Think OUTSIDE *of the Wrap*

Written by
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Networks are getting bashed every day in our industry. Some of it is justified, but some of it…not so much. I feel as if this is a recent phenomenon, but has it been going on for years? I am sure that whoever invented health plan networks saw it as a brilliant idea at the time, and so did their customers. I mean it looks great on paper. Have a selection of doctors, surgeons, facilities and hospitals all available to a select group of people at a discounted rate from their normal fees. The problem is that when you continue to make that network larger, steerage to any particular provider suffers and it loses value to the provider. Additionally, as prices being charged by providers fluctuate and you cannot audit or justify what the charges are in the first place, discounts lose their meaning and the "shine" of the network begins to lose its luster.

I am sure that the recent wave of interest in reference based pricing and alternative pricing options has had a lot to do with the negative viewpoint targeting provider networks as well. Administrators, brokers, and employers seek an alternative to the current health care mess we are in. Brokers are being hammered by their clients, and are bogged down by double digit premium increases. The carriers and their networks are an easy (and big) target to blame.

The Three Stages of Self-Funding

Before we further dissect the current attitudes towards networks, we need to look at how benefit plans are being structured in general. Networks and fully funded insurance carriers often go hand-in-hand, so any movement away from traditional fully-funded insurance will naturally impact network usage. Of the key discussion points missing from the analysis of networks, therefore, is the growth of self-funding. The fact is that employers, their brokers, and consultants are feeling more empowered to get creative with their plan structure.

Self-funding is the focal point of this creative movement. As I like to say, in my opinion there are three levels of self-funding. The first stage is what I call the self-funding GED (the high school level equivalent). These are employers and brokers that have never self-funded before. They don't know much about it other than that many employers and brokers are looking to self-fund as the new and cool way to reduce the overall cost of the plan. Most of these people don't even know what a TPA is. For them, this is the first day of school.

For employees in these GED level self-funded plans, there is no difference between the fully insured plans and the self-funded ones. In fact, they probably aren't even aware that their plan is self-funded. They still have the same insurance carrier logo on their identification card, only now it's solely referencing the network. They still have access to their same primary care doctor. The summary plan description (plan document or SPD) is pretty much the same as their old insurance policy, and any difference between them would never be noticed ... since the employee doesn't look at the SPD unless their claims are denied in the first place, and their financial responsibility is similar or the same. It's business as usual for these plans and their employees!

A vast majority of self-insured plans fall under this scenario and they have no issues with provider networks, wrap networks, or specialty networks. If anything, it's a big reason why they chose the GED level of self-funding in the first place. They liked the fully insured carriers' network, (they just did not appreciate the premium increases), so (they were told by their brokers that) they can have the same access and coverage with the possibility of lower claims costs if they "self-fund." They have no idea about RBP, direct contracting or incentivizing employees to lower costs... as they just

moved into this space. They do not know the true health care environment or the true savings opportunities available outside of the discount game.

The University of Self-Funding Employee Benefits

Graduation time! Ok, now we are getting somewhere. These are the plans that fit most of the readers of this article. These plans have been self-funded for at least a year with some national carrier. While they like much of what the self-funded piece brings to the table, they are starting to get annoyed with some pieces of their new relationships; but the network truly isn't one of them. What they are asking for is freedom in their plan design and the ability to start being a bit creative.

They are asking the basic questions as to why every plan for the national carrier is treated the same. Why does the SPD for my yoga studio plan look exactly the same as the SPD for the truckers' union? The truth is there is no good answer to that question; all we've heard is "administrative ease of use." Every self-funded employer is unique and has different needs. This is the beauty of the TPA industry and what makes TPAs so successful – the ability to customize for a client. The first thing that must be customized is the plan document. This is something that is just not seen in the ASO world and alone takes self-funding to a new college level. However, it does not take long for employers and their brokers in this TPA universe to realize that so much more can be done, particularly as it relates to the primary and wrap networks that so many TPAs work with.

The Graduate Level Self-Funded Employers

When the employer starts to realize that the discounts from billed charges truly don't mean anything, this is when – I like to say – they have seen the light. They have put in the hours, they read the books, they took the courses, they studied all night, and now they are ready to take their bar exam, get their masters' degree, and maybe even a PhD! Wow.

