SIIA Endeavors

By Bruce Shutan

SIIA National Conference Wrap Up

Attendees urged to embrace change, prepare for business disruptions

The desert may be largely desolate, but SIIA's 37th annual National Conference & Expo in Phoenix was teeming with lively discussion at the JW Marriott Phoenix Desert Ridge Resort & Spa. Several keynote speakers at what has become the world's largest self-insurance industry event featuring more than 40 educational sessions addressed the importance of adapting to business disruptions.

When four leading venture capitalists were asked earlier in the year about the hottest area of fintech, "all they could talk about was insurance," noted Rich Karlgaard, editor-at-large and global futurist for *Forbes*.

The first of three megatrends he cited in the opening keynote address was that technology isn't slowing down, but speeding up and spreading. John Chambers, Cisco's executive chairman of the board, has predicted that 40% of top 500 U.S. companies will fail within 10 years if they don't keep up with changing technology and other developments, according to Karlgaard.

Rich Karlgaard

He said that understanding these megatrends, which also include extreme valuation differences creating asymmetric warfare and adaptability, along with applying best practices, will help them dodge Chambers' dire prediction.

"This is good news for the self-insurance industry and it's really threatening news for traditional kinds of insurers," he explained, citing Ernst & Young's conclusion that health insurance carriers *"remain in the dark"* as they enter an era of big data. *"The self-insurance wing of this industry is in really good shape because change is your friend. The best employers are going to want to move with that rate of change and the part of the industry that is going to move with them."*

In a similar vein, attendees were told that all it takes is one decision to electrify – or doom – a company. Robert Stevenson, an author and nationally recognized speaker who has spoken at numerous SIIA events through the years, calls it "the Ripple Effect Principle." The thinking behind this conceptual vision is that dropping a single pebble in still water sets in motion ripples that will affect an entire body of water.

When applied to the workplace, Stevenson said passion and enthusiasm can turn individuals into ripple makers. The aim is to open better lines of communication, inspire employees to deliver more and improve retention of top talent, while at the same time increase efficiencies and profits.

He cited troubling research showing that only 21% of employees are "fully engaged" in their company, which can potentially triple operating margins relative to a "disengaged" workforce.

The caveat is to pay attention to the ripples so that they don't turn into waves of destruction, according to Stevenson.

The average lifespan of a Fortune 500 company 50 years ago was 75 years, whereas today it's now just 15 years, he said. Two casualties of the Ripple Effect Principle have been Sears one of the nation's oldest retailers, whose shares he said fell 40% this year alone, and BlackBerry, which owned half the mobile phone market through 2006 before Apple's iPhone took over. Stevenson said the culprit was an inability to see beyond what the company was already doing to meet the needs of changing consumer desires.

Some organizations are able to thrive when they learn from mistakes. For example, he noted that at Dell, one-fourth of new customers came from referrals and the computer company figured it could generate $168 million if just 3% of its detractors could be converted into happy customers.

Branch managers at Enterprise were trained to call critics within 24 hours so they can learn what needs to be fixed and avoid waves of destruction, he added. Since developing its thoughtful Enterprise Service Quality Index, he said the car-rental company went from $2 billion to $20 billion since 1994. The bottom line: customers who feel ignored or mistreated find ways to get even, therefore, he believes they need to be treated with respect and dignity.

Why cyber security is critical for self-insured health plans

The growing intensity of cyber warfare and its collateral damage to health care payers, providers, carriers, third-party administrators, patients and others is clearly cause for alarm. But self-insured employers can adopt a proactive approach to win this battle.

"What we've seen trending over the past four to five years is this huge uptick in health care breaches on the provider and payer side," reported Noah Dermer, security officer for InstaMed.

For example, he noted that 16.6 million Americans were affected by data breaches in 2016, which had the most on the health care side than any year on record, while more than 3.1 million patient records have been breached so far in 2017. He said five of the largest health care data breaches were traced to hacking and IT incidents, which soared 98% between 2015 and 2016.

Robert Stevenson

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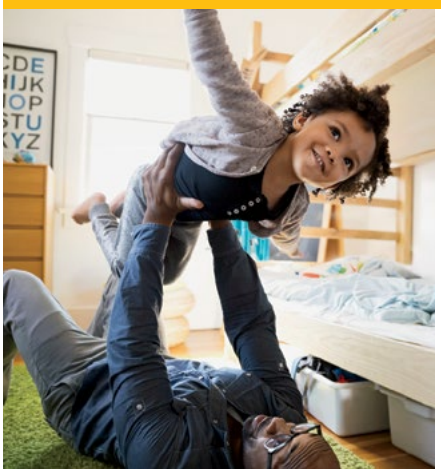

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Moreover, Dermer noted that the 88% of all ransomware attacks in the U.S. last year involved the health care industry and there has been a whopping 133% increase in such attacks in health care compared to the first half of last year. Health data breaches cost the U.S. health care industry an estimated $6.2 billion, according to Dermer, while the average total organization cost of a data breach last year was $7 million.

