What You Don't Know *Can* HURT YOU:

Be Prepared For the Unintended Consequences of Effective Cost Containment

The cost of healthcare in the United States is out of control, and virtually everyone operating in the world of healthcare should know the root of the problem. As stated by Gerard Anderson, a healthcare economist at the Johns Hopkins School of Public Health, 'the prices are too @#$% high.'[1]

A sweeping statement that encapsulates the healthcare conundrum in five simple words. Many in the industry are giving it their all to try to combat those prices, and in no area is that more prevalent than in the world of self-insurance, where a new cost containment idea appears to service daily. But to launch those ideas without a full understanding of all the elements of self-funded benefits plans and all the issues that may arise can put plans and their advisors in the line of fire.

Whether it is through ineffective implementation of a cost containment strategy (make sure your plan language strong before you start repricing those medical claims), misunderstanding the many relationships a plan enters into (consider your stop loss and network obligations before you try to implement any cost containment initiative), or not evaluating the situational prudence of a particular strategy, administrators must avoid going into any cost containment venture blindly.

Written by
Christopher M. Aguiar, Esq.

Why would any plan or administrator rush into a decision with such broad implications on its benefit plan? Quite simply, the pressure is on. Increasingly, courts are holding plans and advisors responsible for their duties as plan fiduciaries and careful oversight and dissemination of plan assets is under a microscope Unless you have been living under a rock, you know how aggressively health costs are rising, but just in case, consider the following statistics:

1. Healthcare inflation has outpaced inflation of the consumer price index every year dating back to at least 2005.[2]

2. In 2015, Healthcare inflation outpaced the consumer price index by 900%.[3]

Those statistics do not even specifically reference some of the shortfalls of the highly touted savior of healthcare, the Affordable Care Act (the ACA).

3. According to the Henry J. Kaiser Family Foundation, between 2014 and 2015, Benchmark Silver Premiums were either flat or increased up to more than 10% in the majority of the country.[4]

4. The number of exchange participating insurers is down approximately 25% from 2013 to 2016 with major players such as Aetna, United Health Care, and Humana all pulling themselves from the marketplace.[5]

Due to the continued increase in costs, benefit plans and their advisors continue to develop viable ways to provide robust benefits. When faced with challenges, business owners rely on their entrepreneurial spirit and seek innovative answers; many are looking to self-insurance as their alternative.

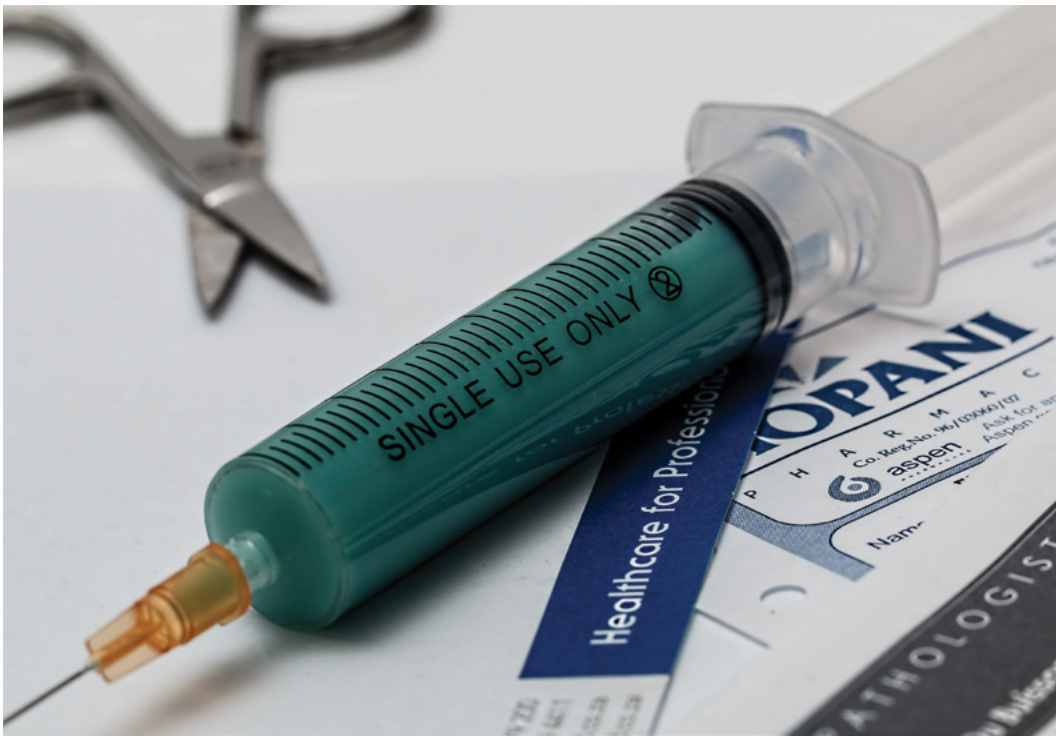
An excellent example of some innovative approaches for which those who seek alternatives often underestimate the downstream consequences is a reference based pricing approach to claims payment. Perhaps the most innovative and often discussed strategies, reference based pricing is still utilized by a small percentage of plans because its implementation is complicated and can be difficult and volatile.