At the end of the day, there is an overall flaw in the system relating to arbitrary and inflated billed charges that have no justification whatsoever. From the typical layperson's perspective the discounts are impressive. However, after 20 years in the industry I have to wonder who the networks consider their actual clients to be – the facilities, the employers, or both? If both, is that a conflict? Who are they fighting for? I understand their struggle as they need providers in the networks to be happy and they need brokers and employers as clients as well. However, their current processes and contracts leave a lot to be desired, as ultimately there is no cap on what providers can charge – nullifying the value of the discounts.

From the plan's perspective, I can see why they feel the need for a network. Their employees like to see the logo on their ID card as it makes them feel safe and secure; generally speaking as well as specifically relating to balance billing. Heck; our own self-funded plan at The Phia Group has access to a national well-known network too, and the access, discounts, and "safety" are well worth it 99% of the time. For many, however, that 1% when the network is more trouble than benefit, they decide it isn't worth network usage at all. These employers go in the complete opposite direction – from full PPO user to no network at all. But unlike most employers we realize that there is a lot of space between the full RBP programs out there and the very strict network plans in existence. As I love to say, there is a lot of room in the middle to do plenty of innovative things. For the purposes of this article, the two I want to focus on are wrap network alternatives and incentivizing smart employee behavior.

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Out of Network & Wrapped Claims

This is an area at which every broker, employer, and administrator needs to take a second look. If you are afraid to make massive changes to your plan but want some easy and significant savings, this is your next area of focus. I understand the reasoning behind a primary network, and I'm telling you that more often than not, eliminating your wrap network (so that anything outside the primary network is now out of network) and changing what you do with those out of network claims has no negative effect on your employer and employee population – in fact it helps their bottom line greatly.

The biggest and simplest way to reduce your claims costs is by simply eliminating your wrap networks entirely, and strengthening your process for dealing with out of network claims. The process is easy; your members won't feel a thing and your costs will go down. So why isn't everything doing it? Because they just don't know that they can.

The current wrap network offerings suffer from the same issues as primary networks (discounts are applied to arbitrary, unfettered charges), but they feature even smaller discounts. Further, the plan has limited or no audit rights whatsoever, being forced to pay what they're told with little to no ability to check for errors, or excess charges beyond the plan allowances. Why, then, do payers subject themselves to this weakest of the weak network? Pay the network rate and there will be no balance billing of the members. This is the reason why networks thrive in the first place. There is no noise – the membership is happy because they aren't being balance billed or sent to collections. The members feel insured!

Well, why couldn't the plan have a lower cost alternative to wrap networks while also having any balance billing issues squashed before there is member noise? Eliminating all networks will certainly mean there will be noise, as any and all claims could be balance billed. Eliminating only wrap networks means only out of network claims can be balance billed – a much rarer event. It all comes down to plan language,


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accessible Medicare and claim cost data, and skilled negotiators. It must be stressed that in order to reduce the plan's spend on out of network claims; you need to significantly modify the plan language in the summary plan description. We will discuss the details on this later.

Wrap Network Contracts

Essentially, wrap network agreements state that clean claims (meaning anything submitted to the administrator) must be paid within 30 days and that any other claim (the unclean ones) must be paid within 45 days. In most wrap contracts, covered services are health care benefits and services that a member is eligible to receive under the terms of the plan document. The contracts go on to state that the plan, when accessing such networks, compensate network providers in accordance with network provider agreements and using only contract rates. The interesting piece to note here is that the plan document governs the covered services and yet the plans never get to see the network provider agreements. Therefore, there is no difference between what the wrap agreements state versus the primary networks except that wraps have worse discounts and employees have no loyalty to the wraps since they are out of network. A key difference.

To make matters even worse, many wrap network contracts want exclusivity and place language in the agreements stating the employer plan must eliminate all current wrap and/or out of network area relationships and utilize the wrap network exclusively. So if you already have an out of network deal in place through medical tourism or direct contracting, you would need to terminate the relationship in order to work with the wrap. To top it all off, they will only charge you a fee of 25-35% of "savings" from the inflated charges. Basically, these wrap partners are hoping that hospital charges just keep getting bigger and bigger.

