Part I

Mostly Bad News

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Chapter 1

Myths and Facts about Your Health Benefit

One reason that your spending tends to rise so quickly is likely because a lot of what you think you know about controlling health expenses is mistaken. This shouldn't come as much of a surprise, given that few how-to articles and books are actually written by people who manage health benefits for a living. It is easy to say something saves money if you're the vendor selling it or the consultant getting paid to procure, implement, and evaluate it. But *actually* saving money is quite a bit more challenging. Most money-saving ideas pitched to you have one thing in common: they may or may not save money, but they do cost money. And the funny thing is that while the expense is always in hard dollars, the savings generally require some kind of reconciliation or outcomes report that's laden with assumptions and fallacies.

As one corporate medical director observed, "If all my programs got the return on investment that vendors say they achieved, I'd have negative medical spending."

Well, here's a news flash: you don't have negative medical spending, and this chapter will explain why. More important, it will explain the facts that will allow you to spend less than you are now while ensuring that your employees are better off.

The first two sets of myths and facts correspond with subsequent chapters that are referenced in each set. If you're reading this electronically, you can click through directly to the referenced chapter for a more in-depth discussion. If you're reading the hard copy, you'll have to leaf through the actual pages themselves to reach the chapter in question. (Wellness vendors would not consider this as a chore. They would call it finger aerobics and give you incentive payments for completing the task. Okay, not really, but the stuff they really do, as you'll see, isn't so different.) Not every chapter corresponds with a myth, though, because not every solution begins with a misunderstanding.

Likewise, not every myth corresponds with a chapter. The last set of myths is designed to stand alone, because the story ends there quite cleanly.

Finally, each myth/fact ends with a takeaway that you can act upon posthaste.

I: Myths Covered in Chapter 3: Yes, Even Wellness Can Be Hazardous to Your Health

Despite its many other contributions toward creating a culture of health (if done correctly), the concept of "increasing wellness" is pure mythology vis-à-vis your actual health spending. Hopefully, the five myth-busters here and a chapter on the topic later in the book will convince you of that.

Myth: Actively managing your health benefit and your employees' health will reduce disease and premature mortality.

Fact: Your actual management of your health benefit has surprisingly little influence on a given employee's health. Not none, just nowhere near as much as the amount of effort you put into it would suggest. The greatest determinants of health and longevity include genetics, socioeconomic status/finances, job satisfaction, behavioral risks, personal relationships, zip code, and luck. So the best way for an employer to improve health status and productivity is to create a workplace culture that employees want to be part of. You'll therefore find that we debunk many push-button programs that require vendors, whereas we recommend making internal cultural improvements. (However, Chapter 10 does suggest a comprehensive well-being solution that is partially vendored and goes far beyond wellness to address finances, job satisfaction, and other mitigable, non-health-related factors that contribute to overall well-being.)

Action implication: Spending more and doing more doesn't necessarily pay off. Gold-plated health plans often encourage overuse, overdiagnosis, and overtreatment. So don't be afraid to cut back. Many chapters provide suggestions for specific places to cut back on services you pay for now—and we promise that most employees won't even notice their absence.

Myth: Keeping people out of the hospital via a wellness program is the best way to reduce your health spending.

Fact: As described in Chapter 3 and at length in the companion volume, *Why Nobody Believes the Numbers*, there is not one shred of evidence that a corporate wellness program can reduce the cost of your health benefit at all, let alone by more than the cost of the program. If it can't do that, it certainly can't cover the cost of the average incentive payment, which itself usually exceeds all spending on all health

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risk-sensitive inpatient events that even the most perfect wellness program could possibly prevent. And chances are, your wellness program is anything but perfect. You are likely throwing large incentives and expensive programs at people who simply either aren't going to change in any meaningful way or would change (or maintain their good health) even without incentives. And there's just no way that any claims cost and productivity savings for the sliver of people in between who *do* change in response to incentives and the program itself would be able to offset the program spending on and incentives paid to everybody else.