He suggested establishing a program with vendors to ensure that data is safe and secure, as well as understanding cyber risks "because the time to exploit a weakness in your security architecture is rapidly decreasing." With timely security patching is another essential element, he urged employers to encourage their employees to click on periodic updates from Microsoft, Adobe, Java or Apple.

The trouble with trying to certify compliance as part of a checkbox-audit approach is that "it created the illusion" of cyber security, observed Ian Walters, a senior consultant of health care and life sciences for Coalfire. "I don't have a problem with ISO," he said. "I think it's a fantastic framework. It's just that that piece of paper does not stop the bad guys."

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996, Dermer said it didn't directly account for or envision the notion of cloud-based computing that could leave millions of medical records vulnerable to hacking. A corollary involves explosive growth in mobile devices and apps that he said help patients navigate through their responsibilities or make payments. Indeed, Dermer referenced a significant expansion in health care payment channels.

HIPAA defines three security safeguards under the APT acronym, which Walters said stands for administrative, physical and technical. The first ensures that the right administrative policies and procedures are in place. The second establishes physical controls to protect data such as an ability to distinguish staffers from contractors or visitors across multiple locations. The third ensures that from a technical standpoint, the appropriate technology is in place.

Any meaningful approach to managing cyber security risk involves a team effort and continual battle waged against increasingly organized criminals with bigger resources, Walters suggests. "It's not just the IT department that's responsible," he said. "It's not just if you have a specialized health care department, and then HR and finance don't worry about things. It's across all streams and all disciplines that people have to be concerned with this."

Organizations are highly vulnerable to human decisions or lack thereof. For example, Walters said disgruntled employees may seek revenge or negligent employees may inadvertently click on or open questionable links or attachments that turn out to be phishing attacks.

He suggested an eight-step approach to managing cyber risk. It includes establishing a governance framework; determining an organization's risk appetite; maintaining the board of director's engagement with cyber risk; developing supporting risk management policies; adapting a lifecycle approach to risk management; applying recognized standards, educating users and maintaining awareness; and promoting a risk-management culture.

On his flight to SIIA's conference, Dermer had an epiphany when was reading a book by Paul O'Neill about how he instilled a culture of safety when leading Alcoa.

"He was very focused on physical security as it relates to employee health," he explained. *"I think you want to instill that same culture. That is, there is nothing wrong with reporting suspicious physical or security activity, or just having questions about the overall architecture of your security environment or organization itself."*

How Wall Street investors view the value of TPAs

Third-party administrators have captured the attention of Wall Street and other financial centers, according to a former long/short equity analyst who joined a fast-growing TPA that seeks to connect doctors with patients more efficiently.

Vincent Esposito, chief operating officer of Endeavor Plus, Inc., invested across multiple sectors for nearly a decade until transitioning into the TPA market in late 2014 to help support an investment made by a former hedge fund boss. His former employer, Wexford Capital, managed about $6 billion in assets.

With $3.5 trillion in annual spending that represents about 18% of the nation's gross domestic product, he believes the health care industry is poised for major disruption driven by technology and creativity. This, in part, is why Kaiser estimates it could reach $5.2 trillion by 2023. There has been a nearly 250% increase in money flowing into insurance technology in recent years, he noted. To wit: the $841.5 million invested in 2014 swelled to $2.9 billion in 2016.

Prospective investors in this space realize the typical U.S. consumer can no longer sustain rising out-of-pocket costs relative to wage and inflation growth, according to Esposito. "There are solutions to make health care more affordable," he said, citing the efficiency potential of mobile apps and telemedicine, whose return on investment has been estimated at 5:1. "We need to offer innovative plan designs."

The aim of TPAs given these circumstances is to arm health plan members with the information they need to make wise choices and leverage the power of their health benefits, he explained. His firm's proprietary approach embraces "true" consumerism alongside health savings accounts, health reimbursement arrangements, wellness incentives, value-based reimbursements and care management tools.