Whatever happened to bottom up pricing? Instead of discounts off a charge, why not pay a premium above the cost of the care? This is what your plan document should say regarding how it pays out of network claims. You will be pleasantly surprised how many well-known facilities and top quality physicians will accept your reasonable, reliable and correctly priced payment structure.

The reality is that most wrap networks charge exorbitant fees and offer discounts as low as 2% off of billed charges. For the privilege of getting 2% off your bill, you have to agree to exclusivity? What type of discount would you get without exclusivity?

Reference Based Pricing

RBP can yield amazing savings for plans, yet in the marketplace the RBP model has had much more bark than bite. Everyone is talking about it but not as many are taking it all the way. Most of the ones that have replaced their primary networks have

been successful but it's the horror stories that scare most brokers and employers away. Therefore, replacing a primary network often isn't viable even though the savings could be great. I would argue that roughly 10% of the current self-funded employers out there are ready to go full RBP, while the rest run away as fast as possible. Yet, unless these plans find a way to reduce costs, they will one day have no choice but to do RBP as many union plans are beginning to see.

One way of balancing the two is by creating a narrow primary network with an RBP based "wrap-network-replacement that – in essence – increases the number of out of network claims, firms up how out of network claims are treated, and makes provider membership in the remaining network more valuable. If done properly, these out of network claims can be paid and resolved fully by the plan, eliminating balance billing. Currently, while out of network claims are rarer than this proposed approach, they almost always result in balance billing. I envision there being more out of network claims, but less instances of balance billing – so long as out of network claims are paid properly, and not with some ambiguous "usual and customary" approach.

This process will reduce the cost to the plan (and therefore to the member), will virtually eliminate medical trend increases, provides reasonable reimbursement to providers for services rendered to members, and utilizes accepted and understood rates as benchmarks. This way you can keep a primary network but ditch the wrap. You can have the model built on the same chassis as a successful RBP program without having to eliminate access to the network that your employees have been accustomed to using. What makes me shake my head in disbelief is that so

many employers and administrators still use wrap networks when they have no reason to do so.

The Wins We Have Seen

Instead of just telling you how this can hypothetically work, I think a better approach is to actually share some wins that I have seen across the country with self-funded employers that decided to ditch their wrap networks and fundamentally change the playing field regarding the treatment of out of network claims. I have omitted actual names to protect the innocent!

There was a cochlear implant claim in Flint, Michigan with billed charges of $184,000. If the plan and its administrator had used the national wrap network, it would have received a discount of 15%, leaving the payable amount of $156,400. The plan has a stop loss deductible at $70,000 meaning they would have had to file a stop loss claim as well. That's not a great thing for renewal purposes.

