Alternative Reimbursement Strategies

Biography

CHRISTOPHER MONROE
Senior Vice President, Employee Benefits

Chris is a true veteran within the insurance industry with 25 years experience. Chris is a prominent key member of USI's Connecticut office employee benefits sales team. He is able to create innovative and cost-effective plans for his clients and his insight into client relationships enables him to provide a (360) degree approach. Chris started his career as an underwriter in 1992 with CIGNA Healthcare. In that capacity he worked with various employer groups within various industry segments – municipal, non-profit, financial services, etc. As an underwriter, Chris was exposed to a multitude of topics including product development, funding evolution, benefit administration, and risk analysis. Harnessing that experience, Chris joined the consultancy ranks. During his tenure as a health and welfare consultant, Chris held senior leadership roles with RC, Knox and Company, Constitution Advisory Group and now USI Insurance Services.

Christopher holds a B.A. from Providence College.

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Biography

LOKESH NIGAM
Senior Vice President, Employee Benefits

Lokesh began his career over 15 years ago with CIGNA in their Defined Contribution division. He spent his final two years at CIGNA in healthcare managing national accounts such as Walmart and Philips Electronic. Lokesh moved over to the broker side in 2002 with Northwestern Group Brokerage and then to the HealthConsultants Group where he continued to specialize in Employee Benefits.

Lokesh joined USI Insurance Services in late 2011. In his current position he is a key member of the Employee Benefits team, and is responsible for developing and managing clients through New Business Development and Retention with ultimate Account responsibility. Lokesh works with clients on a local, regional, national and international basis and focuses on the healthcare industry.

Lokesh is a graduate of Central Connecticut State University. Lokesh serves on the Young Leaders Advisory Council Executive team for Hartford Hospital. He is a mentor with USI's program in affiliation with the Governor's Prevention Partnership.

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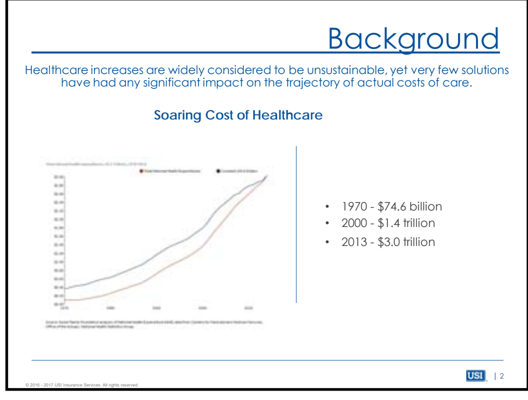
Background
Healthcare increases are widely considered to be unsustainable, yet very few solutions have had any significant impact on the trajectory of actual costs of care.
Soaring Cost of Healthcare
1970 - $74.6 billion
2000 - $1.4 trillion
2013 - $3.0 trillion
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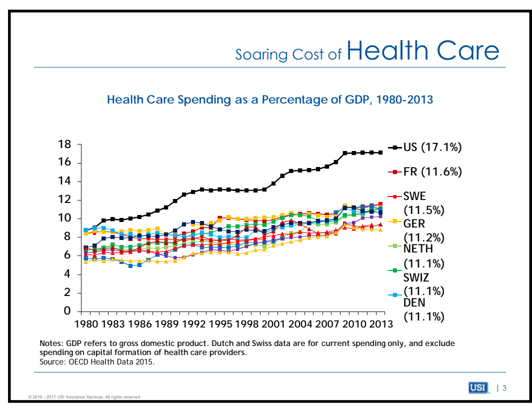
Soaring Cost of Health Care
Health Care Spending as a Percentage of GDP, 1980-2013
US (17.1%)
FR (11.6%)
SWE (11.5%)
GER (11.2%)
NETH (11.1%)
SWIZ (11.1%)
DEN (11.1%)
1980 1983 1986 1989 1992 1995 1998 2001 2004 2007 2010 2013
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.
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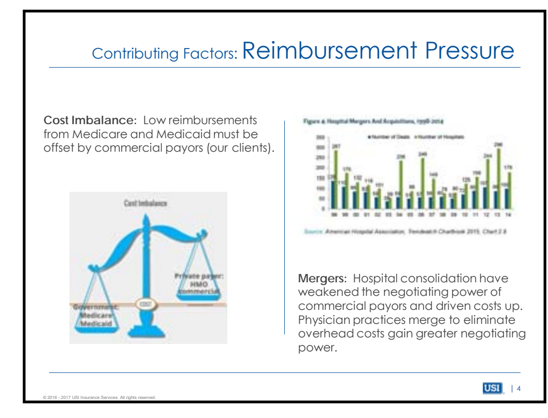
Contributing Factors: Reimbursement Pressure
Cost Imbalance: Low reimbursements from Medicare and Medicaid must be offset by commercial payors (our clients).
Mergers: Hospital consolidation have weakened the negotiating power of commercial payors and driven costs up. Physician practices merge to eliminate overhead costs gain greater negotiating power.
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Contributing Factors: Uninsured or Underinsured

