SIIA ENDEAVORS

A GOLDEN GATEWAY TO INNOVATION
SIIA KEYNOTERS DRAW LAUGHS AND RAISE EYEBROWS

Written by Bruce Shutan

SIIA's 39th annual National Conference & Expo in San Francisco offered a veritable gold rush of innovative solutions for an estimated 1,900 industry professionals.

The world's largest self-insurance event featured nearly 40 educational workshops across five tracks and an exhibit hall floor teeming with 131 service providers. In addition, keynoters served up food for thought and comic relief.

Greg Schwem, a renowned business humorist and award-winning Chicago Tribune syndicated humor columnist, stressed the importance of humor in the workplace and laughing at oneself. In a hilarious presentation entitled "Work, Laugh, Repeat: How Technology Contributes to a Funnier World," he gently ribbed SIIA for showing up late to the Google game. Schwem cited identical acronyms belonging to others who surface in web-browser searches.

Vinnie Tortorich, one the country's leading fitness and nutrition experts and creator of a new documentary questioning mainstream dietary guidance, weighed in on a serious topic – though often with humorous insight. In a compelling talk about rethinking the decades-old food pyramid, he said self-insured employers need to better educate their employees about nutrition. He warned that poor eating habits are causing or worsening numerous health conditions and spiking costs. In addition to dispelling popular myths about food, Tortorich shared his inspiring battle against leukemia.

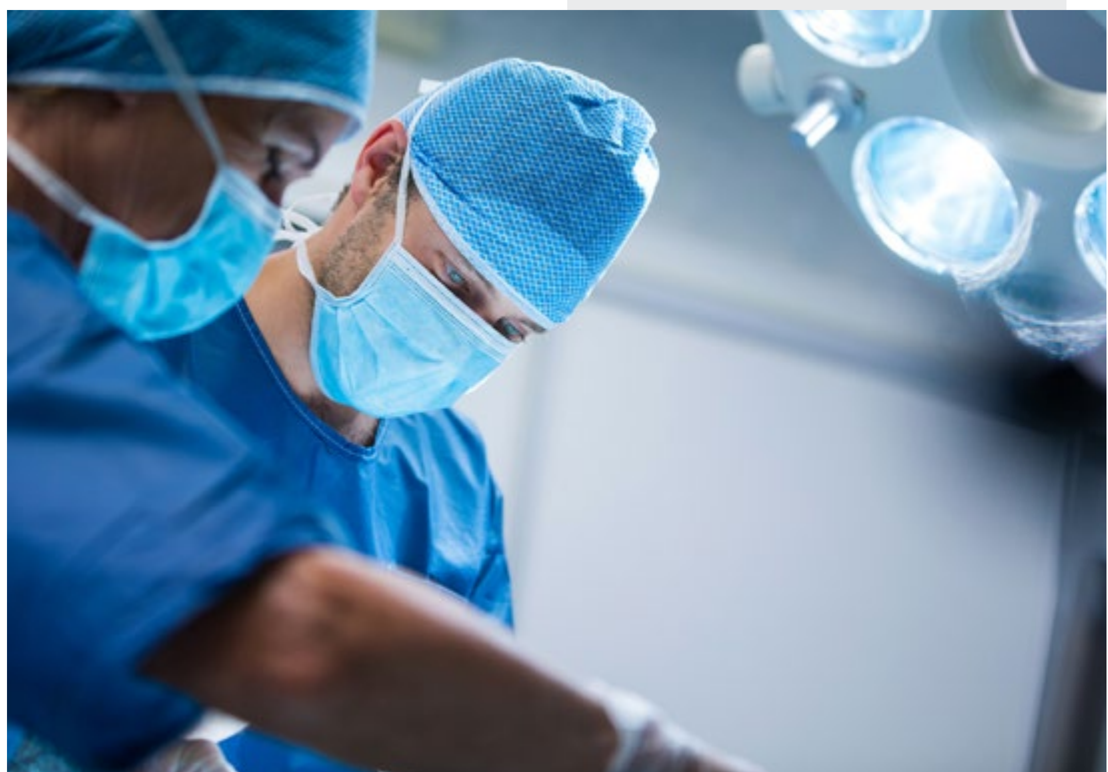
BUNDLING DIRECT CONTRACTING WITH RISK PROTECTION

Direct contracting is all the rage, but when coupled with a robust layer of risk protection, one panel discussion showed how it can turbo-charge self-insurance.

