SIIA Endeavors

written by Bruce Shuntan

SIIA Endeavors: SIIA's 36th National Educational Conference Wrap Up

Mulling Political and Business Disruption

Everything is bigger in Texas, as the saying goes, and the depth of meaningful content at SIIA's 36th National Educational Conference in Austin certainly lived up to that billing. In fact, a towering theme hung over both the opening and closing keynote addresses: making sense of significant disruption to U.S. politics and business.

Attendees were treated to a political science lesson from Chris Stirewalt, digital politics editor at the Fox News Channel who kicked off the event. He devoted most of his insightful talk to how the nation arrived at a point where both major political parties chose presidential candidates with such high disapproval ratings.

"The single most important story of this election was a husband and wife demographer who studied morbidity and mortality rates," he noted.

What they found was white men age 40 to 60 were dying sooner because of drug abuse and suicide. The culprit: a loss of hope, disruption, displacement and a feeling that what was promised, predicted and known was turned upside down.

While the future belongs to women, he said Clinton miscalculated their role in the election – which is why poll numbers showed a tight margin based on gender. Donald Trump emerged as a political outsider who represented hope for the disenfranchised, he added, referencing the cusp of a second machine age driven in large part by robotics and breakdown in the family unit.

Asked what will likely happen to the Affordable Care Act under the next president, Stirewalt doubted that Congress will have the political will to repeal and replace the ACA or embrace a single-payer solution. Instead, he predicted several patches to the landmark legislation to help better control rising costs.

Stirewalt also opined that Americans will need to take more personal responsibility for adopting healthier lifestyles rather than expect a national government solution. He noticed 15 wheelchairs lined up at the gate upon stepping off an airplane a few days prior to his appearance at the conference, figuring obesity is playing a major role in shaping the health policy debate.

Facing adversity head on

As much as Trump clearly disrupted the 2016 presidential campaign, several scrappy startups have done the same across various industries, according to Robert Stevenson, an author and nationally recognized speaker who has spoken at numerous SIIA events through the years.

His folksy and often humorous chat, entitled "Business Success in the Age of Disruptors," he lauded the surprising success of companies like Uber and Airbnb and suggested to attendees a winning formula for helping their firm become a disruptor or protect their market niche from being disrupted.

"If you don't like change, you are going to hate extinction," he quipped.

Stevenson noted how $1.8 trillion will be stolen from business people by the year 2020, while more than 60% of CEOs fear a data breach, whose latest highly publicized violation involved information on at least 500 million Yahoo user accounts.

What successful companies do is identify what's draining energy, money and resources from their business and eliminate them, he explained. They also figure out ways to diversify their income streams or simply adapt during times of significant market disruption. One such example involved a U.S. manufacturer that completely changed course after the North American Free Trade Agreement decimated its industry by producing bullet-proof vests that were too high end for anyone to produce for less outside the U.S.

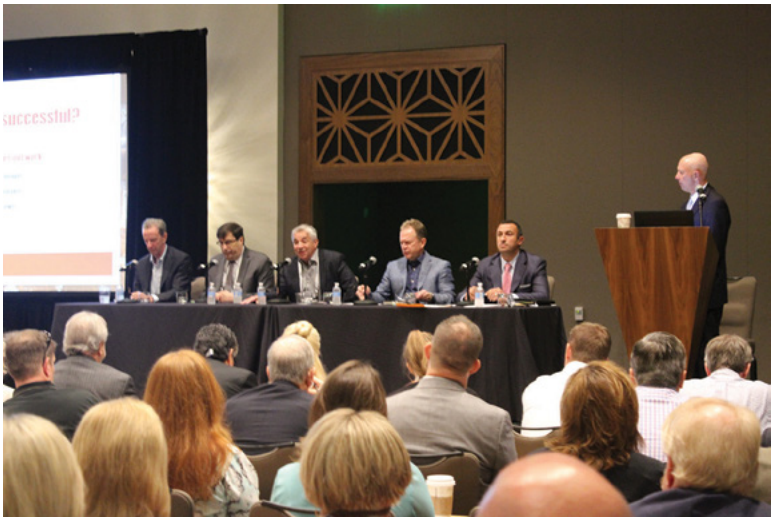
Another key ingredient is to build customer service around honesty and respect when handling complaints, Stevenson said. "People are more forgiving than we think," he observed, noting how 75% of patients will not sue for malpractice if a doctor admits to making a mistake.

