Governance, Risk and Compliance Management Strategies for Self-Insured Health Plans
How Senior Executives Can Use Healthcare Performance Management as a Business Strategy
Executive Summary

In this report, we examine how Healthcare Performance Management (HPM), combined with self-insurance, can empower organizations not only to better manage their governance, risk and compliance exposures, but also to deliver bottom-line business value to a company. By applying the right people, processes and technology to those three focus areas, HPM can empower companies to execute a powerful business strategy that can reduce healthcare costs while also improving employees’ health outcomes.

The first step rests with how companies choose to deliver health benefits to their employees. There are two ways that organizations can provide coverage: through fully insured plans, in which they purchase coverage from an insurance company, or through self-insured plans, in which they directly cover employees’ healthcare expenses.

Self-insurance recently has become the option of choice for a majority of the workforce. In 2008, the nonprofit Employee Benefit Research Institute (EBRI) found that 55 percent of workers with health insurance were covered by a self-insured plan. The decision to self-insure has been embraced enthusiastically by large corporations — 89 percent of workers employed in firms with 5,000 or more employees were in self-insured plans in 2008.

By self-insuring, employers can control the costs of providing health benefits to their employees because it allows them to:

- Obtain more specific information about their actual healthcare expenditures.
- Control costs, because instead of paying health insurance premiums that typically rise 9 to 10 percent per year, they can pay for routine expenses such as doctor visits, procedures and prescription drugs through a self-insured plan, obtaining lower-cost catastrophic or “stop-loss” policies to cover major medical events.
- Enable better “human capital management” by recognizing in advance what types of health events are emerging in their covered population in time to help employees avoid a catastrophic event.

“But the benefits of self-insurance can be realized only if the process is actively managed through the strategy of Healthcare Performance Management (HPM),” says George Pantos, executive director of the HPM Institute and former deputy under secretary at the U.S. Dept. of Commerce.
“Traditionally, health insurance has been treated as a compensation or benefits issue that was almost solely within the purview of the human resources department. HPM represents a shift in that paradigm because it enables a set of processes and procedures that engages key players within the organization,” he explains.

An HPM strategy has profound implications for senior management in the three critical areas of governance, risk and compliance. This manifests itself in the following ways:

- Governance requires the active engagement of business units beyond human resources — strategic planners, financial and operations executives, and the IT group.
- Self-insured firms must manage their own risk, so access to real-time data that is tied to the plan is imperative.
- Although corporations have dedicated resources to compliance activities, an HPM system is automated and therefore can deliver those required reports as an ancillary function. This way, organizations can generate the necessary documentation for auditors, regulators and others without devoting valuable resources to that single function.

“By putting the right people, processes and technology in place around each of those areas, companies can cut costs, reduce risk, improve governance and compliance, achieve strategic insight into potential risks, and improve the health of their employees,” says Stuart Hersch, President and CEO of Cantor LifeMarkets.

This is a view supported by Todd C. Thompson, chief technology officer (CTO) for the Financial Services & Human Capital line of business in Lockheed Martin Corporation.

“There are so many opportunities to improve the quality of healthcare, to manage services proactively, to provide better services for the employees at a more aggressive price,” he says.

But in order to do that, organizations need to develop a sophisticated set of policies that are proactively managed by employers with an interest in reducing costs and improving outcomes.

Thompson said that there needs to be a clear view into the plans – when to engage them, as well as when engaging them would be counterproductive. “We have to develop procedures for actively monitoring the use of healthcare management resources and to establish guidelines [governance] on how frequently we assess the services that are being provided,” he said. “And finally, we have to be prepared to adjust these strategies as we better understand the needs of our constituency. The bottom line is that the more proactively and responsibly these programs are governed and managed, the more effectively they can be targeted and executed to deliver value.”
The Benefits of Self-Insurance

If 55 percent of all organizations and 89 percent of companies with 5,000+ employees have embraced self-insurance, there has to be a compelling value proposition. According to the Self-Insurance Institute of America (SIIA), these are some of the significant benefits to employers who choose that approach:

- The ability to customize a health plan to the specific needs of its workforce
- Employer control over the health plan reserves, which maximizes interest income
- Better cash flow, because the employer does not have to prepay for coverage
- Exemption from conflicting state insurance and benefit level mandates, since self-insured plans are regulated under the Federal Employee Retirement Income Security Act (ERISA)
- Exemption from state health insurance premium taxes (usually 2 to 3 percent of the premium’s dollar value)
- Freedom to contract with any provider or provider network
- Self-insured employers have the option of administering claims in-house or subcontracting to a third-party administrator (TPA).

