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CFO Insights
Bending the cost curve on health care

With the U.S. Supreme Court's blessing and the security of the 2012 election results, the Patient Protection and Affordable Care Act of 2010 (or ACA) is rolling out nationwide. And while many of the law's major components—the mandate to buy insurance and the expansion of Medicaid, for example—take effect in 2014, others do not kick in for several years.[1] That does not mean companies should be complacent about the law or their health-care costs—not by a long shot.

In fact, while the exact impact of the ACA on health-care costs remains uncertain, it's clear that those costs will continue to go up faster than the general rate of inflation and business growth. Chief financial officers (CFOs) agree: in the third quarter of 2012, about 70% of U.S. CFOs in our *CFO Signals* survey expected their company's health-care costs to rise as a result of health-care reform, and many pointed to a 10% increase.[2] Those increases are expected to be across the board—deductibles, co-pays, penalties for noncompliance, and out-of-pocket maximum expenses.

To contain them will require more than the steps companies have typically taken, such as the move to consumer-directed health-care plans, which are now offered by almost 60% of large companies.[3] It will require companies—and in particular, their CFOs—to take charge of their health-care costs and manage them like others in their financial planning and analysis (FP&A) process. In this issue of *CFO Insights*, we'll dissect health-care costs and ask what CFOs can do to limit those costs now.

Target: waste and wellness

In the Q3 2012 *CFO Signals* survey, finance chiefs overwhelmingly said that despite the ACA, their companies would maintain current enrollment levels and/or maintain the levels and scope of benefits they provide. Just 2% said they were considering limiting coverage to the legal minimum, and none were considering dropping employer-sponsored coverage and paying the applicable penalties.[4]

Those findings, of course, were tallied before the ACA took full effect. But while large companies have normally had the option of dropping coverage, the ACA does not substantially improve that option. One of the major provisions of the law—the creation of the health insurance exchanges—may be unveiled next year, but those exchanges will initially be for individuals without access to health insurance or companies with 50 or fewer full-time employees. It won't be until 2017 at least that states may choose to allow larger companies (>100 employees) to purchase their plans through the exchanges.[5]

In the meantime, health-care costs will inevitably add up. According to the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary, national health spending increased 3.9% in 2011—the third year health spending overall came in under 4%, compared with annual increases of 6% or higher during the previous decade.[6] But that 3.9% doesn't tell the full story, such as the cost shifting that produces a "hidden tax" when the shortfall on Medicare and Medicaid costs is borne by commercially insured employees. Moreover, other trends, such as medical innovation and increasing longevity, will also increase costs.

Up until now, companies have tackled the problem with three main tactics: pushing as much cost onto employees as possible, slimming programs down, and experimenting with wellness options. But those tactics have not produced the results envisioned—or desired. Going forward, CFOs should instead target the costs at their roots—in the areas of waste and wellness—and be prepared to back up their actions with data.

Waste. The truth is that 30% of the medical care provided in the U.S. system is unnecessary.[7] Part of the problem is the fragmented purchasing habits of many medical facilities and the lack of incentives for cost-effective care. But much of it involves unnecessary care and regional price disparities. Take the recent study conducted by *The Journal of the American Medical Association* that looked at hip replacements done in 122 U.S. hospitals. It found that the price-point differences were 10-fold—ranging from $1,000 to $126,000—for the same procedure done in the safest and highest-quality hospitals.[8] Similar evidence can be found for knee replacements, bariatric surgeries, and a host of other procedures where little or no evidence exists as to a) the necessity of the procedure and b) what the high- and low-cost options are if the procedure is indeed required. For CFOs, getting a handle on such costs and managing them is beyond what many companies have done, but it can be vital to containing costs going forward.