Critical Reference Points: 3 Perspectives

What's a 'Reasonable' Price to Charge?

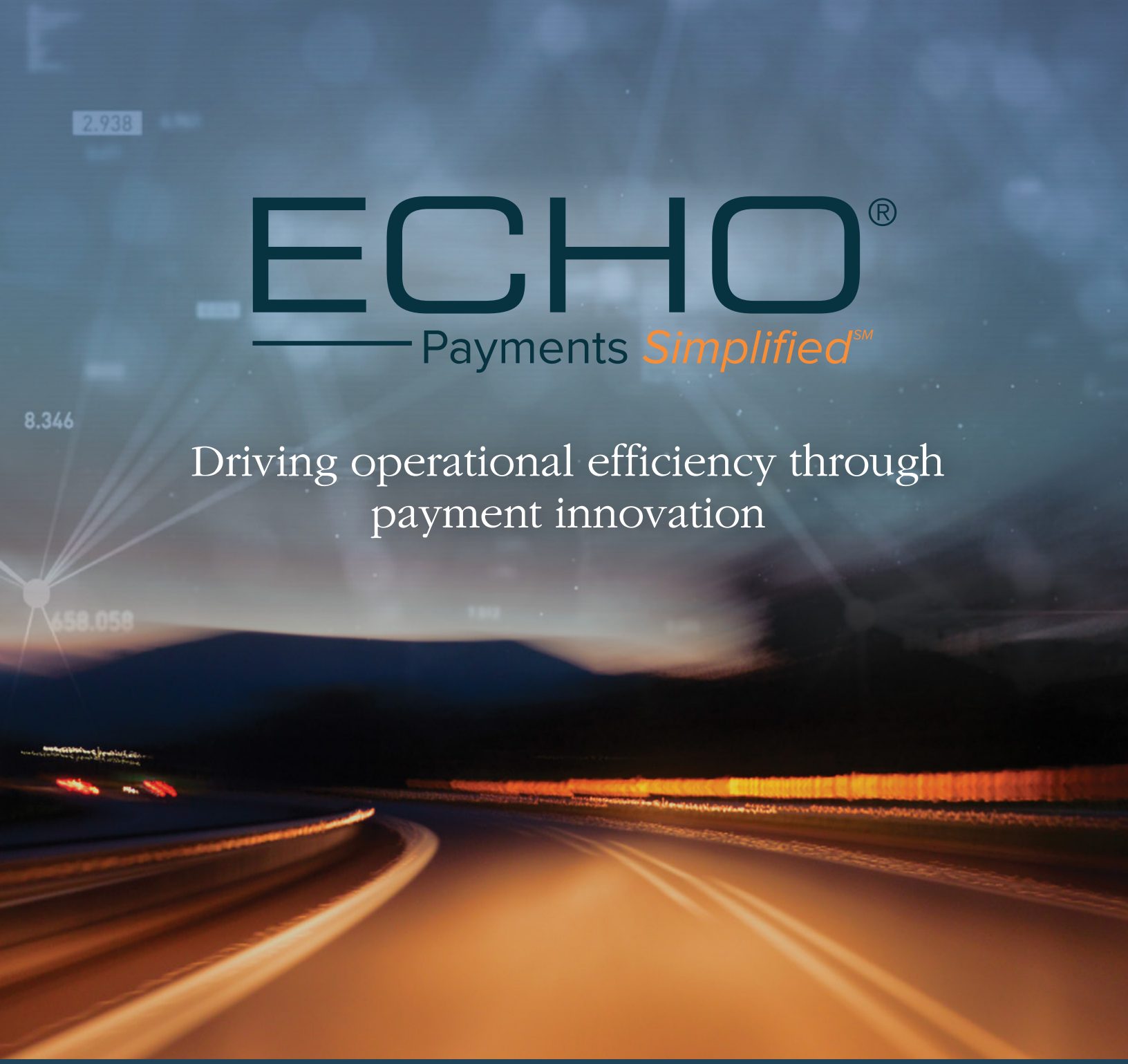
In each of the many discussions about reference-based pricing (RBP), speakers and attendees alike sought to answer the proverbial $64,000 question: What exactly is a fair market price that will please all major stakeholders?