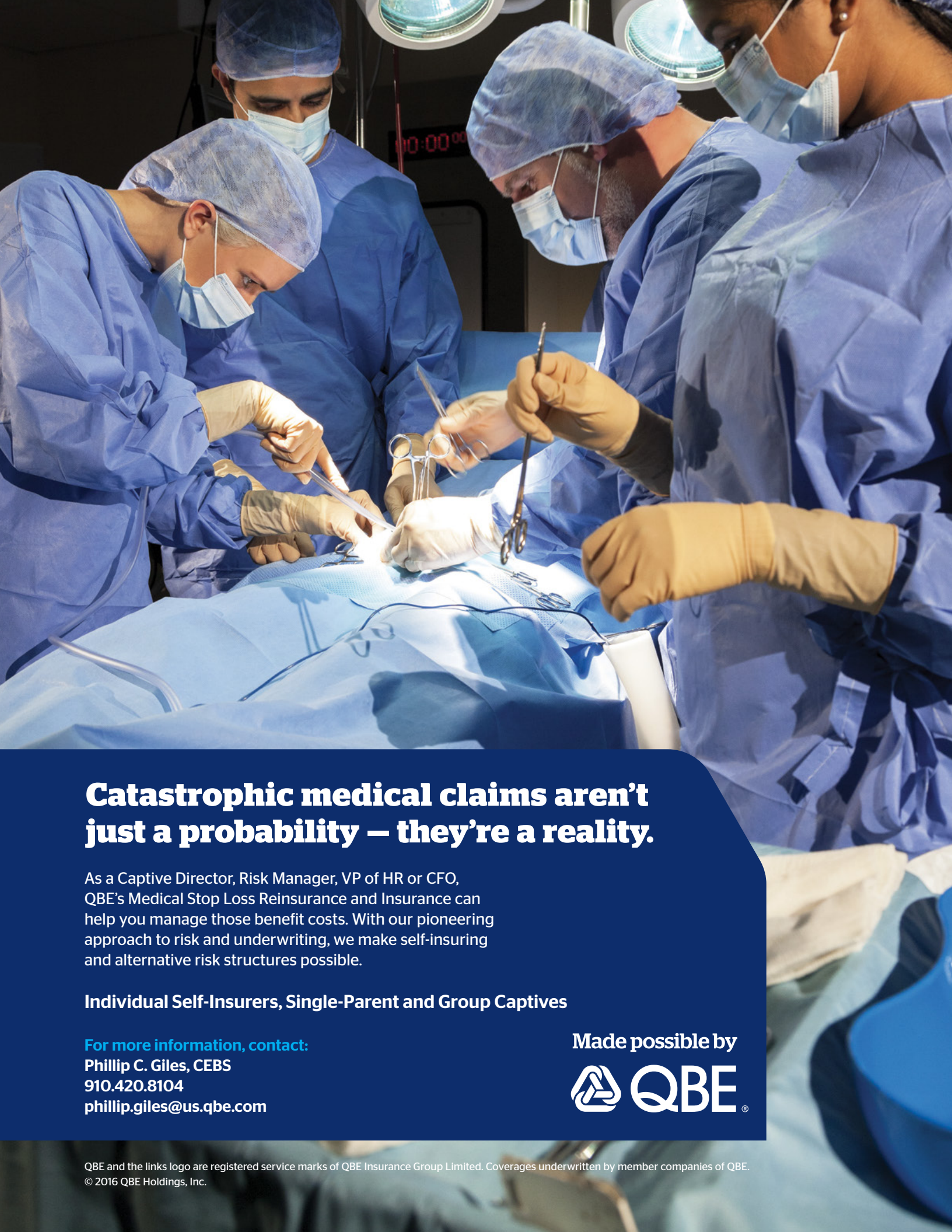
Instead, the plan had improved; specific language tied to how it would pay out of network claims, managed to carve out these claims and treat them as out of network, and ended up paying $63,735 with sign off from the facility. Not only did the plan save an additional $92,000 above the wrap discount, but it did not have to get the stop loss carrier involved at all.

The second example is a knee replacement surgery in Manhattan, Kansas. The total billed charges were $106,800 and the wrap network offered a great discount of 40%, leaving the plan to only pay $64,080. Now, most brokers in this country would look at that claim as an example of why wrap networks make sense. I mean 40% off is great until you realize that you are talking about 40% off some arbitrary and unsubstantiated bill.

Now, instead of accessing the wrap, this employer used specific language in the SPD (basing its payments of out of network claims off the cost of the care itself) and received sign off from the provider for payment of the claim at a total of $23,920. The plan had zero percent in discounts and still paid over $40,000 less than the wrap discounted amount. Now that is what I call savings. What brokers and employers need to do is stop being addicted to discounts and instead start getting addicted to net payments.

For every large discount percentage we see in the wrap network world, there are the amazing 5% discounts we all seem to apply to air ambulance charges. We saw a billed charge of $55,895 in San Antonio that had a $53,100 payable amount after the discount. The plan had luckily removed air ambulance from their wrap, and inserted cost plus type language in its documents ... and paid $15,002 with sign off from the provider (following some intense negotiations), saving the plan an additional $38,000 above and beyond the wrap.

The non-use of a wrap network is not just for large dollar claims. Smaller claims can have the same level of success using an alternative. We recently saw an emergency physician claim in Fresno, California with a



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billed charge of $7,500 that had a wrap discount of 12% available, meaning the employer plan was to pay $6,600. Well, by just picking up the phone, sharing the cost data with the provider, and having sustainable language in the plan document, the plan was able to negotiate a payment of $582. We are talking about a savings of over $6,000 above the wrap network discount.

