



Self-Funded Employers and the Free Market

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What is Self-Funding?

- In 1974, ERISA was established
 - Allows employer groups to self-fund and exempts these Plans from state regulation
 - Plans are exempt from many state mandates
 - Plans avoid most state premium taxes
 - Defined the fiduciary responsibilities of self-funded plans
 - Self-funded employer health plans must provide quality healthcare to their employees at a reasonable cost
- Employers who self-fund their employee benefit plan are responsible for 100% of eligible claims under the Plan, regardless of whether or not they purchase stop loss.

What is Stop Loss?

- Employers who choose to self-fund their employee benefit plan can purchase stop loss insurance to protect them from catastrophic individual claims (Specific Stop Loss) and/or high utilization of the Plan as a whole (Aggregate Stop Loss).
- According to ERISA, a stop loss contract must be a reimbursement contract. As a result, the employer is responsible for paying all eligible claims under the Plan and then filing for reimbursement under the stop loss contract.
- Stop loss is a contract between the stop loss carrier and the Employer. Stop loss protects the employer against high claims. Stop loss does not provide insurance to the covered members under the Plan.



The evolution of managing claims for a self-funded plan



Preferred Provider Networks

- As cost of healthcare continued to increase, insurance carriers began contracting with hospitals and providers for discounts to control cost. These contracts included:
 - DRGs.
 - Capitation arrangements.
 - Discounts off of billed charges.
- As hospitals and providers continued to feel the squeeze from various claim payors, network contract negotiations became more challenging.
 - DRG arrangement with hospitals started to disappear.
 - Capitation of physicians also began to disappear.
 - As DRGs and Capitation disappear, so does transparency.
- Today, the majority of network contract are based on a discount off billed charges. How do you define billed charges though?

Issues with today's Preferred Provider Network contracts

- Hospitals believe they deserve a higher reimbursement from the insurance carrier, while the PPO networks wish to maintain or improve on their discounts.

Issues with today's Preferred Provider Network contracts

- Carriers are giving in to other provisions of the PPO contracts in order to maintain their discounts as well as their market share.
 - Carriers are becoming lenient with their Utilization Management of claims in order to keep their discounts in place.
 - Carriers end up paying for claims that may not have been medically necessary.
 - Patients end up staying in the hospital for longer lengths of stay.
 - Carriers end up paying for services that are not standard of care.
 - Carriers and PPO networks are getting more lenient in the contract language, including language that precludes the Plans from auditing claims or negotiating discounts until after the claim has been paid.
 - Claims are paid for services that are not medically necessary or are not standard of care.
 - Carriers can then audit the claims after the claims are paid and try to recoup money they believe has been overpaid.

Issues with today's Preferred Provider Network contracts

- What are today's "billed charges"?
 - No consistency in billed charges.
 - Mark-up can exceed 1000% for supplies.
 - Cost shifting to self-funded employer groups very evident.

Solutions to address the issues with PPO contracts

- Reasonable and Customary language in the Plan Document.
 - Limits the Plans exposure to unreasonably high billed charges.
 - Does not protect the claimant from balance billing.
 - Places the claimant in financial danger.
 - Costly for hospitals to chase after balance bills.
 - Such wording can conflict with PPO Network contracts.
- Hospital bill review firms.
 - Review hospital bills for unnecessary treatment.
 - Review hospital bills for appropriate levels of care.
 - Adds a layer of cost to the Plan that can be expensive.

Solutions to address the issues with PPO contracts

- Bill negotiation firms

- Review hospital bills for excessive charges.

- Negotiate with the hospital for lesser payments.

- Typically charge the Plan 15-25% of savings for their services.

- Some vendors get sign-off from the hospital and others do not.

- Occasionally vendors make more money than the providers.

- EXAMPLE: A dialysis provider was billing a plan \$6,350/day, or \$990,600/year, for dialysis treatment. A vendor was put in place by the Third Party Administrator to negotiate the claims. The vendor was successful in obtaining a significant discount and the provider was paid \$950/day for the dialysis treatment. However, the vendor was receiving 25% of savings which resulted in a payment to the vendor of \$1,350/day.

Solutions to address the issues with PPO contracts

- Medicare Reference Based Pricing vendors.
 - Plans are now eliminating PPO networks and moving to an open plan design that is based on a percentage of Medicare reimbursement.
 - Payments by the plan are made based on the percentage of Medicare in the Plan.
 - Vendors act as patient advocates to address balance billing.
 - Vendors can charge significant fees to the Plan to provide their services.
 - RBP vendors need to be monitored closely to be sure they are not just building a network.



How does transparency in hospital billing impact the current state of health plans?