While most elective surgeries are scheduled three to six weeks in advance, precert utilization review usually doesn't happen until 24 to 48 hours before the procedure, explained Scott Haas, SVP of USI Insurance Services. The result is a narrow window to determine medical necessity, but no time to do anything about the price.

This ties the hands of patients who have already made arrangements for family members and/or pets during their aftercare, creating a largely negative consumer experience.

But he's wresting control of these scenarios by writing in plan documents that his employer clients reserve the right to deny any surgery that's not prior authorized within 14 days of the procedure. "The plan sponsor has a fiduciary obligation to know what the surgery is going to be and what's going to be paid prior to the surgery being delivered," he said.



His firm has created and placed a stop-loss mechanism inside the case rate that shields health plan members and plan sponsors from additional charges up to a certain amount related to surgery complications. The upshot is that it removes pressure off the overall specific stop-loss on potentially large claims, he said.

Bundling direct contracting with risk protection helps drive competition by lowering price points "down to what we're achieving in the market," according to Hass. Employees benefit greatly from these programs when surgical case rates are zeroed out.

But there's also something in it for providers for whom payment is expedited at the point of service. Under direct contracting arrangements, he said they're paid up front and no longer need to chase accounts receivable.

Agreeing on price points in advance means providers don't have to worry about billing, collections or bad debt,

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Matosich said, but the trick is capturing all the data and making sure it's transmitted to administrative partners for reporting, analytics, stop-loss purposes, etc.

In some cases, experts say travel may be appropriate for certain medical procedures. "The more complicated the service is that a plan member requires, the more you should be willing to look at regional or national options," observed Korb Matosich, co-founder and president of Asserta Health, which enables cash payment for virtually any kind of health care service. "No one in their right mind should get a knee replacement done at a community hospital in a rural setting. It just doesn't make any sense in the world. They don't do enough volume."

Haas provided a startling example of a patient in Pocatello, Idaho whose local medical center was going to charge him $85,000 for knee-replacement surgery. He ended up getting a round-trip ticket with his wife to a facility in Spokane, Wash., where they were taken to a surgical center by limo and stayed at the swanky Coeur d'Alene Resort on a per diem. The patient was discharged with no complications after the second night. Total expenses, including travel, were just $22,500.

Ensuring that direct contracting works as well as can be hinges on knowing the true cost of risk for a surgical episode or bundle. Regi Schindler, EVP and director of insurance operations for Leavitt Risk Partners, developed a quantitative insurance premium financing model to accurately price these procedures for the best possible risk protection.

"You hear about frequency in terms of mortality and morbidity," he said. "We had to create the second half of that equation by effectively coming up with the severity part of it, which is the cost of the medical care when we have one of these known events happen. So the model becomes frequency times severity, and that allows us to come up with a price per case."

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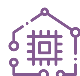 Quote-LinQ

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Risk protection provides amazing insight into quality, Matosich added. For example, tracking loss ratios, complication rates and their cost narrows the range of acceptable surgeons so that risk is being taken intelligently.

Value plays a critical role in the convergence of direct contracting and risk protection Schindler's firm rewards providers who exceed performance measures with lower premium charges and does the opposite for those who under-perform. "Over 40,000 cases over a dozen years that's proven to be probably the most valuable part of our process," he noted.

FINDING VALUE AMID PROVIDER MARKET POWER

Consolidation of U.S. health care providers is happening at an alarming rate and spiking prices with almost no end in sight, industry observers caution, but they also note that there are still ways to find value in the face of this trend.

"We heard a lot of nice stories over the years about how consolidation was going to lead to better continuity and coordination of care, more efficiency, less duplication of tests, but unfortunately, the evidence is about a mile high that it leads to higher prices," lamented Suzanne Delbanco, Ph.D., executive director of Catalyst for Payment Reform (CPR), which advocates value-based purchasing. Nearly half of Federal Trade Commission's challenges to mergers between 2000 and 2008 involved the healthcare industry, according to Jaime King, associate dean and professor of law at the UC Hastings College of the Law.