Just as with health status as described above, most research suggests that the best way to reduce medical spending and absenteeism is to establish a culture that makes people *want* to go to work. Easier said than done, for sure; but reallocating the money that you would have spent on incentives (an average of $521 per person in the Fortune 500, according to the National Business Group on Health) toward internal cultural improvements or total well-being (as described in Chapter 10) is a start. The wellness chapter will propose that one step toward that goal is to redirect your spending from complex, outsourced, vendored programs involving health risk-oriented assessments and blood draws to internal cultural improvements that say "my company cares about me," even if they don't actually save money. One terrific example of this is Comcast's employee cafeteria. It offers employees a 360-degree view of Philadelphia, along with ambience and food that match those of many fine restaurants. It certainly saves money by enhancing productivity, in the sense that employees have no reason to want to go off-site to eat, and it certainly brightens their day—figuratively and, with floor-to-ceiling two-story windows 50-something floors up, literally. However, these aren't savings you're able to measure directly.

But don't just take my word for this. The next time you're addressing a group, ask people to raise their hands if they've had a health problem that could have been avoided by talking to a wellness coach. Next, ask people to raise their hands if they've ever been the victim of a medical error. You'll get 10 times the number of hands for the latter, and you'll see why *Cracking Health Costs* wants to focus you both on avoiding the errors themselves (through hospital selection) as well as the opportunity for those errors to occur in the first place (through discouraging overutilization of hospitals). Since little of what presents

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people with the opportunity to fall into the treatment trap can be prevented through wellness (and is sometimes itself the result of a wellness-generated health screen, as we'll see), *Cracking Health Costs* follows the money.

Action implication: Save money by curtailing your vendored wellness program, and see if it makes more economic sense to procure a scaled-down version directly from your health plan. Employees should still have access to the program, but don't pay or give them other incentives to coax them into doing something of no inherent interest or value to them. In the immortal words of the great philosopher Yogi Berra: "If people don't want to go to the ballpark, you can't stop them."

Myth: We shouldn't eliminate those incentives. We should raise them and tie them more closely to behavior change like the Affordable Care Act wants us to do.

Fact: Perhaps this might work on your planet. However, here on Earth, while you and your wellness vendors are handing out shareholders' money to people who promise to eat more broccoli, the tobacco and food industries are spending billions to figure out new ways of hooking your employees on their products without them even being aware this is happening.

If you still think incentives are any match for those industries' technological and financial resources, I might suggest reading "The Extraordinary Science of Addictive Junk Food," in the *New York Times* magazine (February 26, 2013). You'll learn that, against your incentives, the junk food industry is pouring billions of dollars into addiction science, studying and exploiting the brain's cravings for sweets and fats that have been evolving since the earliest primates roamed the earth. The wellness industry's counterattack: even *higher* incentives, on the theory that surely there is some amount employers can pay employees to cure an addiction they don't even know they have.

Action implication: Give up on incentives. Or find one reputable behavioral economist who thinks they work.

Myth: Even if a full-blown wellness coaching program is a waste of time and money, we should still get employees to complete health risk assessments (HRAs).

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Fact: Who decreed that HRAs were going to solve the United States' healthcare crisis? For most people, these things are a complete waste of their time and—especially if you pay people to complete them, like many companies do—your money. (The people who wouldn't be wasting their time and might learn something are also the people who don't complete them in the first place.)

Here's how an HRA works: if you smoke, the feedback printout from your HRA will tell you to stop smoking. If you don't wear a seat belt, you'll receive a printout telling you to wear a seat belt. (And, in an ideal world, since almost every car beeps and buzzes until you do, you would also get a printout telling you to test your hearing.) If your employees are so un-self-aware that they don't realize they should stop smoking or wear seat belts until an HRA tells them to—well, then, you probably should have hired different employees.

One other point: people lie on these things. Yes, you know you don't read their responses, but *they* don't know that. (They do know you can read their private e-mails.) You can reassure them of this a thousand times, but odds are that they'll still lie, just in case you are. Think about it—wouldn't you? Especially when the question is: "How many times did you drive drunk last year?"

Action implication: You can take the same approach as you do with the wellness program. Free HRAs can be found online at sites like at www.realage.com. Let people know where to find them, and offer assistance in interpreting results—and leave it at that.

Myth: Fewer healthcare dollars are spent on slender people and nonsmokers over their lifetimes than on overweight smokers. Therefore, our company should incentivize people to enroll in weight loss and smoking cessation programs.