In a heavily attended session entitled "Reference Based Pricing – Exploring Different Strategies and Approaches," panelists agreed that Medicare reimbursement can be used as a baseline charge. What's unknown, of course, is the additional layer needed to settle each balance bill in a rational way as part of a standard methodology for RBP. They said it can range anywhere from Medicare plus 20% to 140% and even higher (i.e., a hospital administrator's hope). One panelist suggested the 40% to 45% range as a sweet spot for self-funded plans.



Since Medicare sets a fixed payment amount, it's "the easiest calculation any underwriter could ever do," said Mike Dendy, CEO of Advanced Medical Pricing Solutions. Under this approach, he explained that "the plan document defines exactly what the employer will pay, and the stop loss carrier is an extension of the employer plan, and that's what they'll pay, so they're bulletproof."

Another suggestion is to examine BUCA (Blue Cross, United, Cigna Aetna) out-of-network claim contracts that are clobbering employers in order to help benchmark RBP rates, he said.



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"When most of the BUCAs pay an out-of-network claim, they do it at a flat 110%, 115%, or 120% of Medicare," Dendy added. "That's all they pay, and they provide no advocacy."

Regional differences also play a huge factor in deciding what's reasonable. "How you answer that question in Boston is very different than how you answer that question in a town where there's two major hospitals, or another place where there's five hospitals, or a city where everyone is using a PPO," explained Adam Russo, CEO of The Phia Group.

At times, there were a few testy exchanges. In response to one attendee's question about what constitutes a reasonable reimbursement that will allow many struggling hospitals to stay in business, several panelists bristled and reminded attendees that there are some very profitable hospitals operating across the U.S.

Hospitals that are losing money simply need to operate more efficiently and innovate rather than pressure patients in employer-provided plans to pay hefty balance bills, Russo opined. One panelist even noted that the CEO of the HCA hospital chain earned $34 million last year, the University of Pittsburg Medical Center's CEO made $8 million and Sutter Hospital in Northern California has 32 executives whose annual earnings are more than $1 million a year.

Be that as it may, there's a growing acceptance that balance billing is inevitable and steps must be taken to educate health plan members on this topic, observed Steve Kelly, president and CEO of ELAP Services.

He recalled a startling change of attitude about RBP among providers, referencing a cordial meeting the day before his talk with a major health care system in Austin where the conference was hosted. Their initial encounter about eight years ago featured "a completely different atmosphere."

Threat of regulation

When viewed in a much larger context, it's critical that a market solution be pursued to avoid Congress stepping in at some point and setting prices directly, cautioned Edward Day, CEO of HS Technology Solutions, Inc.

He described regulations on financial-assistance policies as "very vague," though they still impose some discipline and limit expenses to average managed care prices, the usual, customary, and reasonable structure, or Medicare prices.

Also noting how the Department of Labor released some quasi-regulation on RBP, Day said "it's clear they don't really quite understand it." The oversight was geared more toward a CalPERS-type plan with hospital contracts whose health plan members were "stuck holding the bag for the difference between the contracted price and the reference price," he explained.

Hospitals realize that as unregulated utilities transitioning the way they conduct business (i.e., embracing RPB) is always preferable to oversight, Dendy observed. But their backs are against the wall considering that 99% of Americans "can't pay an extra $5,000, $10,000 and certainly not $100,000" in balance billing, he explained. Another potential risk hospitals run involves PR fallout in their local community from patient billing horror stories.

