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Controlling Medical Costs in Self-Funded Employer Benefit Plans

Employers that offer health benefits to their employees through self-funded health benefit plans are seeing costs attributed to their plans constantly rising. Traditional cost containment solutions are becoming less effective and more burdensome on employees. This paper will address the cost drivers and why the traditional solutions are becoming more and more ineffective. New solutions and how to implement them will also be discussed.

Cost Drivers

The cost of medical care continues to increase. In its report "Medical Cost Trend: Behind the Numbers 2017", Price, Waterhouse, Coopers predicts medical costs to increase only 6.5 percent in 2017. The report lists the medical cost increase trend since 2007 as follows:

2007	11.9%
2008	9.9%
2009	9.2%
2010	9%
2011	9%
2012	8.5%
2013	7.5%
2014	6.5%
2015	6.8%
2016	6.5%

The trend is often presented by the medical community as a favorable trend. Medical providers cheerfully sing that the medical cost trend is increasing at a decreasing rate. The reality is the costs are still increasing and these costs increases have been felt by plans and their covered members.

Health plans have traditionally relied upon their plan's preferred provider organization (PPO network) to provide discounts to their plan and covered members. PPO networks take the billed charge and subtract their contract discount amounts. The result is the allowed amount and is the starting point of benefit calculations. These networks are accessed either through an insurance company that is acting as the plan's Third Party Administrator (TPA) by providing administrative services only (ASO) or through an independent TPA that rents access to a PPO network. Regardless of the source of the network access, all PPO networks tout the strength of their network by advertising their savings as a percentage of the amount billed by the hospital or medical services provider (i.e. 55% savings off of billed charges). If you take nothing else away from this paper, know this: **THE BILLED CHARGE AMOUNT MEANS NOTHING!** The problem with this claim of savings is there are little to no constraints placed on the medical providers concerning the amount they charge for services rendered. Inquiries about how the amounts

allowed by the networks are calculated are usually declined with the carriers/network citing the confidentiality of their agreements with the providers. The plan's agreements with the carriers and networks almost always prohibit the plan from attempting any type of a direct agreement with network providers that would be more advantageous for the plan and its members.

Traditional Solutions Presented to Self-Funded Plans

Rising health plan costs have traditionally been addressed in the following ways:

- Benefit Plan Structure Changes – Increasing member deductibles and co-pays therefore reducing plan benefit payout assuming all other factors remain constant.
- Increasing the cost share to employees and their covered dependents – Requiring the employees to shoulder a bigger portion of plan costs.
- Narrowing the PPO Network – Accepting carrier/network recommendations to reduce the number of providers in the network leaving (ostensibly?) the providers with the "best" network contracts.

All of the above-mentioned are recommended, often in combinations. Briefly, here are some difficulties:

- Benefit Plan Structure Changes – This does not affect the total costs incurred, it simply makes the covered member pay a larger share. This is usually not welcome news to covered members. Also, the Affordable Care Act (ACA) contains Cost Share Limits which restrict the amount plan members have to pay for essential health benefits. In other words, there is a limit to how high a plan can raise its members' out-of-pocket costs. Many high deductible health plans (HDHP's) are now at the statutory Cost Share Limits.
- Increasing the cost share to employees and their covered dependents – This also is usually not well received by covered members. A complicating factor with this strategy is section 4980H of the Internal Revenue Code. This is another gem from the ACA. Under section 4980H, a covered employee must not be required to pay more than 9.5% of his adjusted household income for employee only coverage. The section does not limit what an employer's plan can charge for spouse and dependent coverage. Plans can charge away for spouses and kids. Again, not conducive to a happy workforce.
- Narrowing the PPO Network – This does not answer the PPO Network fee schedule dilemma discussed earlier. Employers are told things such as "This is the best contract in the network. You'll save 60% with this provider" (usually hospitals). 60% savings from what? The billed charge? Remember what you are supposed to have learned about the billed charge. The tactic also will cause disruption to your covered members.

New Cost Containment Option – Reference Based Pricing

How to control self-funded health plan costs while staying in compliance with federal statutes without increasing the financial burden of coverage and/or medical claims to employees. This is the tough nut that must be cracked.

Referenced based pricing (RBP) is a process where medical claims are not reduced by a PPO contract but instead, are reduced down to a known amount, usually a multiple of the provider's Medicare fee schedule. This allowed amount is the point of beginning for benefit calculations. We will discuss the following:

- Plan benefit structure
- How to arrive at an allowable amount for a medical claim when there is no network
- Support for the plan and the member concerning the methodology of calculating this allowed amount
- Balance billing issues for the plan and member
- Working with stop loss carriers
- Summary plan document, ID card & EOB structure
- Case study
- Items to watch

Plan Benefit Structure

You will need to put aside your traditional views of the prevailing health plan benefit structure. Namely, the two tier benefit design that has in-network and out-of-network benefits. There will be only one benefit tier. The recommended benefit structure resembles a traditional HMO. The object is to limit the member's benefit out-of-pocket amounts to co-pays without calendar year deductibles. The structure might have a $100 per day co-pay for inpatient confinements, a $150 co-pay for outpatient surgery, a $75 co-pay for emergency room visits and high tech radiology and a low ($10) co-pay for doctor office visits. The member should have "skin" in the game as opposed to the plan paying 100% of the allowed amount.