The number of primary care physicians and specialists acquired by hospitals in the U.S. has nearly doubled between 2010 and 2018 to a point where almost half of all physician practices are now owned by a hospital, reported Richard Scheffler, a health economics and public policy professor at the University of California, Berkeley's graduate school.

In addition, he said there aren't any good guidelines or methodology for judging a rash of vertical mega-mergers such as CVS/Aetna and Cigna/Express Scripts, both of which he opposed. Changes in the healthcare industry in the past decade or so have been the most profound and rapid he's seen over the past 40 years.

All three branches of the U.S. federal government, as well as scores of state houses, are responding to health care market consolidation in numerous ways.

The Alexander-Murray Lower Health Care Costs Act (S1895) is the most significant of six bills in Congress that address surprise billing, four of which are bipartisan, King said. Among the proposed reforms: creation of a federal all-payer claims database that would include self-insured health plans, surprise billing protections, and a ban on gag clauses and anti-competitive contract terms.

President Trump's June executive order on price transparency "would require all hospitals to release in a consumer-friendly format their negotiated rates for a series of shoppable services," she explained. At the state level, King said 28 states have passed regulations over surprise billing, 13 of which are comprehensive, while15 other states offer some protection without arbitration or only in certain instances.

In addition, she noted that 20 states have passed most favored nation prohibitions, which allow insurers to negotiate just the lowest rate among their competitors.

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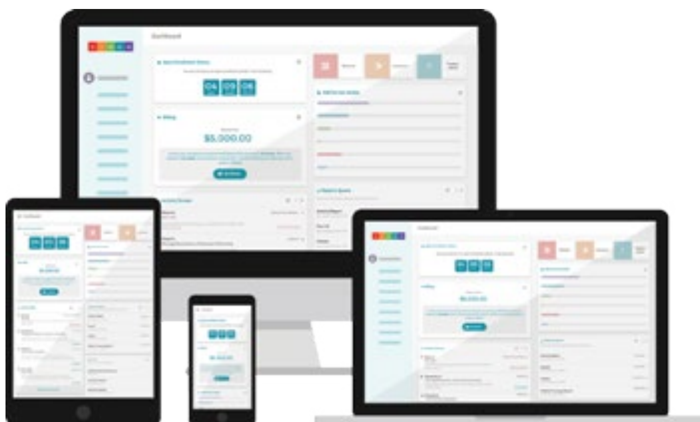
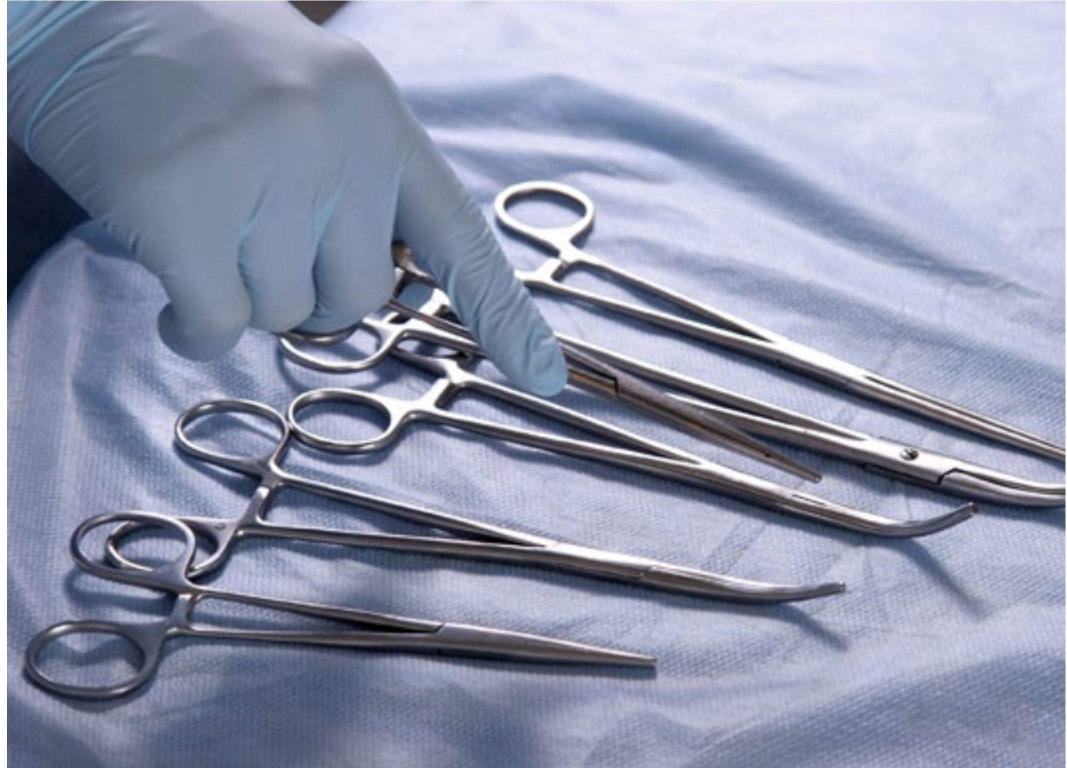