"So by having any of us act as a fiduciary for a plan, the medical extortion corridor is shut off," he said. *"Now the hospital has to deal in good faith."*

Kelly encouraged attendees to have open discussions about billing disputes with high-performance health providers and said patient advocacy on the front end will vastly reduce the number of balance bills. But he also mentioned that it's important the hospital community understands that employers are prepared to litigate in the absence of good-faith negotiations, even though that it rarely happens.

Another helpful tip involved the use of technology, which Day said can more easily help identify appropriate prices in different markets. "As we know, health care is not a one-size-fits-all [proposition], so using the technology to filter, manage and communicate effectively has proven very effective for us," he added.

RBP Seen as Powerful Transparency Tool

Conference rooms, hallways and exhibit-hall booths were buzzing with talk of reference-based pricing (RBP) perhaps more than any other topic. In one particular session entitled "The Future of Stop Loss – Industry Leaders Weigh in," it was standing room only.

Bob Baisden, president of International Assurance of Tennessee, Inc. who was one of five panelists weighing in on this topic, described RBP as the latest incarnation of transparency. He said California Senate Bill AB72 and Florida House Bill 221 are leading the way to protect patients from surprise hospital bills.

RBP also has emerged as a welcome solution for paying rising pharmaceutical bills, especially with regard to the specialty pharmacy area which accounts for about half of Rx trend, according to Tom Doran, president of Medical Risk Managers. He noticed how some clients with 8% of their stop-loss costs tied to specialty pharmacy are now in the 15% to 17% range.

RBP is one of the "shining examples" of ways the self-funded industry can price coverage

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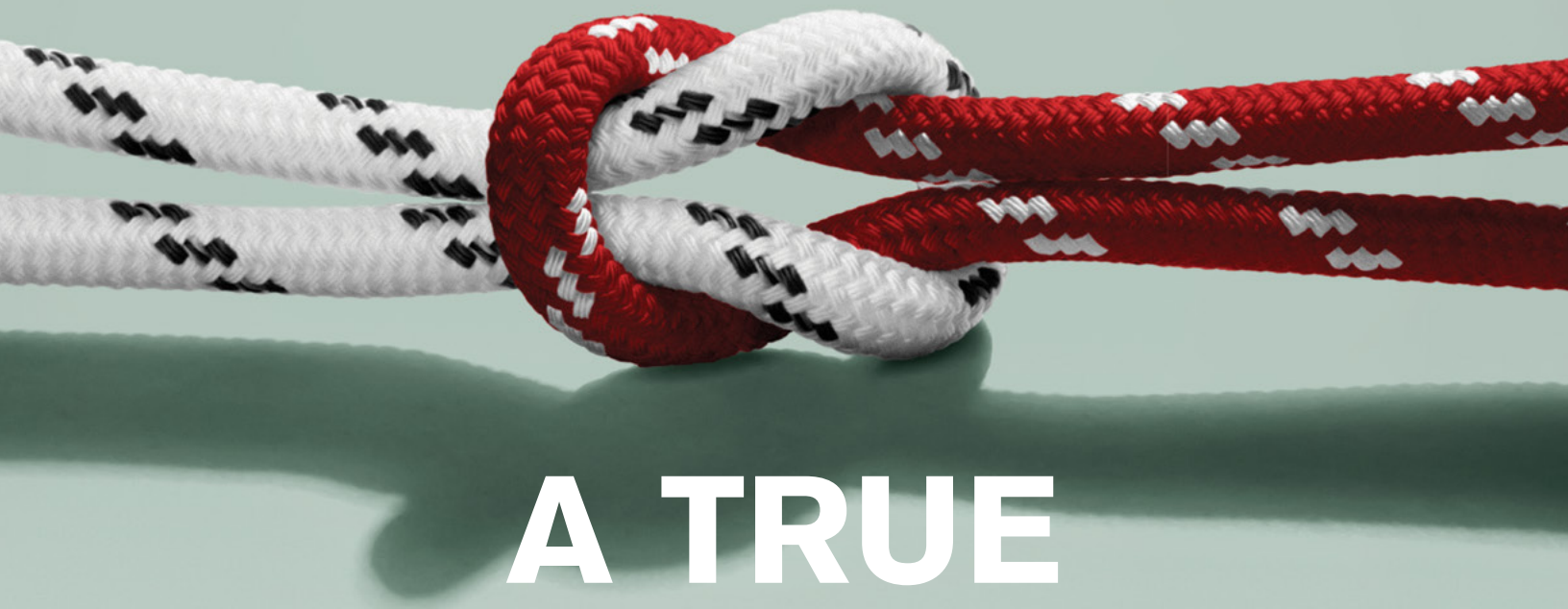