There are different types of reference based pricing plans that can help minimize the disturbance while maximizing its impact on savings. Some plans choose to go with a very aggressive approach, severing all arrangements with networks and instead paying all claims as if they are out of network by setting pricing parameters based on several data references derived from publicly available data such as Medicare or the hospitals' cost data. On the surface, an approach like this can be sold quickly by savvy sales professionals because they can tout hundreds of points in savings, virtually overnight.

Unfortunately, there are some very important details that must be consider before proceeding:

1. No pricing model will be successful unless you have airtight plan language;

2. Unless you work with a stop loss insurer that understands the complexities of a reference based pricing model and who will support the efforts, any reference base pricing approach will likely fail; and most importantly,



3. Any aggressive repricing model will experience backlash as hospitals use the best resource they have against the benefit plans, the patients.

The stark reality and the unrest it causes often leads to the demise of such innovative endeavors. As so many self-funded professionals will tell you, and especially with the new batch of organizations looking to self-fund in a post-ACA world, once burnt, a self-funded employer flees to the world of the fully insured, never to take on the risk of self-funding again, regardless of how lucrative the rewards might be.

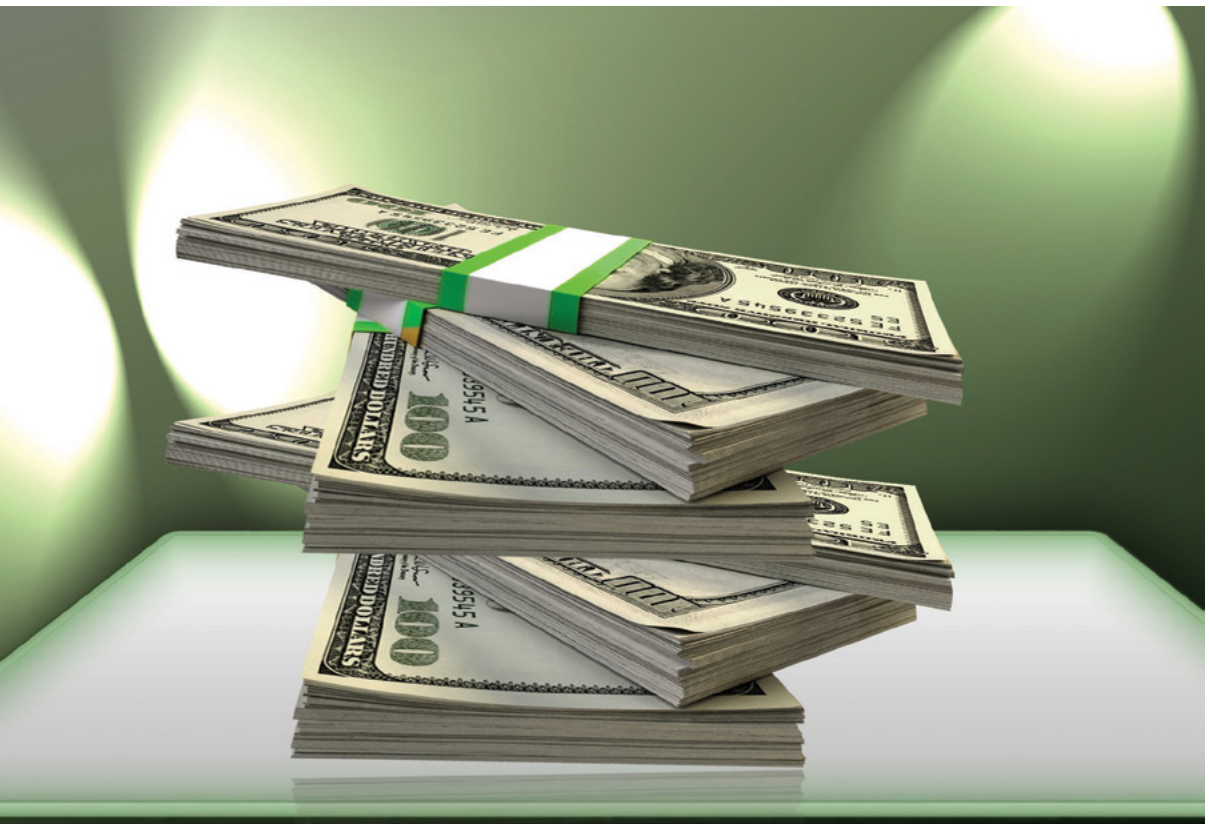
Amongst all of the innovative approaches discussed in the self-insured marketplace, all of which could have a separate article concerning the potential consequences of an ineffective implementation or execution of the model, many of the consequences and considerations discussed above are relatively contained within the confines of the model itself. But what about these models' impacts on other, oft overlooked, perhaps more downstream cost containment tools?