"When I say consumerism, I don't simply mean the lowest-price solution out there," he cautioned. *"I'm talking about arming the members with education so that they can navigate effectively with transparency and effective tools for them to access care, and hopefully, drive better outcomes."*

TPAs that describe themselves as adjudicating claims, offering self-funded plans and acting as an administrative services only platform for insurance carriers are sending the wrong message to Wall Street, Esposito cautioned. That's why he said it's critical that they emphasize consumer solutions that transcend commoditized services, which also will draw the attention of investors.

He envisions a convergence of health care, technology and consumer spheres with a platform that enables insurance as a service to employers, also noting the importance of TPAs reinvesting in their business.

"Too many TPAs are doing the same thing, and all that does is marginalize each other," he opined. "The model itself is too fixed-cost intensive. Think about how you can become more financially flexible, then use that incremental capital and reinvest it in your business."

The thesis for forward-thinking TPAs is to create value from making health care delivery more efficient, according to Esposito. With two ends of the market "crying uncle" (i.e., growing frustration among employers and employees, while providers bemoan not being paid on time), he believes the market is ripe for a revolutionary change. He said TPAs can use technology and messaging to maximize their value as health plan members continue to transition into a consumerism approach to health care.

He urged TPAs to explore partnerships with hospital systems to gain market share and pursue reference-based pricing arrangements that are expected to become more popular. He also believes brokers need to be educated about RBP, which they're resisting because of bad experiences they've had with this model.

The bottom line for prospective TPA investors is that they need to be educated about the marketplace's complexity, which he said is a difficult sell when they tend to gravitate toward glitzy investment targets.

"TPAs have to be willing to do everything the BUCAs are doing or not doing and do it phenomenally," he said. But the most important differentiator will be customer service in a market where everything else has been commoditized, he added.

Esposito described TPAs as "big data opportunities" that can analyze claims and predict illness before catastrophic events occur. "Imagine if your adjudication platform had machine learning capabilities, where it was able to build on itself and predict outcomes, and potentially, help manage risk and allow underwriters to give you better medical factors in your plans?" Esposito rhetorically asked.

"This technology already exists," he continued. "It's being used in every other business. Given the economics of health care, I believe it's only a matter of time before it's realized in that market. Most underwriting is done retrospectively, and yes, it's better and easier than predicting a hurricane, but there are better ways to analyze data. With these tools, and with proper buy-in from participants and knowledge base of new technologies, we can become incrementally more competitive against large carriers."

Are level-funded plans good or bad for the industry?

As more small and midsize employers transition from fully-insured to level-funded plans in the self-insured group health arena, a panel of experts examined the merits, opportunities, drawbacks and threats of this approach.

The arrangement funds a fixed amount of monthly premium, claim funding and administration. Level funding typically leverages an aggregate and/or specific stop-loss product to cap exposure to catastrophic claims. However, defining these plans isn't necessarily cut and dried and the panelists had to split a few hairs to stress key distinctions.

SIIA Exhibit Hall

"If you asked everybody in this room what level funding was, you'd have completely different answers," opined Rob Melillo, second VP and head of stop-loss for the Guardian Life Insurance Company of America. He said level funding isn't about being self-funded or fully insured, but rather a choice about how the health care spend is financed.

One audience member questioned the existence of a middle ground in which employers are partially self-funded, noting the issue with level funding is how stop-loss protection is designed. Another quipped that it's akin to being partially pregnant. Michael Meloch, president of TPAC Underwriters, Inc., described the concept as a budgeted amount that only varies by enrollment.

"If it's truly going to be self-insured with stop loss, then what makes this distinguishable from any other self-funded arrangement is simply that there's an expected budget that you pay out to the TPA each month," added Ashley Gillihan, an attorney with Alston & Bird LLP.

What's significant, he said, is that it represents a new opportunity for groups with as few as 25 or 50 lives that are almost always locked into the fully insured market. Larry Thompson, CEO of Benefit Systems, Inc., who moderated the session, called level funding "a self-funded program with training wheels" that has enabled smaller employers to enter the market and reap the benefits of greater cost control like larger companies.

Asked what the difference was between minimum premium and some self-funded plan features, Melillo argued that they're one in the same. While the former involves a per employee per month premium, he said, the latter involves a "roll-up number that you're funding to the max every month. It's just a matter of are you fully insured or self-funded."

Todd Archer, VP of Boon-Chapman Benefit Administrators, Inc., described a minimum premium as "a fully-insured plan with cash flow advantages" and level funding as "a self-funded plan."

There also are distinguishing characteristics between minimum premium payments and stop-loss insurance. "There's a threshold beyond which the carrier takes on all the risk" with traditional minimum premiums, according to Gillihan. "They decide the claims. It is a guaranteed payment beyond that threshold. If a claim is denied, then the carrier is going to have to defend that as either not covered by the plan or it wasn't medically necessary."