Fact: The facts are much more nuanced than they're made to seem in this oft-cited and oversimplified claim. While healthier people will, on average, spend less on medical care than unhealthy people, this is not true by as much of a margin as one might expect, until people hit the magic Medicare-eligible age, at which point they're not your problem. It also doesn't logically follow from the fact that healthy people cost less than unhealthy people that you can somehow pay unhealthy people to become healthy. By way of analogy, Germans are more productive than Greeks, but no one has suggested that Greece's

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economic crisis can be solved if the European Union pays Greeks to take classes to learn how to behave like Germans. Paying unhealthy people to take classes to learn to act like healthy people is only a slightly less ill-considered idea. Nonetheless, enough benefits managers think that, figuratively speaking, they can turn Greeks into Germans that the wellness industry sells about $6 billion/year of completely ineffectual interventions to corporate human resources departments that fail to appreciate this fallacy.

Action implication: Instead of succumbing to a get-well-quick scheme proffered by a vendor, consider a more measured, less expensive, internally focused approach. Some portion of your workforce does patrol its own health. Another portion is perfectly content being unhealthy and won't change on its own, absent a wake-up call like a sibling dropping dead of a heart attack. In between are people who would like to improve their health but just haven't prioritized it, either due to time or economics. For much less money than it costs to pay everyone to complete a health risk assessment, you could subsidize healthier food choices in the cafeteria. You can take dietary economics a step further by using one of the companies that will subsidize healthy food choices in local supermarkets. Food is like anything else: people respond to economics. If you make healthier food cheaper, people will buy more of it. (It is not clear that they will also buy less unhealthy food, though. Subsidies always encourage overuse.)

Time is often an issue when it comes to fitness. Therefore, bringing fitness to the workers via on-site facilities will encourage more participation than simply paying for gym memberships. One caution borne of experience: company locker rooms need to emphasize privacy. Many people who have no problem getting naked in an anonymous gym locker room will nonetheless balk at the idea of their colleagues seeing them in the buff.

And, as mentioned earlier, if you really want people to improve their productivity and health, focus on the more basic human resources function of reducing stress and increasing happiness in the workplace—hence our exposition of "well-being" as a grown-up version of wellness in Chapter 10. Any other get-well-quick vendor schemes are merely distractions from this much more effective approach.

II: Myths Covered at Length in Other Chapters

Myth: Okay, maybe self-reported data is a waste of time, but blood values don't lie. We should do biometric screenings and encourage diagnostic tests.

Fact: For every story you hear of someone whose risk factors were very high and didn't know it, there are a hundred stories you don't hear of people rushing off to the doctor due to a false positive on some kind of screen or diagnostic. False positives are shockingly common. A lab test with 95 percent accuracy sounds like almost a lock. But suppose you are testing for an asymptomatic abnormality present in 1 in every 10,000 people. Yes, you'll likely find that 1 if you test those 10,000 people; but you'll also get 500 false positives, because 95 percent accurate also means 5 percent inaccurate. In other words, even people who test positive would have only a 1 in 500 chance of actually having this abnormality. Those other 499 will go to the doctor and get followed up on, wasting their time and your money—not to mention adding unnecessary angst to their lives.

There are other drawbacks, too. If you make screening voluntary, the people who won't go to the doctor won't be tested, either. Make it mandatory, and you risk an employee-relations issue. Paying people to be screened helps—except for what turns out to be the very considerable expense, and even then you'll miss exactly the people you want to capture.

Action implication: No more paying people to be screened. Spending the incentive on workplace enhancements instead has the other advantage of not generating taxable income. But after you finish this book, you may not want to be screening at all. . . .

Myth: Don't put off doctor visits and wait for a problem to get worse.

Fact: I've found, while running large company benefit operations, that a huge percentage of impromptu doctor visits are for things that would go away on their own. And primary care doctors to whom I've spoken confirm this claim. If people would apply common sense to doctor visits, we could eliminate a great deal of waste. How many millions of visits involve the common cold, which, as the joke goes, could take a whole week to go away if you don't go to the doctor but only seven days if you do? And some doctors will still prescribe antibiotics for colds, driving costs up further while introducing

unnecessary and potentially harmful drugs into your employees' bodies.

All family doctors have patients who see them for frivolous reasons—individuals who are colloquially known as "frequent flyers." Given the number of visits they make, some of them will inevitably receive a prescription for an expensive medication—and have costly and sometimes risky tests. Why are there so many frequent flyers in healthcare? It's simple: because others—defined as you and me—foot the bill for their visits.