The first step for most employers — particularly large companies — as they seek to gain better control over their health insurance costs, is to recognize that they likely are wasting money by being fully insured.

“The next step is more challenging,” says David Feinberg, co-president at WellNet Financial Group. “Now that you are the self-insurer of record, how can you take the information that is coming into your business and your health plan and use it strategically to improve your employees’ health?”

That determination requires a great deal of medical expertise, which is not commonly available in most organizations. In those cases, companies that make the decision to become self-insured are best served by finding a partner with the necessary expertise to help them measure and manage the information, as well as the expenses.

Effectively Managing Governance

Over the past decade, corporate governance practices have attracted growing scrutiny. Since passage of the Sarbanes-Oxley Act — fueled by congressional rage over the collapse of U.S. corporations such as Enron and MCI at the beginning of the decade — scrutiny has gotten even more intense, especially after the economic crisis of 2008. Oversight has turned up the heat on the processes and policies that define the way organizations are run.

“Governance [consists of] the internal rules that organizations put in place to determine how to manage their processes properly to achieve business objectives while complying with key regulations and mandates,” says Pantos. “The governance of a corporation generally starts at the highest levels — the CEO, CFO and board of directors are primarily and legally responsible for the governance of the company.”

Surprisingly, while health benefits are often the second or third largest line item in a company’s budget, the senior leadership typically has been left out of the process of managing those expenditures. In effect,
they have outsourced this important function to insurance carriers, and relegated the management of this relationship to the HR department.

This approach can pose problems, since senior managers have a legal fiduciary responsibility to manage the corporation in the interest of shareholders and employees. Specifically, CEOs have a fiduciary obligation to protect the assets of their companies and set procedures in place to preserve those assets — a significant proportion of which are used to purchase health insurance for employees. HPM is a tool that senior executives can use to manage those assets more effectively.

"The first step in addressing these governance issues is to realize that effective management of health benefits extends far beyond the HR department," says WellNet’s Feinberg.

"Organizations need to begin by identifying all of the critical players within the organization that have a stake in managing health insurance. They need to make sure that all of the appropriate people are then plugged into a system of technology and processes that allows them to appropriately access information and control those costs."

If the senior managers of a corporation use HPM processes and technology to get a better handle on health insurance costs, they will improve corporate governance with more informed decision making. Bottom line: Decision making with better data is better governance.

**Improving Risk Management**

At its most basic level, managing risk is a function of understanding patterns as close to real time as possible. For example, in the recent meltdown of the financial industry, some bankers took extreme risks in managing their customers’ capital. As a result, banks have been forced to elevate the responsibility of internal risk managers and increase visibility into their transaction patterns to ensure that they are complying with internal and external standards to mitigate risk.

"The same basic principle can be applied to health benefits. The CEO and CFO of the company — who are responsible for the human capital of the company as well as its financial capital — should be empowered to put procedures in place to preserve those assets, while gaining healthier outcomes for the workforce," explains Hersch, of Cantor LifeMarkets.

The key to accomplishing those objectives is getting the right information to the right person at the right time so that strategic decisions based on that information can be made before it’s too late. Having an HPM strategy supported by the right systems is critical because without automated systems, health claims information becomes too dated to deliver value.

Automating processes will enable companies to gain real-time perspective on what is happening in the employee population, empowering senior managers to better understand the risks to which they’re exposed today and are likely to be exposed tomorrow. This is key, because it helps them to prioritize their investment of health benefit funds to mitigate those risks.

"Predictive analytics and access to accurate and current data are today’s critical components of corporate risk management. But accurate and current data that is not automated and connected to its native source cannot be collected or managed. If corporate risk managers can take advantage of processes that give them access to accurate, real-time information, they are better able to predict emerging health challenges with a high degree of accuracy," says Pantos.
That information empowers managers to put in place programs — health coaching, fitness programs, and incentives — that help manage risks.

“Reducing the risk to your organization — whether it is identifying symptoms and then the causes behind those symptoms and putting in place controls to try and reduce the recurrence of those symptoms — yields at least two benefits,” explains Lockheed’s Thompson.

“You get to reduce costs and/or you get to offer more services for the same cost. Often this means that a more cost-effective plan emerges that is more targeted to the needs of your employees. Properly managed, it can result in a better healthcare package — a better insurance package for your employees — that covers 20 to 40 percent more services, illnesses, and treatment models at a reduced cost — those are really the benefits that effective risk assessment and management can provide,” he says.

**Addressing Compliance Issues**

Simply put, compliance is the ability to demonstrate to regulators, auditors or other covered third parties that the company is adhering to its policies and procedures. Demonstrating thorough compliance obliges companies to produce auditable reports that typically are generated by dedicated staff.

