That means less competition for individual policies, and less competition always means higher prices.

Hard Costs

There is also a numbers side, the hard costs, in a company's go or no-go analysis.

Suppose an employer currently delivers health care at a total cost of about $8,500 per employee, which is tax deductible to the employer and tax exempt to the employee. If it drops the benefit, it would have to give an employee a taxable raise of more than $14,000 to buy an equivalent policy on an exchange. Plus, the employer may have to pay the $2,000 penalty for dropping coverage. The employee then comes out whole, but the company would be at least $7,500 worse off per employee than if it kept its health care benefit.

Suppose, instead, that a company wanted to drop coverage but be cost-neutral with its current expense of $8,500 per employee. In that scenario, it would limit the raise it gives to an employee to buy a policy to only $5,700.

Unfortunately, in most cases, that added compensation of $5,700 would not be enough to buy an equivalent policy on the exchange. That's true even for many employees even if the employee qualifies for the subsidies offered by

the federal government for buying a policy through a public exchange.

Here's a worse scenario for employees. If the employer drops coverage and offers no contribution, the worker gets hit hard. The employer may pay the $2,000 penalty, versus its previous $8,500 expense, so it saves a lot of money. But the employee is on the hook for a policy that currently could cost the national average of $16,000 or more for family coverage. That's before the rate increases that the new law could cause in the years ahead.

Analysts say a family premium could rise to $23,000 by 2020. That would be unbearable for an uncovered worker, even taking into account offsetting federal subsidies. And it gets close to the Cadillac tax on premiums of more than $27,500 in 2018.

At present premium prices, ACA's federal subsidies for a family of four range from about $3,000 for a household making $94,000 to $11,000 for a household making $31,000. Clearly, that's just not enough. The gap between the premiums and the subsidies could be huge. It's a good bet that future administrations will have to hike the subsidies, which carry an estimated price tag of $23 billion in 2014. That tab will escalate beyond 2014.

When Serigraph did its go or no-go exercise, the after-tax costs were about a wash for keeping or dropping coverage. That assumed a $5,000 annual contribution to each employee if we dropped coverage.

Taking into account the soft and hard costs, the best answer for many employers will be to continue to offer health

care. The obvious exception among medium and large employers is those that do not value a long-term relationship with their workers. Where wages are low and turnover is high, in sectors such as restaurants, hotels, nursing homes, and call centers, employers may choose to pay the penalties. Those uncovered workers will have to head to the exchanges for individual policies and the subsidies.

The Innovations in Health Care Are at Hand

Serigraph's decision to stay in the health care game was made possible because managers in the private sector have invented a new business model that makes it tolerably affordable for companies to offer a health care benefit.

The maelstrom surrounding ObamaCare, which is insurance reform, not health care reform, has proved a monumental distraction from the fundamental problem facing the country—the staggering costs. What I call "real reform" of the delivery system has gained momentum at the grassroots level, as companies have become smarter managers of the supply chain for health care.

ObamaCare . . . is insurance reform, not health care reform.

As three million companies make the go or no-go call on providing coverage, they need to take into account more than just the penalties imposed by the new federal law for bailing out of coverage and the costs they currently see before them. They also need to be acutely aware of the many innovative efforts across the private sector that add up to a radical reengineering of the delivery of health care in America. The innovators have taught us that the costs of health care can be dramatically reduced as workforce health is significantly improved.

Smart employers are doing a better job of improving workforce health while controlling costs.

Note: a widespread default to individual insurance and government plans would sharply raise the national health care bill, because governments and insurance companies are slow movers when it comes to systemic changes. They are not good at managing costs. They are the wrong horses to ride for innovation.

The right horses are sharp corporate payers that are revamping the delivery of health care. They are bending the inflation curve. They and their consumer/employees are the game changers.

Their collective, transformative innovations add up to a megatrend. Their successes make this an optimistic book, regardless of the impact of ObamaCare on the health care insurance industry.

Thanks for checking out this preview of:

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