Commercial payors have to cover the costs of the underinsured or uninsured.

- Estimated 2012 total cost of uncompensated health care =

$45,900,000,000

- The medical community is forced to write-off significant bad debts as a result of:
  - **Emergency Medical Treatment Act** requires hospitals to provide coverage to anyone during an emergency regardless of ability to pay
  - High deductible plans have had a similar impact on physicians
- Those who can pay, pay more to offset for those who cannot pay.
- Community Health Systems, Inc., the 2nd largest for-profit hospital chain **reported 2015 bad debt as $169 million** and **estimated 40% or about $68 million was from patients unable to pay their deductibles and copays.**

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Contributing factor: Cost Variance

Healthcare is the only item or service that most Americans purchase without consideration to price or quality.

Price Variance for Identical Procedure

Procedure Code	Procedure	Allowed
R352	CT Scan - Body Scan	$ 9,087.00
R352	CT Scan - Body Scan	$ 7,871.00

Procedure Code	Procedure	Allowed
R352	CT Scan - Body Scan	$ 636.10
R352	CT Scan - Body Scan	$ 591.00
R352	CT Scan - Body Scan	$ 566.01
R352	CT Scan - Body Scan	$ 566.00
R352	CT Scan - Body Scan	$ 557.00

High = $9,087 | Avg = $2,825 | Low = $557

- High tech imaging negotiated rates can range as much as 500% between stand-alone centers and hospital based facilities
- Surgical rates regularly vary by 100% without a direct correlation to quality

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Contributing Factor: Exorbitant Prices

Is this price gouging?

Actual Examples Found by AMPS during our bill review/audit process

Procedure...	Known as...	Unit Price
Oral cleansing device	Toothbrush	$1050.00
Cranial support system	Neck support pillow	$450.00
Mucus recovery system	Facial/Nasal tissues	$75.00
Tuberculin syringe	Diabetic syringe	$14.00
Acetaminophen Tablet	Tylenol	$513.23
CBC	Blood Count	$280.00
Blood Glucose Monitoring	One Diabetic Test Strips	$20.90

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How are Claims Costs Determined?

Background

- Insurance carriers and stand-alone provider networks negotiate varying fees with providers to achieve a balance between cost efficiency and access.
- Typically, carriers negotiate a discount off billed services with little regard for the appropriateness of the billed charge.
- The increasing need and adoption of alternative reimbursement strategies is driven by the wide variance of these negotiated rates with in-network providers. In particular:
  - High tech imaging negotiated rates can range as much as 500% between stand-alone centers and hospital based facilities
  - Surgical rates regularly vary by 100% without a direct correlation to quality
  - Hospital-based pharmacy charges can be as much 500% of cost

Alternative Reimbursement Strategies

- To address rising health care costs, some insurance carriers and self-funded plans have turned to plan designs focused on reducing overall plan costs by reducing reimbursement rates.
- As opposed to focusing on one specific solution, USI assists employers with a wide range of strategies to control costs, or reimbursements, to providers:
  - Total Cost of Care (Blue Cross Focus)
  - Narrow networks
  - Procedure specific in-network caps on reimbursement rates
  - Cost Plus or Medicare Plus for facility (hospital) providers
  - Cost Plus or Medicare Plus for all charges

Typically thought of as Reference Based Pricing (RBP)

What is a Reference Price?