Another noteworthy development King cited is that the U.S. Supreme Court in *Goveille v. Liberty Mutual* held that "the state could not compel self-insured employer plans to submit their data to the state all-payer claims database, which is why the federal all-payer claims database is important."



The prevailing view of industry thought leaders, however, is that there's no use waiting for government solutions to systemic problems. Indeed, the panelists cited several examples of innovative responses to the challenges posed by anti-competitive behavior in the marketplace.

It's important that self-insured employers pressure third-party administrators or other health insurers working on their behalf "not to enter into contracts with providers that mask what's really going on under the hood," Delbanco said. "Pushing for price and quality transparency is sort of a fundamental building block of many of the things that we think employers can be trying to do."

She also recommended narrow networks that weed out 10% to 30% of the "most expensive, porous quality providers" and a center of excellence (COE) program that addresses areas that generate the biggest health care spend. In addition, she suggested waiving cost-sharing as a strategy that's "better than having someone readmitted or having a complication" that requires additional surgery.

Other solutions Delbanco believes will help bend the cost curve include telehealth, second opinions, reference-based pricing (RBP), and onsite clinics that "increase access to primary care and control referrals out to community providers."

In a case study of Walmart's Center COE program for spine surgery showing the value of second opinions, CPR found that half the patients who were referred by physicians at home for spine surgery were told they wouldn't benefit from the procedure.

For RBP, Delbanco said the California Public Employee Retiree system known as CalPERS was able to reduce the average price it paid for joint replacements by 26%. The nation's largest health care purchaser outside of Medicare decided to set a reference price of $30,000 after paying more than $100,000 and found plenty of providers willing to accept that price range.

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PATH TO VALUE MEANS PULLING COST, QUALITY LEVERS

If value is an outcome achieved vs. a dollar spent, as one industry observer suggested during a panel discussion on value-based benefit design, then self-insured employers may need to rethink their purchasing strategies.

There are two levers to value-based insurance design and value-based payment plans that have to be pulled, according to Shane Wolverton, SVP of corporate development for Quantros, Inc., citing transparent prices and quality.

"If you can connect those two levers, then you can create the proper incentives and alignment to increase the probability that you'll consume less in resources and that you will achieve far greater quality than you've been able to achieve thus far," he said. Without such a connection, he suggested that plan sponsors are violating their "fiduciary responsibility to spend the resources wisely and help consumers, who are largely uneducated about this."

Financial incentives associated with increasing quality and decreasing costs have both positive and negative effects, explained Jim Millaway, CEO of the Zero Card, Inc.

For example, he said health plan members could be subject to a much larger deductible for spinal fusion surgery done at a horribly low-performing health system or may have their annual deductible waived if they access care at a higher-performing facility. In short, his suggestion was that plans "make it exorbitantly expensive" to pursue the wrong choice and "totally free" to make the right decision.

Episodic care payment programs are designed to think prospectively priced and retrospectively reconciled strategies for engaging health plan members in "base shopper programs and positive incentives all the way to complete carve-outs," noted Francois De Brantes, SVP of Commercial business development for Remedy Partners.

One example he gave was maternity care, whose mortality rate in the U.S. "is the worst of all of the developing countries." The objective is to ensure that clinicians have incentives to see patients on an ongoing basis, especially for risky pregnancies, "because it's that prenatal engagement which is going to decide, ultimately, what the outcome of the case is going to be," according to De Brantes.

"If we're going to change the way providers think and are motivated to give care," he said, as well as "commensurately change the way in which consumers perceive their choices, then we've got to do things a little differently, and tying value-based insurance design to value-based payment is a way to get it done."