Self-insured health plans must comply with all applicable federal laws. According to SIIA, they are responsible for all of the following: ERISA, Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), the Americans with Disabilities Act (ADA), the Pregnancy Discrimination Act, the Age Discrimination in Employment Act, the Civil Rights Act, as well as other statutes such as Tax Equity and Fiscal Responsibility Act (TEFRA), Deficit Reduction Act (DEFRA) and Economic Recovery Tax Act (ERTA).

Federal and state privacy requirements are an obvious area where it is necessary to have proper compliance. For example, HIPAA allows private medical information that is used in health administration to be transmitted to a health plan’s “business associates” without an employee’s consent. ERISA requires plan sponsors to manage benefit plans in the best interest of plan participants and beneficiaries.

“But the compliance issues surrounding the handling and storage of that information can still be thorny. A significant amount of medical data transmitted in the course of analytics and metrics is bound to wind up in databases, so it’s important from a compliance perspective to have proper procedures in place to protect individuals’ privacy,” says Feinberg.

Information security is equally important because federal and state privacy laws require that data to be well secured in transmission and storage.

HPM can effectively enhance proper compliance because it eliminates multiple, dedicated processes that are performed by separate groups of people. By automating processes and using the same engine to power governance, risk, compliance and management reporting, companies reduce the chances for human error or fraud. Because data remains tied to its native source, it is more accurate and ultimately costs less to produce.

Technologically enabling broader access to such data highlights the need to have the right processes in place. Companies must document their processes as they relate to health performance management. Specifically, who has access to data, who can change data, how data can be used, and perhaps most important, who in the company is permitted to contact individual employees about health issues revealed in that data.
One way to address these issues is by “sanitizing” the data — placing much of the ability to access data in the hands of a business associate third party. Because that liability offset does not involve hiring, firing, care management or related issues, an employer can have input on how wellness, disease management and other programs are implemented at a high level.

Identifying Best Practices

Information is king in the healthcare arena, and having access to patient medical records has always been an important analytical tool. However, accessing the right information in real time so that decisions can be put into context has been challenging, because such critical information can lag behind by one or even two calendar quarters.

However, as more information becomes available more quickly, larger employers are shifting their strategies to leverage healthcare data into their decision making. To accomplish this, they are turning to automated processes that can capture information and integrate it into initiatives that help them reduce costs and improve outcomes for employees.

Conclusion

Although real-time access is creating new opportunities, employers who now must navigate through this dramatic information surge must take care to remain compliant with key regulations throughout the process.

Engaging early and effectively with plan members will become increasingly critical over time as the workforce ages and the healthcare needs of plan members become broader and more intensive.

Such interventions can help organizations maximize the productivity of their workforce. But it remains imperative that organizations understand the limitations that regulations place on their activities, while maximizing the opportunities that exist to leverage third-parties’ expertise.

Because HPM is not yet a core competency within most organizations, companies need to go beyond traditional vendor relationships to establish strategic partnerships. They can maximize their bottom-line benefits if they partner with organizations that have significant experience both in delivering good plan engagement models and complying with relevant regulations.

Today, there seem to be three certainties in life: death, taxes and rising health costs. According to the Kaiser Family Foundation, a family’s average annual health cost is $13,000. At this rate, the Business Roundtable estimates that over the next 10 years the cost will triple to $39,000 per year.

The companies that pay out the lion’s share of those benefits increasingly are examining management approaches to cut costs, while improving the health outcomes for their employees. HPM will empower organizations to better manage their governance, risk and compliance exposures by placing the right people, processes and technology into those three focus areas.

HPM is an essential tool because it relies on data availability. Companies have access to health plan data, enabling them to analyze loss ratio trends and other factors that drive up costs. Ultimately, this empowers them to predict the future risk of catastrophic conditions in their workforce in time to intervene with health coaches, wellness programs, disease management programs and other such preventive strategies.
About the HPM Institute

The Healthcare Performance Management Institute (HPM Institute) is a research and education organization dedicated to promoting the use of business technology and management principles that deliver better and more cost-effective healthcare benefits for employers who cover their employees.

The Institute’s mission is to introduce and develop the new corporate discipline, HPM, a technology-enabled business strategy that tackles the challenge of controlling healthcare costs and quality in much the same way that enterprises have optimized customer relations, supply chain management and enterprise resource management. HPM provides C-level executives with visibility and control over company healthcare benefits spending trends and risk-management postures, while protecting individual employee privacy. For more information, visit www.hpminstitute.org.

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