We are conditioned to believe that higher cost = higher quality, however no study has proven any direct correlation on a large scale.

- Unlike traditional PPO discount models or capitated ACO models, RBP reimbursements are typically set as a multiple of the Medicare payment rate, or a percentage above the published "cost" the hospital actually experienced to perform the care. Most vendors recommend the greater of:
  - 110% -170% of Medicare
  - 110%-120% above published Charge Master
- **PPO payments after discount vary widely depending on market leverage of the network, and can range from 110% - 300% of Medicare.**
- Hip and knee replacements are ideal RBP services as they are planned weeks and months in advance allowing patients to do some comparison shopping.
- Building a plan based on reference pricing requires careful planning and consideration.

How does RBP work?

Typically, a traditional medical TPA partners with a RBP vendor that negotiates and/or adjudicates the billing subject to the reference price.

- A TPA engages a rental network for doctors only, no hospital network
  - Inclusion of labs, MRI facilities, PT and others within the rental network varies widely by solution
- ~ 80%+ of claims (not total dollars) occur within the rental network and are processed in the traditional PPO in-network manner
- Facility-based claims are subject to cost plus or Medicare plus reimbursement schedule.
  - In these instances, the hospital or facility is reimbursed at a rate lower than billed charges and may seek additional reimbursement from the patient.
- **RBP vendors** offer different solutions as to how to resolve the difference between the hospital billed charge and the actual reimbursement -- there is no network "discount" to rely upon.
- Sample RBP vendors include: AMPS, ELAP, HST

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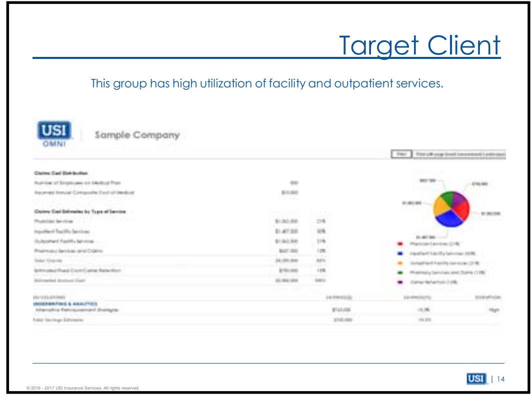

How to Set the Reference Price?

- The market seems to be setting the reference price around 150% or less of Medicare reimbursements.
- Certain vendors will negotiate with providers on a case-by-case basis for the reimbursements to be set at 140% to 200%.
- Employers should consider lowering hospital deductibles and coinsurance which limits the unpaid portion of the hospitals total bill, giving RBP vendor more leverage to negotiate.
- Hospitals with local competition are more likely to accept negotiated payment.

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RBP Compliance Risks

There are various compliance issues surrounding RBP and employers must understand the potential risks associated with these programs.

- ACA Compliance Risk:
  - Member exposure beyond MOOP
    - Balance Billing beyond the MOOP can be a violation
  - Failure to provide preventive care at 100%
    - Some preventive care (colonoscopy) is a facility based service that should be covered at 100%
  - Failure to provide Minimum Value Benefit
    - Does the plan limit benefits to the extent that is less than bronze level coverage?
- ERISA Compliance Risk
  - **Fiduciary Risk:** Does this arrangement meet the fiduciary obligation of the plan sponsor to operate the plan solely in the best interest of participants and beneficiaries.

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Concern: Balance Billing

Balance billing is a major concern from a compliance perspective, vendors have strategies to minimize the risk of balance billing but may not address institutional risk.