While a solid, low-cost case rate for a vaginal delivery or C-section is important, he explained that the delivery method doesn't matter "as much as what comes out as a process of the delivery," which is a healthy birth weight.

De Brantes suggested changing the choice architecture for health care consumers. They will blow through their annual deductible and out-of-pocket maximum under a classic non-consumer-directed health plan, he cautioned. "But if you put the cost sharing or amount of money that ultimately you as an individual is responsible for above the episode price or budget for that particular procedure," he said, "you have a completely different choice architecture."

Noting that health care decisions are based on cost, quality and convenience, Millaway said "we made the cost point completely moot" by not charging patients who went to the best-performing providers for 27,000 unique bundles across 45 clinical categories.

Baseline savings in the bundled arena average about $40 per employee per month for self-insured employers whose mission is somewhat but not totally aligned, he reported. That number rises significantly when direct primary care is put in place from an onsite or near-site shared network, he added, while it's $100 a month per employee per month when DPC and other attributes are combined with engaged HR departments and C-Suite executives "just by giving away everything for free."

Today's fee-for-service medicine is about cost-shifting, while a dearth of incentives to reward excellence means "you can be a hack or you can be amazing, and you get paid the exact same rate," Wolverton lamented. "We've not done anything to fundamentally alter the provider. We value choice, and then we put the provider in the position to where they have to chase their money because we've offloaded that to the plan member."

However, managing poly-chronic patients who are more predisposed to hospitalizations and complicated surgeries is a far better way to have a meaningful impact, he suggested.

CAPTIVE REGULATORS TALK POT, PROCUREMENT TAXES

From medical and recreational marijuana and procurement taxes to blockchain technology and captive manager codes of conduct, regulators from leading captive domiciles examined several hot topics. The lively panel discussion was moderated by Martin Eveleigh, chairman of Atlas Insurance Management, who asked everyone what they see on the horizon in the next 18 to 24 months.

Steve Matthews, captive insurance coordinator for the Office of the Montana Commissioner of Securities & Insurance, is elated that his state legislature now allows public entities to form captives that his office regulates. "We've had some counties that are looking to pooling together to do some stop-loss programs and municipalities that have already formed a captive," he reported.

While some small captives have dissolved in North Carolina, there has been an uptick in producer- or agency-owned medical stop-loss captives, as well as general liability and workers' compensation, according to Debbie Walker, senior deputy commissioner for the North Carolina Department of Insurance's Captive Insurance Companies Division.

Mergers and acquisitions are driving the dissolution of Vermont captives, though new new entities have sprung up for traditional business, property/casualty, medical stop loss and employee benefits, said David Provost, deputy commissioner of the Vermont Department of Financial Regulation's Captive Insurance Division. He also noted that tenant liability is a growing business.

Delaware saw the dissolution of 68 captives this year and 120 last year, reported Steve Kinion, director of the Delaware Captive Insurance Bureau. "You net that against 21 formations this year alone," he said, "I'm already at a -47 if you look at certificates of authority counting."

But that's expected to change. Delaware Insurance Commissioner Trinidad Navarro favors captives becoming involved in insuring hemp or even recreational cannabis, Kinion told attendees, noting the irony of Navarro's background as a police officer. While Delaware state law only addresses medicinal marijuana, he said recreational use could be legalized within the next 24 months.

Noting that banks won't accept money from medical marijuana distributors, one organization recently approached John Talley, J.D., captive program manager for the Missouri Insurance Department, about establishing a trust company with captive insurance that would issue an FDIC-type policy for each account. Talley described the idea as "brilliant" and said he would accept an application if it were filed. Missouri has legalized medical marijuana.

Another lucrative area for state captive regulators could be procurement taxes. Talley believes that one such proposal could arise during the next session of Washington's state legislature. "What a great business model," Kinion quipped, defending Mike Kreidler, Washington's insurance commissioner.

"He doesn't have a captive staff to pay, so he has no overhead. It's all pure profit."

Knowing how scarce tax dollars are, Provost said "every state is looking for every opportunity they can to gain revenue." He said $25 billion in premiums are going to Vermont alone, surmising the overall captive market must be $50 billion to $100 billion.

