NEXT IMPACT

TOP QUESTIONS YOU SHOULD BE ASKING YOUR CARRIER & ADVISOR

QUESTIONS FOR CARRIER

1 **How do you make profits?**
If you are fully insured, you should ask "How does the Minimum Loss Ratio (MLR) provision from the ACA impact?

Rationale
The industry is built on a foundation of misaligned interest. An insurance company's business economics are fundamentally skewed from the employers. Here is some food for thought:

- Most of the major insurance companies are PUBLIC companies, therefore, have a quarterly review and are beholden to their share-holders and analyst.
- A main source of an insurance company revenue is PREMIUM, therefore, to make more revenue they must increase premiums.
- The MLR provision capped the amount of profit per dollar of premium collected by an insurance company… as such, if the profits per dollars are capped, how do they make more profit? **They must charge more.** If you are fully insured, there is no incentive for them to lower your cost… **NONE!**

2 **Do you track quality metrics of the providers/facilities that are in your network?**

- If so, how do you use it?
- How do you help members get to better quality healthcare?
- If not, why?

Rationale
Do you think the carrier, who pays all of the claims, can access CMS quality data? Of course, they can. With that information they are able to benchmark facilities and providers against each other. With this advantage, how do they help ensure that your members are getting the best quality care possible? If better quality of healthcare is safe and produces better outcomes and more often, is less expensive, why wouldn't a carrier focus on driving care to better providers and facilities?

QUESTIONS FOR ADVISOR

1 **How do you get paid?**

Rationale
Alignment of interest. Most advisors make a commission percentage (%) of he premiums an employer pays. This means when your rates increase, they get a raise. You should always have a 100% transparent compensation arrangement with your advisor, preferably one that incentivizes them when your plan performs better.

2 **Tell me about your most creative health benefits design/ program you have successfully implemented with a client? What were the results?**

There isn't ONE answer for this, however, there are a couple aspects to consider:

- The "better" answer contains a non-traditional carrier aspect. As we discussed in the carrier side of this document, the current carrier landscape is not the hot bed for innovation, transparency, and cost savings. It would be like an artist starting to paint a masterpiece utilizing a template or stencil.
- The strategy must be data-backed—**YOUR DATA**. The strategy must be based on your claims, demographics, and helping you achieve a stated desired outcome.

QUESTIONS FOR CARRIER

3 **I have been told before that one of the major evaluation points for a carrier should be their "discount"...**

- What is your discount?
- What is the "off" discounted from?
- How can I get this data to help my members go to the places where you get the best discounts?
- Is the discount applied to the same costs at all facilities?

Rationale

The carrier's discount is applied to the "billed" rate, which is typically between 400%–800% higher than what Medicare reimburses that same hospital for the same services. In simple terms, let's assume that Medicare is equal to the COST of the service. How does a 50% discount applied to an amount that has been inflated by 700% benefit you? Additionally, every hospital "billed" rates are different for the same services and might vary several hundred to thousand percent difference in cost within the same city. Do you think an insurance company has the data to follow how much they pay for an MRI or surgery in one hospital vs. another? Of course they do. The question is, how they help your members understand it, so everyone becomes a better healthcare consumer? The answer is, they don't. To see this problem in a mockumentary, please see the "Adam Ruins Everything – Why Hospitals Are So Expensive" – click here to watch: https://www.youtube.com/watch?v=CeDOQpfaUc8&t=16s

4 **This question is about your prescription drug (Rx) program:**

- Which Pharmacy Benefits Manager (PBM) do you use with our program?
- How do they get paid?
- Do they collect rebates from manufactures?
- IF so, how does our plan benefit from the rebates being generated by our members? Is there reporting we can review?

Rationale

The PBM space is even more opaque than the carrier discount conversation above. The Rx costs are trending faster than your medical costs and carriers ONLY partner, or are in business with, the largest PBMs who have:

- **Huge misaligned interest** – they get rebates on drugs that don't necessarily align with the best cost or quality available for your members to access. The PBM carriers formulary isn't always developed with efficacy or cost metrics in mind.
- **Non-transparent business models** – a PBM is a classic "middleman", however, you have no idea how much they "buy" a drug for and how much they "sell" it to your carrier/plan.

Clients should only be working with PBMs whose business models are transparent and whose interest align with your plan.

QUESTIONS FOR ADVISOR

3 **How does the advisor suggest their strategies lower cost?**

The status quo strategies simply don't work. Any strategy discussed must address the following:

- Controlling the **FREQUENCY** and **SEVERITY** of claims. The strategy must either LOWER the number of claims that will be incurred, or have an impact on the COST of the claim amounts.
- **Location matters.** Based on the fact that both COST and QUALITY of healthcare differs drastically from location to location, the strategies being presented MUST help drive healthcare to higher quality and lower cost. The tools, education, communication, and overall design and strategy of the program must align with this premise.
- **Pharmacy.** First, if they don't mention pharmacy as a strategy, they are NOT the best advisor for you. Second, if they mention rebates when describing the strategies around Rx, they are focused on the wrong thing. Third, the two things that should be discussed are, adding transparency in the PBM pricing and allowing the plan to source medications outside of the PBM formulary (i.e. manufacture assistance programs and international sourcing).

4 **How does the advisor suggest their strategies improve the quality of the healthcare being accessed by their employees and their families?**

Rationale

It has been proven that better quality healthcare achieves better outcomes and is typically among the most competitively priced. With this foundation, a strategy must include:

- Incentives for members when they utilize the high quality (lower cost) providers- aligning interests.
- An advocate to help the member understand their options and help facilitate the member to make the smart decisions.
- A pre-authorization requirement for all high cost services. Remember less than 10% of claims are emergent in nature.

You cannot impact care AFTER it happens. The key to drive better quality/lower cost care is to be able to **IMPACT** it before it happens.