Wellness. Despite the attention given to wellness and disease management, these programs provide mixed results. Sometimes, they're structurally flawed, rewarding those already inclined to healthiness. Sometimes, they're not focused: understanding which employees and what behaviors require change is a precursor to effectiveness. But perhaps the biggest limitation on effectiveness is that the programs seem to lack teeth—there are no consequences for noncompliance. Employers are too frequently timid about making healthiness a company priority that requires serious investment to improve presenteeism and productivity, enhance recruitment and retention, and reduce health costs. To make wellness a core value, plans should be top down, reinforced by benefits design, and mirrored by the lifestyles of those in the C-suite. Otherwise, education about using less salt in diets, exercising more, and taking medications is simply wasted effort.

Overhaul: focus on the data

To get a better handle on both waste and wellness, though, means identifying certain health-care data points. And that should require a new dynamic in the way finance works with human resources (HR). After all, CFOs may be concerned about costs, but they may not know enough about the health-care system to pinpoint where fraud and cost overruns occur. While chief human resources officers (CHROs) may be technically in charge of "fixing" health costs, they can be equally unprepared and more concerned about doing anything that may impact their ability to hire employees and compete for talent.

To change the dynamic should require scrutinizing health-care costs the way finance would scrutinize other costs. Some specific questions that CFOs should ask their CHROs include:

Have you analyzed not just the organization's claims experience but its clinical value? As CFO, do you really know how your workers are spending their health-care dollars and what they are getting for the money? Of those who had a hip replacement, for example, how many actually required them? What were the costs associated with those procedures? What were the protocols pre- and postoperative? From knowing the complications and outcomes of certain cases, CFOs can identify how much was misspent both from unnecessary procedures and for paying more for procedures done in high-cost settings. After all, it's the fiduciary responsibility of the CFO to assure stakeholders that resources are used appropriately and efficiently, and that applies to health care as well.

Have you modeled the demographic of the company? Similar to how the FP&A process breaks down operating costs, HR should model health-care costs going forward. Specifically, the first step should be to get detailed census data. Then, from that data, model out what percent of the population is benefit eligible; what percent will be benefit eligible under the new ACA rules; and what percent may potentially qualify for subsidies on an exchange where employees may or may not be better off than on the employer plan. Such details help create a health profile of your workforce and can help finance better tailor the benefits and rewards offered.

Do you have the data you need? Some of the data required to analyze health-care cost utilization sits in corporate payroll and Human Resources Investment Fund (HRIF) systems. Retrieving it might mean aggregating from multiple sources, but the data is there. Still, to get to waste and necessary care, you need clinical information. You've got to know how patterns of care for diagnosing and treating are done and who does it better and at what cost. You will not get that from a third-party administrator, nor from many insurance companies' claims records. You have to get that information from clinical databases, which sit in hospitals and medical practices. Clinical data from the hospitals and physicians you pay, and the plans you contract with, is your data, and a CFO should be first in line to request access. Some may contract with a benefits consultant to assist; others may secure help from a university researcher. But the point is this: accepting at face value the notion that lag indicators of utilization and cost trends are the way to forecast future requirements can be flawed thinking. For CFOs to manage health costs effectively, they should become students of the industry and make a personal investment in understanding the issues that have made it historically costly and inefficient.

Different perspectives: What influences health-care costs?

	CONSUMERS (2012)	PHYSICIANS (2013)	EMPLOYERS (2012)
1	Hospital costs 59%	Consumer behavior* 82%	Hospital costs 80%
2	Fraud in the system 55%	Defensive medicine* 71%	Consumer behavior* 67%
3	Insurance administrative costs* 52%	Hospital costs 67%	Prescription drugs 66%
4	Prescription drugs 48%	End-of-life care* 67%	Insurance administrative costs* 62%
5	Consumer behavior* 46%	Insurance administrative costs* 58%	Government regulation 60%
6	Defensive medicine* 43%	Prescription drugs 57%	New technologies & equipment 59%
7	Government regulation 41%	New technologies & equipment 49%	Fraud in the system 50%
8	Payment incentives 37%	Government regulation 48%	Overuse of surgery** 50%
9	New technologies & equipment 36%	Payment incentives 41%	Payment incentives 45%
10	Overuse of surgery** 31%	Overuse of surgery** 21%	Defensive medicine* 34%
11	End-of-life care* 31%	Fraud in the system 21%	End-of-life care* 31%