My own experience and observations aren't the only claims evidence that going to the doctor is overrated. According to *American Medical News* (October 15, 2012), the rate of physician visits for adults under 65 fell 19 percent between 2001 and 2010. During that same decade, the rate of emergency room visits and hospitalizations for the five, common, chronic conditions (asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, and diabetes) fell by a similar percentage. While one couldn't infer causality from that correlation, one could certainly infer the opposite: staying away from the doctor doesn't increase one's likelihood of getting sick enough to require emergency or inpatient care.

One "natural experiment"—an experiment for which Al is the country's leading evaluation expert (which is why he is making me cite it three times in this book, so don't roll your eyes at *me* when it comes up twice again*)—did, in fact, determine that increased access to physicians increases cost without reducing emergency and inpatient care. At considerable taxpayer expense, North Carolina has steadily and dramatically increased physician access for its Medicaid enrollees since the late 1990s, while South Carolina hasn't. And yet, for overall hospitalizations, as well as for the set of conditions that the government says are most responsive to outpatient care, South Carolina Medicaid's admission rate has performed better than North Carolina's since 2001. Note that Medicaid recipients are historically considered to be the most in need of access, which indicates that if any population could benefit

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* Also, just before we went to press, the state, acknowledging that Al was right and their high-priced name-brand consultants were wrong, announced their intention to scale back or even dismantle the program. Unfortunately, we need to score one for Al. I say "unfortunately" because he was already insufferable enough on this topic before this happened.

from increased access, they certainly could. Even so, it appeared more likely than not (though not statistically significant) that physician visits were at least to a slight degree driving hospital admission rates higher rather than preventing them.

Action implication: Don't incentivize people to go to the doctor; they'll do it plenty on their own. This includes so-called preventive visits, which as renowned Reuters health/science writer Sharon Begley observed (January 29, 2013), don't prevent much at all.

Myth: If something is seriously wrong with an employee, especially a C-suite employee, that person should have access to the best hospitals in the country, as measured by *U.S. News & World Report* or *Consumer Reports* surveys.

There are three kinds of goods and services. You can judge the quality of one kind before the fact, like a couch. That is, you buy a couch after you sit on it in the showroom and decide it's comfortable. The second kind is experiential: you decide whether a restaurant is good after you eat there once or twice. Healthcare uniquely occupies a third category: a service whose quality you often can't measure even after you've experienced it.

Consequently, these reputational surveys of users (or, in the case of *U.S. News*, mostly nonusers) correlate only loosely with a hospital's actual quality. Why should a large hospital in a big city automatically be considered high-quality merely because people have heard of it? This is why we devote a chapter to hospital quality and why it should matter to you. We highlight some of the best hospitals you've never heard of and show you how to cost-effectively add them to your network.

III: Myths that End Here

Myth: Disease management will help you save money by keeping sick people out of the hospital.

Fact: If wellness is defined as attempting to make your whole company healthier, disease management (DM) is focused on individuals with identified health issues. As with wellness, there are a few success stories of people who really don't know how to manage their condition and, hence, benefit from disease management. The differences—and why DM has intrinsic merit, even if insurance carriers and vendors oversell it—are that DM programs (1) focus on people who

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already have major health issues and (2) don't throw money at people in an attempt to bribe them into getting better. As a result, DM should more than pay for itself.

But intrinsic merit is not enough for your carrier and/or vendor, which will almost inevitably show you massive savings from DM using their "reconciliation methodology," which they (with approval from your consultants) have designed to overstate savings. The reason for this overstatement can be best described via analogy. Suppose everyone who had a past medical event is a "heads" while people who, unknown to you or them, are at risk for their first medical event are "tails." Last year, the heads were much higher cost than the tails, specifically because they had a medical event. Vendors and consultants only measured the heads—the people they knew about—and half of them would flip to low-cost tails on their own. So lots of heads are shown going from high-cost to low-cost, which overstates the savings by ignoring the people flipping the other way. In all cases, the reconciliation methodology measures only the previously high-cost people. Sometimes "high-risk," "complex," or "identified" replaces "previously high-cost," but those are all just synonyms for "a group whose costs will come down on their own even if you do nothing, the same way some heads will flip to tails."

Only the downward regression to the mean is baked in, because it's almost impossible to predict the opposite: which people who were too low-cost to be found in your database will nonetheless have a major medical event. If you had a magic transponder to pinpoint the people you can't find because they don't have claims but who were going to have an event nonetheless, you could offset the savings from the high-cost people declining with the added expenses of previously low-cost people having events. But you don't have a magic transponder—so the savings are made up. The arithmetic behind this observation is outside the scope of this book, but is covered in *Why Nobody Believes the Numbers*.