Stop loss, on the other hand, serves as a reimbursement for the employer *"if it operates correctly"* and isn't a benefit guarantee, he said, adding that *"the plan still has to pay."* If a claim is denied and a court orders payment, then Gillihan observed *"that's a plan liability and the stop loss carrier may not have an obligation to take care of that."*

The biggest strength of level funding is that it affords employers an opportunity "to transaction from fully insured to self-funded" status, Meloch believes, adding that they still need to understand the risk and liabilities of this arrangement.

Gillihan cited "some technical strengths" to level funding, though he wasn't sure whether or not "they play out practically." They include no obligation to provide essential health benefits, which has led to a proliferation of the skinny plans, and avoidance of the Affordable Care Act's health insurance tax, though he suggests having to pay stop-loss insurance may make it a wash.

As for weaknesses, Meloch noted that "there's less of a chance of having money in the account underneath a level-funded program," whereas money will be left over "90% of the time if you fully fund that spec and ag."

Melillo cited "the inconsistency across level funding on the front lines when you've got a broker talking to a client." He further noted how the broker community has its hands full with multiple ancillary benefits and worksite products that can be broken apart into many sub-products that they also need to understand.

An audience member added that oftentimes "what happens with customers that buy level funding and expect that they're going to get that pooled renewal, they get surprised because it's more of a traditional claims pick renewal." Another attendee expressed concern about HIPAA liability, doubting employers with level-funded products "have any appreciation of the fact that they've become responsible for a covered entity under HIPAA."

In response to a question about strict minimum stop-loss laws that appear to be tying the hands of small employers in California, Archer said "every self-funded arrangement has some inherent risks with it, and that includes but isn't limited to level-funded arrangements."

But he added that the way level-funded arrangements are set up makes it attractive to small employers that can simply send a fixed sum of money each month to their TPA who "keeps a portion for fees, pays the stop-loss premium and then pays whatever claims there are. Unlike traditional self-funded plans that fund as they go, he said "I'm taking a big chunk, sending it on, and it will look more apparent that stop loss is being funded with plan assets."

Melillo's biggest concern about level funding has always been is whether brokers are as astute as they should or could be when they make recommendations and that they need to be fully aware of the pitfalls. Cutting a check once a month to cover all the plan participants represents "a financial sale versus a belly button membership ID card sale, he said.

An employer attendee told the panelists it was important "not to lose sight of what's in those numbers. So let's say you're paying $500,000, $600,000, $700,000 a month, whatever your total is, for your employees. You're getting a one-time lump sum, but I hope that there's somebody on the back end, like myself, going through those numbers and making sure your stop loss isn't going up to here for renewal for next year, because that's the biggest problem with this."

In terms of opportunities presented by level funding, Melillo reverted back to "the core fundamentals of why a group chooses to self-fund" (i.e., reducing tax exposure and managing medical spend). For employers that aren't ready to fully leap into self-funding, he recommended a more remedial approach involving level funding on the fully insured minimum premium.

However, there are caveats to consider along the way. Employers that pursue level funding need to "understand the nature of the relationship that they're entering into," Archer said, including knowledge of their pooling level and plan contract.

Is a camel's nose about to slip under the tent?

While panelists in the level-funding session enjoyed a spirited exchange on the use of semantics, as well as pros and cons, in describing this increasingly popular arrangement, one audience member raised an ominous scenario for everyone to ponder.

Several speakers noted that "level funded" and "partially self-funded" descriptions are largely marketing terms considering that employers are either fully insured or self-funded, the attendee said. His concern is how so-called BUCAs abandoning Affordable Care Act markets in favor of administrative services only contracts that feel like fully insured plans in the smaller group market could reshape the state regulatory landscape.

"They're going to take our industry apart the minute we find one insurance commissioner that has a brain and knows self-funding," he posed. Example: *"understanding that if you're keeping half of the aggregate, it never was aggregate and it shouldn't have been counted toward the minimum ag rule in the state law. And the minute you funded something with a carrier, it's now a plan asset. You can't give it back and spend it on new computers."* What's damaging about level funding isn't the product he said; *"it's the misuse of it that we have to be really careful of to keep the government out of our business."*

Larry Thompson, regional president of POMCO Group who moderated the session, issued a thoughtful reply. As chair of SIIA's Government Relations Committee, he admitted to spending a great deal of time addressing this growing issue. He also noted that SIIA has a staffer who devotes all of his time to state laws and regulations.