Last but not least is the emergency room admission at an Orlando, Florida hospital. For those of you that have heard me speak at a conference, you know the facility that I am talking about. This one is by far my favorite. The claim we saw had billed charges of $220,000 with a wrap network discount of 20%, meaning a payable amount of $176,000 for a group that is self-funded with a stop loss deductible of $250,000, meaning the entire payment is at the risk of the employer plan. I can tell you most experienced brokers would think this is a great deal, especially since it's an out of network claim. Think about how many people travel to Orlando with their families every year that end up in the ER! That's a lot of money going to this facility. Well, to make a long story short, this plan decided to negotiate the claim and got sign off at the amount of $88,000.

The net result for these five claim examples using different types of claims from across the country is all follows. There are total billed charges of $574,195 with a wrap network payable rate of $456,180. The amount that these plans actually paid with a signed agreement from the facilities was $127,504. For those of you that still believe in discounts I will tell you that this equates to a 77.8% savings off billed charges and 72.1% in savings above the wrap rate. Not bad for a few paragraph changes in the plan document, repricing the claims using cost and Medicare data, and negotiating with the facilities.

As long as there are dialysis facilities that are receiving over $700,000 a year in payments per patient after the network discounts are applied, there will be opportunities to lower the cost of claims. These facilities are receiving $100,000 for the same patient care if that patient was on Medicare. Paying them 200% of the Medicare rate would still save the plan $500,000.

As long as a rural Oklahoma hospital can receive $90,000 after the wrap network discount when Medicare would be reimbursing $14,000 there will be plenty of articles like this one. We as an industry complain about overcharges, yet we are slaves to wrap discounts that we have no reason to be chained to. Regardless of your feeling on PPOs, if you are using outdated methods for calculating out of network payments, allowing subsequent balance billing to occur, and take advantage of costly wrap arrangements, you are likely outdated. When Medicare pays an air ambulance $11,500 and your client is paying $47,500 for the same flight, there should be outrage and change; not just outrage.

The Plan Language Innovations

So you are ready to take some action... right? Great. The first thing you need to do is review how your summary plan description pays out of primary network charges. Speaking of plan language, as an attorney who couldn't write you a will but can draft a plan document in his sleep, I say that a vast majority of self-funded employee benefit plans have horrendous out of network language that pays claims based on normal area charges. When I talk to employers, brokers, and administrators everyone tells me that their language doesn't state that providers can name their own price, yet somehow most of the plans I see do have those exact terms. Don't be embarrassed about your language; just change it to ensure that your plan has the right weaponry in its arsenal.

Take the "Usual and Customary Charge" language (please), and remove any connection to what a provider may charge in any given area. That just breeds claim inflation. Instead, give your plan the flexibility to pay for covered expenses using a variety of factors. This may refer to payments typically accepted for medical services, care, or supplies, made by other medical professionals with similar credentials or of similar standing, which are located in the same geographic locale.

The plan sponsor has a fiduciary duty to be prudent with plan assets. Therefore, the plan's payment level should be determined based upon the cost to the provider for providing the services or Medicare reimbursement rates. At the plan administrator's discretion, the amount paid by the plan can be determined and established using Medicare cost to charge ratios, average wholesale price, or manufacturer's retail pricing.

Typically, plans will calculate the payment amount as a multiple of the Medicare allowable amount, such as 120% to 170% of Medicare for the services or supplies. Since there are claims that do not have corresponding Medicare pricing – think pediatric claims – the plan should have language that utilizes Medicare approximations or equivalency tools, including cost data and other metrics at its disposal, in determining the payment amounts.

This language alone will save your self-funded employee benefit plan millions of dollars in claims payments. Every stop loss carrier and MGU should be offering significant discounts to employers with similar language since it reduces their claims risks significantly.