How to arrive at an allowable amount for a medical claim when there is no network

The allowable amount under this type of benefit structure should be at least 140% of the referenced based price baseline amount. RBP usually uses the Medicare fees schedule as a baseline to determine the allowed amount. The main reasons for using Medicare are:

- It is a known standard payment system for all providers.
- Most providers already accept the Medicare fee schedule.
- The fee schedule is based on cost.
- The plan is providing the provider a margin above Medicare.
- RBP has been determined to be "reasonable" by several courts.

The plan will have claims where there is no Medicare allowable amount (obstetrical, pediatric, etc.). In these cases the plan (or RBP vendor) will have to perform analytics to arrive at a reasonable allowed amount.

Balance billing issues for the plan and member

So, your plan adopts referenced based pricing and receives a claim for $100,000. The plan quickly computes the allowed amount of $15,000, pays the claim with the member owing a $100 co-pay and the $85,000 amount that is above the RBP allowable is listed as not patient responsibility. Everything is fine, right? Of course it is, until the hospital balance bills your minimum wage + $5 an hour employee $85,000!!! Houston, we have a problem! Statistics show that plans with reference based pricing have balance billing issues on less than 2% of all claims paid. Jason Davis, Business and Product Development Consultant with the Phia Group, LLC, on balance billing, "we continuously work in and evaluate a multitude of RBP plans, and we see balance billing rates of 2% or less overall. That said, some markets may experience more balance billing specifically rural, single health system areas. Conversely, markets with a more vibrant and diverse provider competitive context will see less balance billing and more opportunities for direct relationships." Regardless of the plan's market, balance billing issues occur and must be handled. Members must be educated to turn balance billing issues over to the Plan Administrator **as soon as possible.** Allowing time to pass before beginning negotiations only complicates the issue. The plan (or the RBP vendor) should be prepared to **take over the balance billing issue from the member and negotiate the bill to a conclusion**.

The competent RBP vendors do handle the negotiations well. A respected RBP vendor lists the following results of 3 years of claims:

- $288,800,000 of billed charges (remember, this means nothing)
- $112,300,000 of RBP allowed including settlements
- 61.2% of savings (this ratio is from billed charges, means nothing)
- 282,220 total claims
- 1,550 balance billing issues (less than 1% of total claims, **this means something**)
- 0 unresolved claims (**this REALLY means something**)

Working with stop loss carriers

By adopting reference based pricing, your plan will realize significant claims cost savings. As a result, the plan's stop loss carrier will have diminished risk and this should mean lower stop loss costs to the plan. The lower cost could be converted to lower specific deductible and/or aggregate stop loss attachment points or simply lower stop loss premiums. The biggest issue with stop loss and reference based pricing are the balance billing settlements that are negotiated. There are several quality stop loss carriers that understand referenced based pricing and allow coverage for the settlements. Usually, these carriers have a particular (or perhaps a few) RBP vendors with whom they prefer to partner. As long is the settlement is negotiated by the stop loss carrier's approved vendor, the settlement will be allowed.

Summary plan document ID Card & EOB structure

The plan's summary plan document will need to be modified to reflect reference based pricing. Namely, the allowed amount will need to be properly defined. The ID cards will need to be properly worded so

not to insinuate a PPO network. The explanations of benefits (EOB) will need to be structured so the amounts in excess of the reference based pricing amount will not be listed as patient responsibility. EOB wording should also include how a provider may appeal.

Case study

Recently, a plan had one year's worth of claims analyzed to see how the plan would have performed had reference based pricing at 140% of Medicare been in place instead of its PPO network. The results were:

- Original PPO allowed amount $3,614,928.95
- Claims repriced to 140% of Medicare $1,253,212.81
- Annual expense for RBP vendor $172,752.00
- Savings had RBP 140% been in place $2,188,964.14

The RBP vendor in this case charges the plan on a per employee per month (PEPM) basis for pricing calculations and settlement negotiation.

Items to Watch

- Be sure the referenced based pricing vendor's fees are completely disclosed. It is recommended (highly) the fees be on a PEPM basis as opposed to a percentage of savings.
- Negotiations and patient advocacy should be provided by the RBP vendor.
- Pay close attention to how the RBP vendor calculates allowed amounts. If you see language like "Medicare allowable or provider costs, whichever is greater", RUN! Providers play games with cost figures and you may wind up no better than a commercial PPO network, maybe worse.
- Educate the covered members. Balance bills need fast attention.
- Coordinate with stop loss carrier **before** implementation.

Summary

Examples where referenced based pricing has been successful:

- California Public Employees Retirement System (CalPERS). Saved $5.5 million in the first 2 years
- Safeway Supermarkets. Started with imaging and laboratory testing.
- Lowes Home Improvement. Started with cardiac surgery.

Referenced based pricing, if handled properly, will fairly compensate medical providers for covered services rendered to self-funded health plan members. Health plans will be better able to control costs while offering plans to their employees that minimize the financial burden on the covered members. Covered members will enjoy a lighter financial cost both in costs to participate in the plan and out-of-pocket expenses resulting from claims.