Action implication: Vendors and consultants generally want you to pay a per-employee-per-month fee for these services, and/or pay for everyone who doesn't actively opt out. However, it is much cheaper and equally effective to simply pay for the people who most want to use the service, instead of forcing people to tell you that they don't want it. The folks who opt in should benefit—cost-effectively from your point of view—from the added information and support.

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Myth: The 10 percent of people with chronic disease account for 80 percent of your health spending. Managing them is the first step toward controlling your overall costs.

Fact: There are certain facts you need to commit to memory, the kind of facts you need to have at your fingertips, because in this hypercharged, dog-eat-dog survival-of-the-fittest economy, they give you a major advantage over competitors and coworkers who don't know them. However, this "10/80 rule" is not one of those facts. It's more like the opposite, the kind of cliché people spout when they want to sound smart but don't actually know anything. Here's the upshot. First, that 80 percent canard covers *all* costs incurred by people with chronic disease, such as someone with asthma having a baby. Second, that 80 percent also covers people whose chronic diseases are not the usual cardiometabolic ones but are rare diseases that they control using specially developed "orphan drugs" at great expense. There's little you can do to reduce that expense further, because it's already driven by preventive medication.

Third, speaking of prevention, a huge chunk of this 80 percent generally is already being spent on drugs and other preventive measures. For instance, you are spending literally 10 times as much on drugs for asthma as you are spending on emergency room and inpatient claims for asthma. And yet consultants keep telling you to spend even more, in order to reduce emergency room visits still further. What they won't tell you—because they've never done the straightforward math—is that you'll spend about 10 times as much to prevent additional ER and inpatient use by asthmatics not already taking their drugs than the occasional "crash" would cost. You have to medicate a lot of unmedicated mild asthmatics in order to prevent a single one from crashing. Because doctors (and certainly disease managers) can't predict who is going to have an attack, they often medicate people only *after* they've had an attack on the statistically surprisingly unlikely theory that they are going to have another one, rather than beforehand when it would have done some good. In that sense, trying to predict and prevent asthmatics from going to the ER is a bit like whack-a-mole. And as with most other overtreatment and overprevention issues, it's not just the expense. It's all those drugs being introduced into people's bodies, day after day.

I'm not saying you should discourage asthmatics from taking their drugs. I'm simply suggesting that you should avoid incentives that interfere with, or attempt to outthink, the natural doctor-patient relationship when it comes to drugs for diseases like these. Doctors will overprescribe plenty on their own, without prodding from you.

Fourth, that 80 percent was spent on *last year's* 10 percent—people who won't overlap much with this year's 10 percent. Once again, a whack-a-mole situation—you'll be focused on last year's high utilizers. Worse, if you find a vendor to manage last year's 10 percent, it will claim credit for the reduction in its costs, which, of course, would have fallen anyway as others take their place in this year's 10 percent generating the 80 percent.

This classic vendor trick of saying "send us your sickest patients and watch us reduce their costs" has been around in one form or another for almost 20 years. Yet it still seems to work, as benefits departments have almost no institutional memory.

There is, however, one situation where addressing the 10/80 rule works, and that's where you identify some of those 10 percent *before* they incur their costs. Not through predictive modeling, which is bogus enough to earn its own entry as the next myth, but rather through referrals to Company-Sponsored Centers of Excellence (CSCOEs), the use of which proactively prevents some of those costs. CSCOEs are an important enough part of the solution to merit their own chapter.

Action implication: Commit this section to memory, as the 10/80 rule comes up time and time again in one form or another and is always wrong. Show the door to any vendor that promises to reduce costs for people who are high-risk, high-cost, complex, or any adjective derived from last year's spending.

Myth: Predictive modeling can identify the people who will benefit from our interventions.

Fact: If there were a reality show to pick healthcare's biggest fraud, the runner-up to wellness would be predictive modeling based on claims data. The only question about debunking predictive modeling is where to start. To begin, consider two people with identical amounts of plaque in their arteries and other risk factors. The first is on medication and has had a stress test and therefore—since you need a test, procedure, or event to get a heart disease diagnosis—has been

identified as a heart patient. The other hasn't been to the doctor for a preventive physical in 20 years.