Panelists also weighed in on the use of emerging technology in the captive space. Provost, for example, cited a project in Vermont with the secretary of state to incorporate captives using blockchain technology. "Technically, it's pretty straightforward," he said. "Instead of a linear approach, it sort of goes through a web, and you can cut one piece of the web and all the other pieces stay in place, so it's very tough to hack. When somebody does hack a blockchain, it will be a spectacular failure and very expensive, and they will be famous in their dark web community."

The panel expressed concern about the role of cryptocurrency, which Provost said is usually built on a blockchain. While not having a problem with collecting premiums and paying claims in crypto, he cautioned against paying premiums in crypto and collecting claims in dollars "because there's a moral hazard. Crypto's way down, the dollar's way up, I'm going to be a big winner."

Kinion agreed, noting that cryptocurrency is very volatile. "About a year ago, remember, Bitcoin was at $19,000," he said. "Now it's below $10,000. It has lost more than 50% of its value, and anything like that makes me question whether that is a good currency to be using in the insurance industry."

Another hot topic for discussion involved a professional code of conduct. Talley noted that CPAs and other professionals have to abide by their own codes. While liking the idea of applying it to captive managers, he's not interested in policing their conduct.

"We want our service providers to work at the utmost of the ethical level necessary to do their job and to do it well for their customer," he observed. "It's not something that we want to regulate for two reasons." They include the need for licensing and enforcement.

USING RBP TO TAME THE HOSPITAL COST-SHIFT

The key for self-insured health plans to lower hospital costs may be a combination of leveraged purchasing power and reference-based pricing (RBP), suggested an industry researcher and experts from Colorado and Montana who shared their success stories.

"Hospitals are charging what the market will bear," explained Robert Smith, executive director of the Colorado Business Group on Health (CBGH) whose state markets he said "are consolidated not unlike the rest of the country."

About 50% or 60% of physicians are owned by a health system across the state where Smith noted that the nine most expensive hospitals earn more than 400% of Medicare with one facility raking in 782% on outpatient care. "All nine offer at least some services that are in the bottom quartile of all hospitals nationally" in terms of quality, he added, while most of the state's nine most affordable facilities charge under 200% of Medicare with all offering virtually undistinguished quality.

This robust health care marketplace appears to be taking a terrible toll on some state residents. For example, Smith lamented the fact that as much as 25% of young teacher salaries in Colorado go toward health care, while the state's average teacher pay is dead last in the U.S. However, steps are under way to reform the system.

"We intend to get the state of Colorado, some of the larger school districts and several counties to negotiate better prices, and then to make those prices available to the insurers to use," he explained. But two conditions first must be in place: a promise to pass any savings onto small business customers and willingness to offer Affordable Care Act-compliant products on the state exchange.

The intent is to not just reduce pricing and costs for self-funded employers, Smith said, but also for the fully-insured and individual insurance markets. As such, the CBGH is working with he governor's office and has been asked to become a statewide purchasing coalition.

In order to negotiate contracts on a reference-based price, Smith said payers need to know prices as a percent of Medicare and the best alternative to no deal. They also need scale. Unless employers have the size and/or moral standing in their community, he cautioned that they're not going to get where they need to be and costs will be shifted onto patients. CBGH's effort is similar to a number of coalitions across the nation that have banded together to significantly reduce hospital prices, he added.

Like business groups and private employers, state governments face the same pressures to revamp their health plans, especially since taxpayer dollars are at stake.

Montana's largest self-funded plan, which covers 31,000 state employees and their dependents, found itself in deep trouble in 2014. That's when a -$9 million actuarial projection of reserves for 2017 was issued assuming no meaningful plan design changes were made. An ultimatum was issued the following year when legislators passed Senate Bill 418: the plan would be dissolved if it was still mired in red ink two years later.

Marilyn Bartlett, special projects coordinator for the Montana Commissioner of Securities and Insurance, explained how she and her team eventually turned things around. At first, none of the nine respondents to a request for proposal would agree to a Medicare-plus RBP contract awarded to Allegiance Benefit Plan Management, a third-party administrator.

Negotiations began in the summer of 2015 with all state hospitals, since the governor didn't want a narrow network, and the new plan went live a year later – but not without eye-popping revelations and hard-fought victories along the way.