Bear in mind that many of the cost containment mechanisms that are sought after and publicized today are designed to control costs before the claims are actually paid, whereas more traditional cost containment strategies (e.g. subrogation) are focused on recovering funds that are already spent. So every cost containment model designed at reducing the amount spent will necessarily have an impact on the execution of an effective third party recovery program.

Consider this example: ABC, Inc. sponsors a self-insured employee benefit plan. It utilizes a referenced based pricing model with no network obligations, instead, it has established very effective plan language that provides for payment of 200% of some reference price John Smith is a beneficiary of the benefit plan and suffers injuries in an automobile accident. The benefit plan receives $200,000.00 in medical bills. Mr. Smith brings a third party claim and obtains the full insurance limits available to him, $50,000.00. Of that $50,000.00, he owes his attorney a 33% contingency fee, leaving him with a net settlement of $33,333.37.

Assume that 200% of the reference price as established by the terms of the plan totals $100,000.00. Because the plan established its program effectively, the plan's payment is entirely defensible. On the surface, the provider received a fair payment derived from publicly available data which covers the costs incurred in providing the services as well as an additional amount to ensure profitability. So, what is the problem? Recall that the provider's initial bill for its services was for $200,000.00. When Mr. Smith went to the hospital, he signed a document wherein (the hospital will argue) he agreed to pay any balance remaining once his insurance pays for the services.

As a result, the provider in this case now puts a lien on Mr. Smith's settlement for $100,000.00, i.e. the difference between the $200,000.00 charge and the $100,000.00 paid by the plan. Of course, Mr. Smith also has an obligation to reimburse the Plan the full amount of his settlement.



Balance billing, the practice by which the provider seeks the remainder of a bill from a patient after the insurance payment, is an unintended consequence of a reference based pricing strategy and can negatively impact the plan's rights in a third party recovery case. It occurs because the only way to prevent a provider from seeking full payment from a patient is to enter into a contract wherein the provider agrees not to bill the patient upon receipt of payment from the plan, subject to other conditions.

Without this agreement, in almost every situation, the provider is free to request payment from Mr. Smith. As this hypothetical example is designed to illustrate, the provider's ability to bill Ms. Smith for the remainder of the bill causes complications in the plan's ability to recover the third party funds from Mr. Smith's settlement. Note that even if Mr. Smith wanted to issue reimbursement to the Plan, he now has a rather large elephant in the room – a $100,000.00 provider lien.

In this scenario, the best a plan can likely hope for is that the provider agrees to some split between the parties of the remaining $33,333.37 rather than insist on full payment. Otherwise, the only way to successfully recover money for the plan is with a lawsuit challenging the enforceability of the agreement Mr. Smith signed when he arrived at the hospital. In many jurisdictions, the plan participant's lawyer will simply deposit the money with the courts and file an interpleader, i.e. an action which forces all interest holders to appear before the court and prove their claim to the money.

As many who have engaged in any dispute with a hospital over a perceived debt can attest, providers will make their claim with exhaustive persistence often refusing to concede the actual value of their services or the questionable legality of their contract with patients guaranteeing payment. In order to obtain a recovery, the plan or its administrator may need to engage legal counsel and incur additional expenses thereby calling into question the prudence of such a pursuit; once those costs are factored in, and in light of the limited funds available, it may no longer make financial sense to pursue the recovery.

Some advisors will stress the plan's duty to seek every recovery dollar as required by the terms of the plan and its fiduciary duty under ERISA. While this is unquestionably a very important obligation of the plan, many plan advisors will forget the second, perhaps more important duty of a benefit plan administrator, to exercise prudent in its administration of plan assets.

In the end, it is imperative for plans and administrators to understand the complexities and consequences of every decision and benefits strategy they choose to utilize. There is a bevy of innovative tools and cost containment mechanisms that can be used to help benefit plans maximize savings.

These include but are not limited to the reference based pricing strategies discussed above as well as some of the more hybrid approaches customized to give benefit plans the best of both worlds (strong plan language controlling out of network charges and some form of network for a feel as seamless as their fully-insured counterparts), self-insured plans can be tailored to fit the needs of the plan.

As more benefit plans become more aggressive and experts come up with new strategies, it is important that those who establish benefit plans understand the full range of issues that may arise from their decisions. Utilizing experts that understand the self-insurance industry is an absolute necessity. Whether an administrator, a plan document drafting partner, a repricing agent, or a subrogation expert, understanding the self-insured marketplace improves the experience for the benefit plan, and puts it in the best position to succeed, and ultimately, remain self-insured. ■

Christopher Aguiar is an attorney with The Phia Group, LLC. Beginning his career in 2005 and specializing primarily in subrogation recovery, Chris has managed thousands of cases nationwide and spearheaded negotiations between plan participants, plaintiffs' counsel, and plan administrators on matters of State and Federal Law as well as ERISA Preemption, recovering millions of dollars on behalf of benefit plans. Since receiving his license to practice law in the State of Massachusetts in 2014, Chris has also handled plan drafting and plan consulting matters ranging from plan language analysis, claims appeal assistance, balance billing defense, pre-payment claim negotiations, overpayment recovery, stop loss, PPO, and administrative service agreements.

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