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and do a better job of controlling cost when balance billing occurs, said Mike Kemp, head of the North America accident and health business unit of Swiss Re Corporate Solutions . The goal is to achieve a level that the payer and provider agree to be reasonable pricing. While some hospitals are using bill collectors, he noted that others are willing to negotiate and this practice will help grow RBP.

Steve Gransbury, president of accident and health at QBE North America, has seen rock-solid outpatient advocacy playing a part of the RBP model. "The most important element to these arrangements is when you prepare a claimant or an employee that they might get a letter, nasty-gram, or threat of a second mortgage or somebody taking away their home in balance billing situation," he opined.

The Leapfrog Group helps consumers evaluate hospital cost and quality in terms of surgeries, number of services offered and mortality rates, Doran observed. As part of that movement, he said there's also momentum to improve practice patterns.

However, it also would be helpful for the industry to give more thought to using pricing transparency as a tool at the employer level rather than expect consumers to take action, Gransbury suggested. Most of the top brokers have approached him about having a producer panel in place to help steer employer clients to the right resources for managing their risk.

Indeed, employers expect more collaboration in the marketplace than they ever have and this will be a key theme in the next three to five years, predicted Brad Nieland, VP of stop loss at Sun Life. He said there will be some cost containment wrapped around a producer panel to improve coordination with stop-loss carriers, especially in light of growing pharmacy trend. In fact, Nieland has seen a 25% increase in $1 million claims largely driven by specialty drugs and believes it's only a matter of time before the trend will include $2 million claims.

In a Mercer survey of employers with 1,000 lives or less, Nieland noted that more than half carved out their stop-loss business rather than bundle it with administrative services only carriers. He believes greater use of producer panels will help promote this trend.

Benefits eligibility is seen as a huge issue with regard to stop-loss claims when balance bills are submitted, though a key question remains about who exactly owns the claims eligibility reporting. There should be a reference to employee handbooks in a plan document to help stop-loss claims analysts, Kemp suggested. A big problem is when a $500,000 claim is made for someone who's not eligible for the plan, Baisden noted.

Captive traction

Panelists also addressed the rise of captive insurance to help control employee health benefit costs. Gransbury, whose single-parent and homogeneous group captive business is thriving for groups in the 1,000 lives range, explained that it can be challenging and time-consuming to spread volatility among smaller groups.

He also said there's more traction with captive risk financing in terms of claims management and ensuring there aren't overages, less reliance on spreadsheets with captives and no shortage of carriers and reinsurers serving the marketplace.

A key component to the captive model is the level of employer engagement, according to Kemp, who said it creates a self-selection process that draws like-minded groups that want to take a more aggressive stance on health benefit costs. It creates "a self-selection process that brings in and attracts those employers that really see the value of their health benefit plan, but want to do something about the cost," he noted. "They're managing just like any other cost of business."

Kemp said there's a need to educate and train brokers to understand what the captive means and doesn't mean and that one size doesn't fit all their clients. Whether it's the use of captives or alternative funding, the marketplace is looking for solutions and brokers are looking for differentiation, added Nieland, who believes these arrangements will continue to gain market share as more employers move to self-funded health plans.

Montana's Data-Driven Approach to RBP

In the reference-based pricing (RBP) arena, it's not unusual to raise eyebrows in response to crunched numbers. There was a telling moment during intense negotiations between the state of Montana's health care and benefits division and 11 hospitals.