Impact to the Plan

- Eliminates excessive billed charges, thus allowing the Plan to abide by their fiduciary duties.
- Eliminates the need for bill review vendors and the costs associated with these reviews.
- Eliminates the need for bill negotiation vendors and the costs associated with these negotiations.
- By eliminating the threat of patient balance billing, employers offering self-funded plans to their employees enjoy a better employer/employee relationship.

Impact to the Hospital

- Eliminates long waits to collect their money.
- Less to no out-of-pocket expense to the patient that the hospital has to collect.
- Plans that allow for 100% coverage for transparent facilities provide steerage and higher volume to the facilities.
- Easier billing to the Plan for payment.

Impact to the patient

- No concerns over balance billing.
- Comfort of knowing they will receive quality treatment.
- Employee satisfaction knowing they have quality medical insurance.

Impact to the stop loss carrier

- Eliminates the cost of coordinating with bill review vendor along with the costs associated with the review.
- Eliminates the cost of coordinating with bill negotiation vendors along with the costs associated with the negotiation.
- Reduces the cost of auditing Plan payments.
 - Simple invoice for services provided.
 - Clinical notes to support the services provided.
- Underwriting for risk can be more predictable.
- Reduces the overall costs, thus reducing the cost of stop loss to the employer groups.



Can transparency also work for Prescription Drugs?



PBMs

- Specialty Drug costs are a big concern and can also be a significant revenue generator from the PBM.
- PBM contracts vary widely.
 - Some PBMs keep the rebates from the manufacturers as a way to enhance their revenue.
 - Some PBMs hold savings from coupons to enhance their revenue.
 - Employers are often blind to the costs associated with PBMs and are giving away their savings to the PBM.

Reference chart on next slide for examples.

PBMs

RX	Plan Cost	GoodRx with Coupon
Abilify Tab 20mg	\$ 1,272.54	\$ 80.00
Ability Tab 15mg	\$ 660.44	\$ 80.00
Ambien CR Tab 12.5mg	\$ 1,019.20	\$ 75.00
Donepezil Tab 5mg	\$ 107.07	\$ 12.00
Doxepin HCL Cap 50mg	\$ 57.99	\$ 15.00
Effexor XR Cap 150mg	\$ 775.18	\$ 22.00
Effexor XR Cap 75mg	\$ 356.42	\$ 18.00
Fenofibrate Cap 130mg	\$ 147.51	\$ 35.00
Furosemide Tab 20mg	\$ 1.96	\$ 5.00
Gabapentin Cap 300mg	\$ 13.73	\$ 17.00
Glimepiride Tab 4mg	\$ 12.44	\$ 14.00
Hyzaar Tab 100-25	\$ 160.77	\$ 16.00
Norvasc Tab 5mg	\$ 158.16	\$ 9.00
Pioglitazone Tab 45mg	\$ 82.98	\$ 28.00
Pravastatin Tab 40mg	\$ 22.24	\$ 17.00
Prempro Tab .625/5mg	\$ 491.82	\$ 195.00
Synthroid Tab 0.025mg	\$ 35.09	\$ 38.00
Synthroid Tab 0.2mg	\$ 35.09	\$ 38.00
Xanax Tab 2mg	\$ 572.10	\$ 17.00
	\$ 5,982.73	\$ 731.00

PBMs

- There are many PBMs these days moving into a transparent model.
 - Transparent PBMs will charge a per script fee for their services, resulting in a more predictable cost to the Plan.
 - Plans are billed net of any applied coupons.
 - Be sure your PBM is following all coupons available.
 - All manufacturers rebates go back to the Plan.



Transparency's impact on Plan costs



Transparency's impact on Plan costs

- Plan payments to providers are predictable and lower on average.
- Eliminates the need for vendors to review bills and the costs associated with bill reviews.
- Eliminates the need for claim negotiation vendors and the costs associated with negotiations.
- Creates maximum savings on prescription drugs to protect the Plan.

Transparency's impact on Plan costs

- Reduces stop loss exposure, thus reducing the cost of stop loss to the Plan.
- Improves employee morale knowing their employer is providing them with quality benefits at a reasonable cost.
- Allows the employer to abide by their fiduciary duty by providing employees with quality benefits at a reasonable cost.



Setting up a self-funded plan



What should employers ask when setting up their self-funded plan?

- Are the TPA's quoted fees all encompassing, or do they derive revenue from any of the vendors they are using?
- Does your stop loss provider generate any revenue from the vendors that are being used?
- Will the Plan allow the employer to fulfill its fiduciary duties to their employees?
- Are the fees the PBM is quoting all-encompassing or do they generate revenue elsewhere?



Questions?