Most insurance departments don't have a granular enough understanding of the definition of level funded vs. spec and ag, he said, though California and others have tried to limit self-funding arrangements.

"We're seeing all kinds of attacks," Thompson observed. "There are a lot of people who are working really hard to fight that fight. Keep contributing because we really are winning a lot of battles."

Why leveraging health care consumerism is one key to success

For many self-insured group health plans, the key to success is motivating employees to make appropriate health care decisions that compliment various plan design features. This health care consumerism approach often results in cost savings and more efficient care.

"We're trying to get people to behave in the way they purchase health care the same way they do in every other area of their life," said Mark Gaunya, CEO, Captivated Health.

Health care consumerism is clearly a missing piece of the puzzle for self-insured employers. Consider, for instance, that the U.S. health care system was designed for government, hospitals, big pharma and the BUCAs – not individuals, according to Gaunya. The promise of the health care consumerism movement is that it educates patients, improves engagement and empowers them to make wiser choices.

There are five elements of health and wellbeing: physical, financial, workplace, community and mindful spirit, according to Gaunya. By addressing all of them simultaneously, he said self-insured employers will be able to leverage the power of health care consumerism.

Gaunya called health care literacy in the U.S. "abysmal" at only about 13% of the population. "Cost and quality information is available, but employees need tools and incentives, and you have to find the right providers of those transparency tools," he said.

With self-funding the only way to achieve complete price transparency, he said price variation across procedures and regions deepens consumer frustration. He related a story about his neighbor learning that a particular prescription drug had different prices at three local CVS pharmacies. His advice: use a cool app called GoodRx to help make a more informed choice.

Despite such wild variations, there are signs of progress in terms of lowering prices. One area is Lasik eye surgery, which traditionally isn't covered by insurance. Gaunya said eye care providers must compete based on cost, quality and service. He noted how the competitive balance has shifted significantly in that the procedure is now about $1,000 less than it was 18 years ago.

Also, he cautioned that none of the medical billing is made transparent to patients in a group health plan prior to services being rendered. Indeed, the Catalyst for Payment Reform gave U.S. health care transparency a failed grade point average of 0.72, Gaunya noted.

"I'm actually shocked that we would tolerate this level of performance," he lamented. *"Transparency is the only cure for what ails our health care system. In my opinion, it is the foundational principle of which real change would happen, and until we do it, we're never going to get a different answer."* An equation to remember is that transparency, plus education and incentives, equal consumerism, he added.

Another huge obstacle involves how medicine is being practiced. He cited several troubling statistics suggesting that 37% of diagnoses are wrong and 75% of the time the prescribed treatment didn't even help patients.

This has paved the way for companies like Best Doctors, a clinical concierge service offering second opinions, which he said had 30 million people covered on their roles in 2015 from 40 or 50 countries worldwide. The service, which was founded by two Harvard physicians, features a network of 53,000 specialists and sub-specialists.

A closer look at health care economics shows why there's a need for more innovative products or services to help bend the cost curve. Medical trend is comprised of a unit cost (50%), service (35%) and provider mix (15%), he said, but he said it ignores the Consumer Price Index and wage growth.

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He labeled rising prescription drug costs "the biggest problem in health care," noting that the U.S. pays about 75% more on average than it should "because we are subsidizing the rest of the world relative to prescription drug costs." Although the U.S. Food and Drug Administration will not allow group health plans to purchase drugs overseas, he said the benefit can be designed to take advantage of importing lower scripts from where they're made. Some cost-minded employers also have used medical tourism as an alternative to the high cost of certain procedures.

Closer to home, Gaunya recalls asking fellow members of the Commonwealth of Massachusetts Health Insurance Connector Authority board of directors on which he serves why they focus on rising premium vs. the underlying cost. "You would have thought I just asked how do I fly to the moon and back," he quipped, recalling how they thought that was simply too complicated.

At the corporate level, he discussed the importance of critical governing documents that include a summary plan description, TPA services agreement, stop-loss contract and employee handbook. "Most people don't think about the handbook relative to a self-funded plan," he explained. His point is that the document can be modified "to actually help people understand that they can make money through their health plan."

He believes the right incentives and engagement strategies will produce desired behaviors. Examples include reducing or eliminating coinsurance or deductibles, direct contracted care and mobile apps that streamline the patient experience or wellness programs.

Self-insured employers also can consider alternative risk transfer arrangements. Gaunya runs a captive program that enables 33 mid-market employers with 10,000 belly buttons in seven states to share, retain and transfer risk. "The shared layer is meant to act as a volatility shock absorber," he said. ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for nearly 30 years.