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When claims were run through the plan's re-pricer for the largest hospitals, for instance, Bartlett said the highest average price on outpatient care was was 611% of Medicare and around 500% for inpatient visits. Under the RBP program, she noted that "every hospital would have a different rate, but it would all be a percentage of Medicare."

The state also found other efficiencies and savings within the health plan. For example, she noted that numerous fees associated with spread pricing for pharmacy contracting were eliminated and replaced by a transparent pass-through pharmacy that saved $7.4 million in the first year. Another $5.5 million was trimmed by eliminating duplicate wellness services.

Other changes included beefing up a primary care focus with onsite health centers that didn't charge any copays. "We put that particular contract on an admin fee, but a bonus to the vendor based on cohort outcomes," Bartlett reported. In addition, the state rolled out Healthcare Bluebook quality measures for inpatient care so that members could also see the cost, moved to a cloud-based enrollment administration system and updated the summary plan description.

Bartlett credited RBP for saving Montana taxpayers and health plan members substantial amounts. By 2017, there were $112 million in reserves, which turned out to be higher than Montana's general fund. Also, Montana hospital chargemasters didn't rise more than 1% two years after RBP was put in place, whereas the average was 5% a year prior to that time.

The lessons learned in Colorado and Montana aren't lost on Christopher Whaley, associate policy researcher with the RAND Corporation, who noted that RBI must be designed in a thoughtful manner.

That means being able to shop services, which eliminates emergency care from the equation, and measure quality.

He said setting a reasonable price cap, along with offering employees a financial incentive to use high-value and lower priced providers in a more targeted fashion than high-deductible health plans, will move employers from a passive to active purchaser of health care benefits.

Employers and health plans studied in 2017 by the RAND Corp. and Employers' Forum of Indiana could have sliced their total payments to hospitals in half if they used Medicare's payment formulas, according to Whaley. Instead, he said they ended up paying 241% more than what Medicare paid by negotiating a discount off hospital charges. Other RAND research suggests that employers could save an estimated 8.5% of their total medical spend if RBI were expanded to all procedures wherever appropriate.

HOW TO SMOOTH OUT STOP-LOSS REIMBURSEMENT CLAIMS

Friction associated with stop-loss reimbursement, particularly high-dollar claims, are unavoidable in self-insurance, but a panel of executives from third-party administrators and stop-loss carriers shared their recommendations for reducing or eliminating all the unwanted noise.

SIIA's TPA taskforce has sought to address certain complications related to stop-loss claims reimbursement in a consistent manner and develop best practices to help "stay out of the courtroom and off the front page," reported Dave Wilson, CEO of Windsor Strategy Partners, Inc., who moderated the panel discussion.

Ron Dewsnup, president of Allegiance Benefit Plan Management, noted that his employer groups don't always have

practices that match their summary plan description (SPD). "We'll get situations, particularly with leaves of absence, where some of the issues that come back and forth can create gaps in coverage," he said.

His recommendation is to have as much of that information available during the marketing and renewal phases so that the employer, TPA, stop-loss carrier and broker have "a similar, or ideally, the exact same understanding of how all these things work together."

One best practice is having both the employee handbook and plan document available at either underwriting or implementation to spot any discrepancies, according to Jerry Castelloe, a principal with Castelloe Partners, LLC. "The TPA, in my opinion, should be responsible for making sure all the documents and all the provisions are in sync," he observed.

There also may be disagreement with a stop-loss partner on the definition of usual, reasonable and customary charges, Castelloe noted. He said the time to iron out whether claims are in or out of network or provider billing practices are outrageous is early on and "not when you've got a claim that you've already written the check for your client's money, and they're expecting something back."

Another recommendation was to ensure that pharmacy benefit management (PBM) is in sync with the SPD, Dewsnup noted. "We have seen some issues arise over the course of the past few years with regard to higher cost medication being used off label, and then being questioned not at the PBM part, but when the claim is filed with the stop-loss carrier," he said, "because that's the first time it's been looked at and the TPA has been kind of out of that whole equation."

Kurt Haag, SVP of Optum, noted that since brokers are not only marketing more stop-loss contracts, but also PBM coverage, it's imperative to spell out in the implementation meeting when and how Rx claims will be submitted.

"Sell me on it at the time of the RFP," he suggested. "If we can learn more about that and be different on our pricing, then we can be different in terms of the administration as we work with you from a claims and clinical standpoint." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.