Hospital CFOs weren't able to guess their own charges when aggregate data was shared, according to Ron Dewsnup, president and general manager of Allegiance Benefit Plan Management, whose analysis helped the state save millions. He said "it was the first time they had seen anything other than either their chargemaster comparison or their cost to charge ratios."

Marilyn Bartlett, an administrator with the state, experienced her own revelation: "We realized that the higher-cost facilities were coming in with the lowest quality, and the lower-cost were coming in with a higher quality."

These recollections were shared in a session entitled "Data-Driven Medicare Reference Contracting," which detailed a nearly seven-year journey during which the state's largest self-insured plan was able to significantly lower hospital costs and improve efficiencies.
Using data comparing allowed amounts to Medicare as a common reference, the state finalized new contracts by July 1, 2016 with all 11 hospitals across Montana where 87% of state hospital dollars flowed prior to the agreement. Because of its size in the marketplace, the state was able to wield its considerable purchasing power and obtain substantial discounts on hospital services.

The hope was to pursue a collaborative approach based on trust and negotiation in terms of determining reasonable and appropriately priced contracts. One concession the state made was to keep these negotiations under wraps as long as the hospitals agreed to new contracts and avoid balance billing.

But it wasn't easy arriving at that point. Of roughly $200 million in taxpayer dollars that Montana spends each year, 43% went to hospital expenses, 22% to pharmacy benefits and 18% to out-of-state facility charges.

Also noteworthy was a huge differential between the payments some hospitals accepted and deepest discounts, Dewsnup reported. A statistically valid random sampling of various claims in 2013 and 2014 showed inpatient costs up to 322% of Medicare, while outpatient costs ranged anywhere from about 240% to 611% of Medicare.

The state's hospital agreement doesn't define a set Medicare reference; instead, Dewsnup said "it simply says that we will pay up to what we would pay a participating provider." It's certainly a much better deal for Montana taxpayers. A 271 point differential in the state's blended hospital utilization cost in 2014 is expected to be just 28.5 points by 2018, he reported. The state projects that it will save about $34 million during a two and a half year period beginning in 2016.

There were no changes projected in terms of premiums, deductibles, co-pays and coinsurance that about 15,000 employees, legislators and retirees and another 16,000 dependents would pay in the future. In ensuring that all hospital benefits would be provided at network rates, Bartlett said

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the state also was able to avoid narrow networks and steerage to certain facilities, as well as preserve freedom of choice.

"We did not want to do reference-based pricing with balance billing," Bartlett explained. "That would just not work with the state of Montana employee population. So we did have agreements in place where the provider would accept the payment and would not balance bill, except that the member would pay their normal co-pay deductibles and non-covered services."

A hospital perspective

Those agreements are becoming increasingly common among payers and providers who would rather settle unpaid bills in good faith than involve bill collectors or lawyers.

Emily Scott, an attorney with Hirschler Fleischer who advises hospitals that negotiate with self-insured payers that pursue RBP, acknowledged that hospitals and the health care industry in general must become more efficient. "Most, if not all, of the providers I represent are continually working to streamline operations," said Scott, who led a session entitled "Reference Based Pricing – The Hospital's Perspective."

She explained that hospital charges are made up of a complex cost structure that includes the labor force, facility operations and improvements, current and projected technology expenses, a competitive marketplace and the number of uninsured patients who are treated. Another key factor involves the cost of uncompensated care, which the American Hospital Association estimated at nearly $43 billion in 2014 and more than $502 billion since 2000.

In addition, Scott detailed what goes into the cost of an outpatient MRI. Chief among them: expenses related to buying or leasing the machinery, equipment wear and tear, staff salaries, climate control or electric bills, cleaning fees and related overhead such as malpractice insurance.

Scott suggested that members of the self-funded community approach the right person at their local hospital (i.e., someone who understands the expenses associated with balance billing and has the authority to negotiate with TPAs and self-insured employers).

"Talk to that person early and often – certainly before any patient is presented with a balance bill," she advised. Another recommendation is to maintain a conciliatory tone by framing the discussion in terms of cooperating with providers to minimize balance billing, collection costs and bad-debt write offs.