*Denotes items with minor wording variations between consumer, physician, and employer surveys **Employer survey asked "over-utilization of testing and surgical procedures"

Deloitte Center for Health Solutions. 2012 Health Care Consumer Survey; Deloitte Center for Health Solutions. 2013 Physician Survey; Deloitte Center for Health Solutions. 2012 Deloitte Survey of U.S. Employers: Opinions about the U.S. Health Care System and Plans for Employee Health Benefits.

Rx: What else can be done?

Aside from pushing their CHROs and data providers on this subject, CFOs have other ways to create a culture of cost containment. These include:

1. **Hire internal medical experience.** Currently, there are numerous chief medical directors (CMOs) working in Corporate America. Their job is to look at long-term patterns of care and advise the C-suite on both waste and possible improvements. But while not every company has the available funds to hire a CMO and empower him or her to take appropriate actions, there is plenty of evidence that having a primary-care gatekeeper can drive lower utilization of specialists and hospitals, improve outcomes, and reduce costs. To fill that role at a lower cost, CFOs may consider hiring a nurse practitioner or leasing a primary-care doctor, since they, too, know the power to overreach in a physician's orders.

2. **Make wellness programs mandatory.** Currently, many wellness programs are voluntary and contain few penalties for noncompliance. For example, a company may offer financial rewards for diabetics to comply with a treatment protocol, but that policy is not enforced. Or companies may encourage employees to use a facility that does, say, cardiac stent implants exceptionally well, but they still reimburse if employees go elsewhere. Until meaningful carrot-and-stick approaches—such as saying deductibles will double for noncompliance—are implemented, employees will rarely take personal responsibility for lifestyle choices that drive health-care costs higher, and it is up to finance to enforce those approaches.

3. **Join a hospital's or insurer's board.** Finally, as CFO, there are ways to get better educated about health-care costs firsthand. After all, many companies operate in areas near hospitals, and many hospital boards may welcome additional financial experience. Reach out to your local hospital's or insurer's board chairman and inquire about opportunities, or work with your executive recruiter to see what possibilities might open up. A seat at the table, in this case, can be a lot better than leaving your shareholders' money on it.

Avoid the fast-follower approach

From our client work, it appears that many companies are in a holding pattern for 2014. What's more, many are waiting to see how other companies tackle both ACA and health-care costs. But such a fast-follower approach may be unwise. There are no guarantees that companies will be able to leverage medical exchanges by the end of the decade. In addition, it is unlikely that court challenges or legislative rebuffs will give companies a free pass. Still, what's clear is that armed with information—the correct information—about medical care, treatment, and prevention, CFOs can get a handle on their health-care costs, and, more important, help reduce those costs starting now.

Endnotes

[1] Patient Protection and Affordable Care Act, Public Law 111-148, 111th Congress, March 23, 2010.

[2] North American CFO Signals survey, Q32012; U.S.CFO Program, Deloitte LLP September 2012.

[3] "Performance in an Era of Uncertainty;" 17th Annual Employer Survey on Purchasing Value in Health Care, 2012; Towers Watson and the National Business Group on Health, 2012.

[4] North American CFO Signals survey, Q32012; U.S. CFO Program, Deloitte LLP, September 2012.

[5] "For Small Businesses: The Facts on the New Health Care Law," U.S. Department of Health and Human Services, January 2012.

[6] "National Health Expenditure Projections 2012-2021;"Centers for Medicare & Medicaid Services (CMS) Office of the Actuary; January 2013.

[7] "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America;" Institute of Medicine of the National Academies, September 2012.

[8] "Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure." The Journal of the American Medical Association (JAMA); Internal Medicine website; February 2013.

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