- Two areas of compliance risk:
  - **Individual risk:** Members who experience out of pocket costs above the ACA MOOP may file a claim against the employer.
  - **Institutional risk:** DOL investigation may determine that the plan is out of compliance due to lack of stated MOOP regardless of actual harm to employee.
- Typical Vendor Response:
  - Since there is no network, the MOOP does not apply
  - Members are never actually balance billed and are offered limited indemnity from balance bills
- USI Compliance Concerns:
  - IRS FAQ contradicts the no network argument
  - The DOL will review the plan documents for compliance, not necessarily only look for employees who are harmed

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Concern: Preventive Care

The ACA requires that preventive care be covered at 100%, when a network is present it may be limited to 100% in-network only.

- Preventive care includes facility based procedures
  - Mammography
  - Colonoscopy
- RBP plans do not offer a facility network, so all preventive claims must be covered at 100% regardless of cost.

- Typical Vendor Response
  - Plans will cover 100% of allowed reimbursement which is "reasonable" reimbursement
- USI Compliance Concern
  - Facilities may fail to accept lower charge because they know the plan has to cover 100% regardless, resulting in higher costs

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Concern: Fiduciary Responsibility

ERISA requires that fiduciaries act in the best interest of participants and beneficiaries.

- Employer plan sponsors cannot completely avoid fiduciary responsibility, even by paying to establish a co-fiduciary.
- Designing a plan that exposes members to very large balance bills may not be perceived as in the best interest of participants.

- Alternative Response
  - Employers who fail to ensure that plan assets are being spent appropriately are not acting in the best interest of participants.
    - *Is a $1,000 toothbrush an appropriate expense under the plan?*
    - This argument seeks to draw correlation to the 401(k) fiduciary responsibilities where plan sponsors must ensure expenses are appropriate

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Appendix

- CalPERS case study – This is not a USI client but it is a well-known example of RBP reducing plan costs.
- New case study of a USI client implementing RBP

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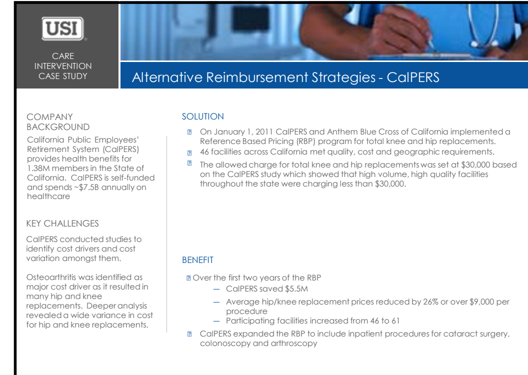
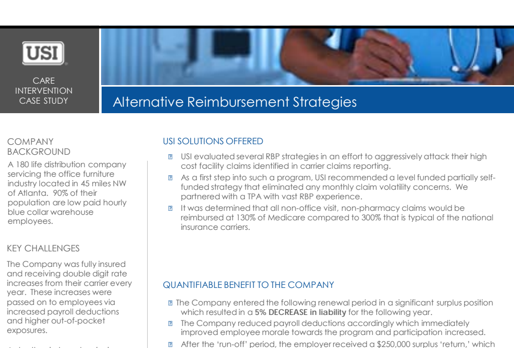
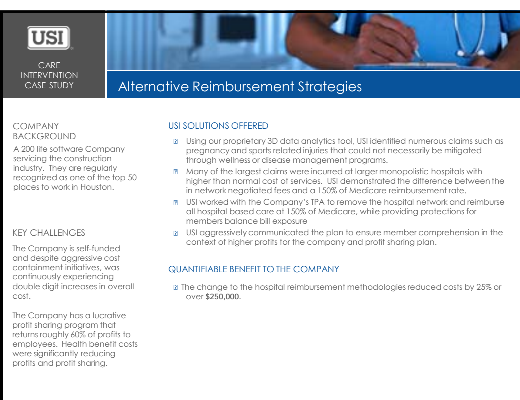