The second person is far more likely to crash. However, the predictive model will pick up only the first—ironically, largely because that person is patrolling his health closely enough to seek a diagnosis and treatment. It will recommend that you focus disease management on that person, which we know is the exact opposite of what should happen. This second person is not hypothetical: I just described television journalist Tim Russert, fitness revolution leader Jim Fixx, and any number of other people who simply dropped dead from sudden heart attacks but who never would have been predicted to do so by a claims-based model for the simple reason that they didn't have any claims. (Jim Fixx, for one, was in total denial of doctors' advice he had received before he starting running.)

Next, assume you do go to the doctor, who examines you, tests you, and tells you your risks. They are just that: risks. Even your doctor can't give you a "yes" or "no" on whether you are going to fall victim to a heart attack, let alone when. If your own doctor can't predict that you'll have a heart attack or other event, how can someone who has never even met you do so simply by looking at your medical claims? Oh, and did I mention that these medical claims are usually three months out of date? And that while these medical claims summaries do indicate whether someone has had a lab test, they don't disclose those tests' results? How useful is the former without the latter? It would be like a contestant on *Let's Make a Deal* knowing that there is something behind Door Number One but having no clue what it is—and then trying to use it as collateral.

Action implication: If someone wants to sell you a predictive model, give him last year's data and see how well he would have predicted this year's utilizers. Since anyone can straight-line last year's high utilizers to predict some of them to be this year's high utilizers, too, see how well the model predicts the low-to-high utilizers. *That* is true prediction.

Myth: On-site clinics will reduce your medical spending and increase your productivity because employees don't have to go off-site to the doctor.

Fact: The good news is that, unlike most of the other myths in this chapter, this one is not obviously a total fallacy. If you substituted on-site medical visits for trips to the doctor on a one-for-one basis, you'd certainly save money, because the latter cost much more than the former.

But in real life using this approach increases total physician visits, for various reasons: the visits are usually free, the doctor is right there, and many people would rather go to the doctor than do their jobs. Still, even if doctor visits climbed somewhat, you'd be ahead of the game if the cost savings/visit offsets the extra utilization. "Somewhat" is a vague word, specifically because the actual break-even number of extra visits depends on many factors: what you pay now per visit; how many of the new visits generate prescriptions and specialist referrals; whether you pay employees their hourly rate to miss work for doctor visits; whether they will make up the lost work on their own or you'll have to pay someone to do it; or how acutely the person's absence will be felt, like in an inbound call center, where short staffing can increase hold times.

Very few consultants and self-insured organizations actually run the numbers on these variables. Instead, they simply compare the cost per visit for off-site, to the cost per visit for on-site, as Wisconsin's Beloit School District did. As reported in the *Beloit Daily News* (September 4, 2012), the district saved about $419 on each of the 670 on-site clinic visits by its employees versus what it would have spent if they had gone to the doctor for those same visits. According to this logic, each additional visit to an on-site clinic saves about $419; therefore, more visits generate more savings. This logic is a little like Subtraction Stew in *The Phantom Tollbooth*, where the more you eat, the hungrier you get. (A savings of $419 per visit also suggests the district needs to renegotiate its existing physician contracts.)

While it is not clear—and it will vary by situation—whether on-site clinics save money, we do know three things for certain. First, on-site clinics won't help you manage your chronically ill employees much, if at all. You'll learn this if you try getting an on-site clinic vendor to go "at risk" for chronic disease events. The vendor will make all sorts of marketing representations but won't guarantee a reduction in those events in the contract. And for good reason: while many employees would stop by an on-site clinic for sprained ankles or an acute illness, few want your doctor involved in their ongoing health issues.

Second, it boggles the mind how many vendors will try to pitch on-site clinics in decidedly subscale workplaces that may only have 500 or 1,000 employees on-site. Consider a grouping of 1,000 employees. Figure half will prefer their own doctor even if the on-site doctor visits are free. Half of the remaining half will only use on-site clinics for urgent

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care needs during work hours, and/or won't want to discuss their ongoing personal issues with a doctor their employer is paying. Once you remove those potential visits from the mix, you don't have enough visits to cover the cost of the clinic. And this assumes that remaining quarter works the day shift when the clinic would be open.