Instead of telling their employer clients to pay more in premium, deductibles, out of pockets and co-pays, brokers should be telling their clients and the employees the real reason behind the high cost of health insurance – the unjustified facility charges. Facilities are taking advantage of the fact that most employees only care about their out of pocket, co-pays and deductibles – not the entire bill. This in essence is the best thing about networks and the worst thing about networks. There is no patient noise because they don't care. If they only have to pay $20 or $250, the fact that it costs the employer $20,000 or $200,000 doesn't matter. So how do we get the employees to care? Easy – give them cash – incentivize them.

Incentivizing Your Employees

It all starts with your plan document. On page two of ours, where most of you have your table of contents, we have a section titled "cost containment incentives." It truly is a page in the document that tells employees how they can make money and put cash in their pocket by looking at the whole bill and not just their co-pay. The first time an employee gets money in their pocket by having skin in the game, it spreads like wildfire throughout the organization. People talk about it at the water cooler and whether it's $100 in savings or $30,000, every bit counts and adds up.

Our plan document features numerous provisions enabling participants to enjoy substantial savings and benefits when they take proactive measures to contain overall plan expenditures.

We address the various instances where responsible, cost-containment behavior is incentivized.

We created a claim audit review program designed to reward employees for identifying erroneous charges on bills recoverable by the plan. Simply put, if the patient identifies something in their bill and the plan doesn't have to pay it or is able to recoup the payment, the patient gets 25% of the savings in their pocket, regardless of the amount. Trust me; we only pay for services that actually occurred! One employee received a check for over $10,000 for identifying $40,000 in claims we didn't have to pay. This is promoted across our entire organization.

This next one has saved us hundreds of thousands in potential claim costs. Participants who preemptively consult with our human resources department regarding proposed, non-emergency, to-be-scheduled medical procedures, to discuss options available to the participant, can receive a financial reward. We had a recent situation where one of our employees needed a surgery. The employee's surgeon could have performed the operation at two different facilities. The employee met with our HR team and after reviewing the claims data available to us we realized that the higher quality facility would have a total cost of $7,000 to perform the operation, while the other facility, using the same surgeon, would cost $40,000. We saved $33,000 and our employee received 25% of this amount in a check payable to them! That's called having skin in the game.

At any other self-funded plan, employees would just go to the place that may be closer to their home, or maybe they know a friend who works at the hospital, or they pick one over the other for any other reason ... perhaps they choose a location with better parking because at the end of the day, they have the same co-pay and deductible regardless of where they go. They have no idea that one facility will cost the plan tens of thousands of additional dollars for the same exact procedure. However, at our company they do know and they do care ... and that's a real difference maker.

We have a provision stating that there is no co-pay for the use of urgent care facilities in lieu of a hospital's emergency room. Think about how much time and money this saves the patient and the large bill that doesn't exist for the plan. We took it a step further by stating that the co-pay normally applicable to diagnostic services if performed at a hospital is waived if the service is sought at any self-standing non-hospital facility. What this provision has done is change the behavior of our employees. When they need testing done, they ask if it can be done at a non-hospital facility. In addition, in order to encourage the use of generic medication whenever possible, we waived any co-pay.

The cultural change affects every aspect of our health plan and the reduction of overall plan spending. Under our current network, you can purchase a nebulizer after the discount for a total plan cost of $200. If you go to Amazon.com, you can purchase that same nebulizer for $118 with free two day shipping on Amazon Prime. It's a savings of $82 and the employee receives a check for 25% of that amount. While it's a small amount for the overall plan expense, it's a huge change in our employees' behavior. They look for ways to reduce the cost, whether it's big or small, because that $20.50 is added to their paycheck.

In Conclusion

At the day of the day, what really matters to employers? Do they care what the network is, what the logo looks like, what the overall discount is, how many free tickets to the ballgame they receive or how fancy the website looks? I would argue no. As an employer myself, I feel that I have the right to answer this question with some level of authority. I want my employees to be happy. I want my employees to feel secure and that security includes a respectable pay check for a hard week's work and health insurance

coverage that will be there for them and their loved ones when they need it most.

The only way to ensure they the reliable health coverage will be available to my employees in the future based on their needs is to innovate. The simplest ways to innovate right now and get the most bang for our buck is to remove the wrap networks, treat out of network claims differently, and incentivize employees to care about the overall cost of care.

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