USI
CARE INTERVENTION CASE STUDY
Alternative Reimbursement Strategies - CalPERS
COMPANY BACKGROUND
California Public Employees' Retirement System (CalPERS) provides health benefits for 1.38M members in the State of California. CalPERS is self-funded and spends ~$7.5B annually on healthcare
KEY CHALLENGES
CalPERS conducted studies to identify cost drivers and cost variation amongst them.
Osteoarthritis was identified as major cost driver as it resulted in many hip and knee replacements. Deeper analysis revealed a wide variance in cost for hip and knee replacements.
SOLUTION
On January 1, 2011 CalPERS and Anthem Blue Cross of California implemented a Reference Based Pricing (RBP) program for total knee and hip replacements.
46 facilities across California met quality, cost and geographic requirements.
The allowed charge for total knee and hip replacements was set at $30,000 based on the CalPERS study which showed that high volume, high quality facilities throughout the state were charging less than $30,000.
BENEFIT
Over the first two years of the RBP
– CalPERS saved $5.5M
– Average hip/knee replacement prices reduced by 26% or over $9,000 per procedure
– Participating facilities increased from 46 to 61
CalPERS expanded the RBP to include inpatient procedures for cataract surgery, colonoscopy and arthroscopy


USI
CARE INTERVENTION CASE STUDY
Alternative Reimbursement Strategies
COMPANY BACKGROUND
A 180 life distribution company servicing the office furniture industry located in 45 miles NW of Atlanta. 90% of their population are low paid hourly blue collar warehouse employees.
KEY CHALLENGES
The Company was fully insured and receiving double digit rate increases from their carrier every year. These increases were passed on to employees via increased payroll deductions and higher out-of-pocket exposures.
A death spiral was beginning as healthy employees were dropping off of the plan due to its affordability.
USI SOLUTIONS OFFERED
USI evaluated several RBP strategies in an effort to aggressively attack their high cost facility claims identified in carrier claims reporting.
As a first step into such a program, USI recommended a level funded partially self-funded strategy that eliminated any monthly claim volatility concerns. We partnered with a TPA with vast RBP experience.
It was determined that all non-office visit, non-pharmacy claims would be reimbursed at 130% of Medicare compared to 300% that is typical of the national insurance carriers.
QUANTIFIABLE BENEFIT TO THE COMPANY
The Company entered the following renewal period in a significant surplus position which resulted in a 5% DECREASE in liability for the following year.
The Company reduced payroll deductions accordingly which immediately improved employee morale towards the program and participation increased.
After the 'run-off' period, the employer received a $250,000 surplus 'return,' which was ~15% of the total premium paid into the program.
75% - 80% facility savings from billed charges were recognized with the RBP strategy.
There were no reports of members being harassed or balance billed by facility providers.


USI
CARE INTERVENTION CASE STUDY
Alternative Reimbursement Strategies
COMPANY BACKGROUND
A 200 life software Company servicing the construction industry. They are regularly recognized as one of the top 50 places to work in Houston.
KEY CHALLENGES
The Company is self-funded and despite aggressive cost containment initiatives, was continuously experiencing double digit increases in overall cost.
The Company has a lucrative profit sharing program that returns roughly 60% of profits to employees. Health benefit costs were significantly reducing profits and profit sharing.
USI SOLUTIONS OFFERED
Using our proprietary 3D data analytics tool, USI identified numerous claims such as pregnancy and sports related injuries that could not necessarily be mitigated through wellness or disease management programs.
Many of the largest claims were incurred at larger monopolistic hospitals with higher than normal cost of services. USI demonstrated the difference between the in network negotiated fees and a 150% of Medicare reimbursement rate.
USI worked with the Company's TPA to remove the hospital network and reimburse all hospital based care at 150% of Medicare, while providing protections for members balance bill exposure
USI aggressively communicated the plan to ensure member comprehension in the context of higher profits for the company and profit sharing plan.
QUANTIFIABLE BENEFIT TO THE COMPANY
The change to the hospital reimbursement methodologies reduced costs by 25% or over $250,000.