Third, there is some good news. The exact issues that make on-site medical clinics questionable are what make on-site *dental* clinics a winner. While some people may prefer going to the doctor to going to work, no one prefers going to the dentist to anything not involving the IRS or their exes. This means that you won't generate extra visits, and dentists rarely prescribe or refer to specialists (and when they do, it is likely needed, if not overdue), so you won't generate extra ancillaries. You still have an economy-of-scale issue, though, which doesn't go away unless the dental clinic vendor can offer less than full-time care. Onsite Health (www.onsitehealth.com) is one vendor that does this; it allows employees to schedule dentist appointments a few days per week or month when either a mobile dental practice or a fully self-contained portable dental unit is on-site. With the rare exception, such as an abscess, dental issues are typically unlike medical issues in that even most urgent ones can wait a few days. A toothache isn't going to get better on its own; but your employee will almost never crash from it, either.

There is even a unique second high note in this myth-busting chapter: dental or medical, a clinic tells your employees you care about them. And remember the mantra from earlier in this section: make your investments in employee health visible and convenient, because you are trying to create a workplace that tells your employees they matter. Despite the other controversies surrounding them, clinics are visible and convenient.

Action implications: First, poll your employees to gauge interest and only enter into a contract if you are at scale, based on employee count and interest. Second, when measuring outcomes, don't use Beloit's Subtraction Stew approach. Count total doctor visits—on-site and off-site—as well as cost per visit, and compare to the baseline numbers for both. And don't overlook the hidden costs of physician visits at either site—prescriptions, tests, and referrals coming out of these visits. The true cost of a physician visit takes into account these downstream effects, as one clinical provider, We Care TLC (www.wecaretlc.com), does. Finally, check into dental as an alternative or complement to on-site medical.

We Care TLC: A Standout in the Field

Like most of the categories covered in *Cracking Health Costs*, there is no shortage of vendors for corporate medical clinics. Different vendors will fit different needs, but we are highlighting We Care TLC.* While this program—along with every other vendor in every other category—will itself offer multiple reasons it is unique, we like it because one of the principals, Brian Klepper, is also a reimbursement expert (quoted at length later in the book on that topic). Brian embedded mechanisms in his clinics' management controls and physician contracts to prevent patients from falling into the "treatment trap"—that is, receiving inappropriate and unnecessary referrals from their clinics to overpriced, perversely incentivized specialists and surgeons. And the We Care clinics themselves include all services (such as lab tests) on an all-in-one-price basis, which means that their incentives are aligned with yours as the buyer and, hence, quite consistent with the model we espouse for providers generally.

Myth: Access to a 24/7 nurse triage line will reduce emergency room visits.

[Pause.] Sorry about the delay there. I was laughing too hard to write. First, have you ever counted your ER visits before and after implementing this program? I'm guessing you haven't—so go do that now. [Pause again while you do this.] Notice any reduction? I didn't think so. (If there is a reduction, I'd be willing to bet that you raised copays along the way, too, which is the main reason ER visits are declining.) The nurse triage line vendor's job is to *pretend* that you reduced ER visits. Vendors do that by showing you a report that says "here's what people say they would have done if they hadn't called this

* Note that a "highlight" is not an endorsement. This book doesn't "endorse," where endorse is defined as, "We have reviewed all the vendors and these folks are the best." Rather, "highlight" is more like: "We know this vendor and believe it to be worthy of a serious investigation in most situations, but we can't guarantee that you won't find another vendor whose offering in the category in question fits your needs better."

line," with some large number of people claiming that they would have visited the emergency room.

Al once did a forensic review of a case in which the number of people saying they would have visited the ER was actually quite a bit larger than the actual number of emergency room visits the year before the program started. Additionally, the number of ER visits didn't decline at all after the program was implemented. So the vendor's claim was impossible two different ways: the number of ER visits they claimed to have avoided exceeded the number even available to be avoided, and the program had no impact, anyway.

Second, focus for a minute on what you paid for this service per-employee-per-month versus the number of times you (or your employees) use it. Look at the aforementioned vendor report. Did your vendor do the obvious math and divide the annual fee by the number of phone calls to calculate your cost per phone call? Once again, I didn't think so. If you do this math, you'll see that these 10-minute phone calls cost you about $100 apiece. In one case, so few phone calls were made that the employer would have spent less if there was no phone option and every caller simply went to the ER instead. In another case, a major health plan executive (finally) did the math for its $7 million a year program, and told its vendor: "I've just reviewed the data for the last three years and concluded that you've basically stolen $21 million from us."

Third, these people have liability issues, too, you know—and those liability issues often *increase* ER visits. Al had the following unpleasant experience upon calling a 24/7 nurse triage line one morning when he woke up with vertigo. All he wanted was answers to a couple of questions and a physician referral. Five minutes later he found himself in the back of an ambulance. Apparently there is a 1 percent chance that vertigo signals a stroke—and although he's a triathlete and Ultimate Frisbee player with zero risk factors for stroke, they had to rule out that possibility with a $2,000 ambulance ride to the $1,000 ER. These vendors often brag during their sales presentation about how they've never been sued—and this is why. No matter what the cost to you or the inconvenience to your employees, they don't take chances.

This is not an isolated story. I once installed a nurse triage line for a company and saw the ER visit rate go way up afterward. Problem was, it's easy and nearly risk free to the vendor to recommend an ER visit to callers. It was also profitable for the vendor, as the call times went way

down, as well. Obviously the program was cancelled quickly, because we had the sense to run the numbers. You might suggest to your consultants that they dust off their calculators and try it sometime.

Action implication: Review your reports, do the arithmetic, and then take the following step: change the vendor contract to per-call pricing, at about $30 a phone call. You'll save about 70 percent with no negative impact on employees.

Myth: Maybe 24-hour lines are a waste of money and our employees don't use them, but our healthcare advocacy lines are a valuable service. Our employees use them.

Fact: Unlike calls to 24-hour lines, which at least end with an action step for the caller, those healthcare advocacy "incoming call" figures are hugely inflated by calls from people who didn't get what they wanted. For instance, my friend Bob called to find an oncologist for his mother, who lived across the country. The list he got was form-generated. He could have gotten those names online, and, in any event, none of them took Medicare.

Bob's wasn't a sensitive personal issue, but when employees really do have a personal health issue, do you seriously think they are going to call people who you don't just pay, but specifically pay to control your health spending? To tell these people their depression has gotten worse? To ask where to get an HIV test? Obviously you and I know that these healthcare advocates aren't making a list of these calls and emailing it to your board of directors, but your employees can't be sure. Someone calling one of these numbers has a lot on his mind and does not feel the need to add job insecurity to that list. Also, most of these numbers are available only during business hours, so people would need to call from their cubicles to discuss their prostate test results? I think not.

The way you can tell your services aren't being used is by looking at the massive growth in private, standalone B-to-C health advocacy services, which are usually local to an area and don't work through employers. They often send someone to the home, after hours, to have the conversation. (An example would be www.pathfindersmedical.com, if you'd like to get a closer look at true health advocacy. They were the ones who ended up finding Bob's mother a suitable oncologist by working through a network of other advocates.)

So if you want to be helpful, drop the per-employee-per-month subscription service that you're using now. You aren't just paying for a

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service that's not appreciated. You're paying for a service that your employees actively don't want you to provide. Surely there are better ways to spend that money. It would be hard to imagine a worse one.

Myth: As a cost reduction strategy, auditing is soooo pre-millennial. These days automated software and the carriers/TPAs take care of finding overpayments/ineligible employees, and so on, so there's no reason to pay for it.

Fact: Auditing of eligibility, claims, workers compensation bills, stop loss, and vendor programs can reduce annual healthcare costs by 3 percent or more. For example, a recent audit of "hours worked" identified 3 percent of employees as ineligible for medical benefits since they failed to meet the "minimum hours worked" requirement. In another example, nearly $500,000 was erroneously paid because a TPA didn't realize that an employee on dialysis had become Medicare-eligible.

But don't take our word for this opportunity. There is at least one vendor—www.HRbestpractices.com—that not only takes contingency payments for audits but also leaves the savings calculation on which the contingency payment is based completely in your hands. You can stiff them for any reason—you can tell them it's because the Yankees (pick one) lost/won/were rained out—and there's not a darn thing, contractually speaking, they can do about it. The fact that vendors willing to do this even exist means that auditing should be a gold mine for you.

As Benefits Administrators, What Should We Do Next?

Read the remaining chapters. The action steps in this one are easy because they primarily involve doing less of things that don't work. They require no budget—and honestly, most employees won't even notice these changes (unless your incentive payment to complete HRAs was so high they count on it every year, in which case you'll need a communications plan to disengage gently). Part I, "Mostly Bad News," recommends clearing your plate of worthless interventions and creating a pool of resources so that you will be well-positioned to get the most out of Part II, "Mostly Good News."