Stop-Loss Captives Said to be on the Rise

A promising solution is emerging in the alternative risk transfer arena, and while not much is known about stop-loss captive programs, industry experts are forecasting solid growth but also cautioning self-funded employers to manage their expectations.

The value proposition of a stop-loss captive is that it's a gateway into self-insurance for limiting risk and volatility, noted Andrew Cavenagh, managing director of Pareto Captive Services who serves on SIIA's board of directors and once chaired the Alterna-

tive Risk Transfer Committee. His talk was entitled "Stop-Loss Captive Programs – The Basics Plus Lessons Learned."

Captives not only fill a void in the stop-loss market, they also enable like-minded employers that band together to share in the spoils and help service providers become more profitable, according to Cavenagh. To some degree, he said, they represent a unique offering that is trickling down market to smaller groups.

But given the stop-loss captive structure, it would be unrealistic for each employer member that invests its own capital to expect any sort of rate reduction in the first year, cautioned Brian Johnston, an employee benefits attorney with Polsinelli who moderated the session. He said based on his experience in the industry, a three- to five-year commitment is necessary before being able to reap any ROI from the arrangement.

Each member of a stop-loss captive has its own plan and rate based on experience, while the group will share large claims, which Cavenagh called a key component of the arrangement. His firm has found that heterogeneous captives tend to be a bit more successful than homogeneous arrangements, which could be attributed to more freedom to focus among employers that do not compete in the same industry. Group decisions are collectively made with regard to renewal or service providers, wellness, plan designs and options.

At the employer level, he explained that each organization sponsors its own health benefits plan, as well as chooses its own plan design, TPA and provider network. While each individual employer will retain the smaller predictable claims, he said "the group will share a mezzanine layer of claims typically, and then you buy catastrophic protection above that."

Serving as a backdrop for their rise is the increasing cost of benefits, though that argument equally applies to self-insurance and other alternative risk transfer arrangements. While there are tax-deferred advantages with stop-loss captives, Cavenagh said they're not as large as on the P&C side. The duration of stop-loss captive claims "is much lower than it is on the P&C captive because the dollars are going out the door so quickly," he explained.

Program evolution

While stop-loss captives date back to the 1980s when ACE created the market, the first employee benefit captive program Cavenagh knows of was in the '90s. In 2008, he said there were three different structures that have since morphed into a single vehicle involving traditional stop loss. One is a captive direct that writes stop-loss coverage directly in a given state and is subject to a particular state's regulation. Other popular captives involved risk retention groups (RRG) whose advantages were similar to direct captives and fronted captives. The latter ended up replacing the former after California regulators pursued legal action involving an RRG.

In 2013, the number of stop-loss carriers and captive managers expanded dramatically, Cavenagh noted, and there have been very large jumps in growth since then now totaling $500 million. But it could climb much higher. Cavenagh predicted "explosive growth" if there are more defections to self-insurance from an estimated $700 billion to $800 billion in pool of premium among fully insured group health plans. He also said the stop-loss market is about $13 billion.

Considering the old axiom about managing only what can be measured, a full understanding about the potential of captives is still being formulated. There wasn't much data on captives being shared in a recent SIIA membership poll, Cavenagh reported. Still, he lauds SIIA for doing "a great job of educating the industry" about captives.

A dearth of information about stop-loss captives, however, can lead to unfortunate assumptions that serve as an obstacle to growth. All captives fall under the ERISA definition of a multiple employer welfare arrangement (MEWA), Johnston noted.

In essence, they involve two or more employers that band together in an aggregate structure to provide benefits to employees of multiple organizations and co-mingle assets. And since states consider MEWAs unlicensed insurance companies, he said it was critical for the self-insurance industry to educate regulators about the differences between MEWAs and captives, as well as demonstrate the latter's money saving potential.

There also can be legal pitfalls associated with stop-loss captives. For example, since employee contributions to a plan are defined by ERISA as plan assets, they cannot be used to pay for non-claim related expenses in a captive, according to Johnston. That could be deemed a prohibited transaction, among other things, he said, adding that the captive does not pay claims – it reimburses for expenses.

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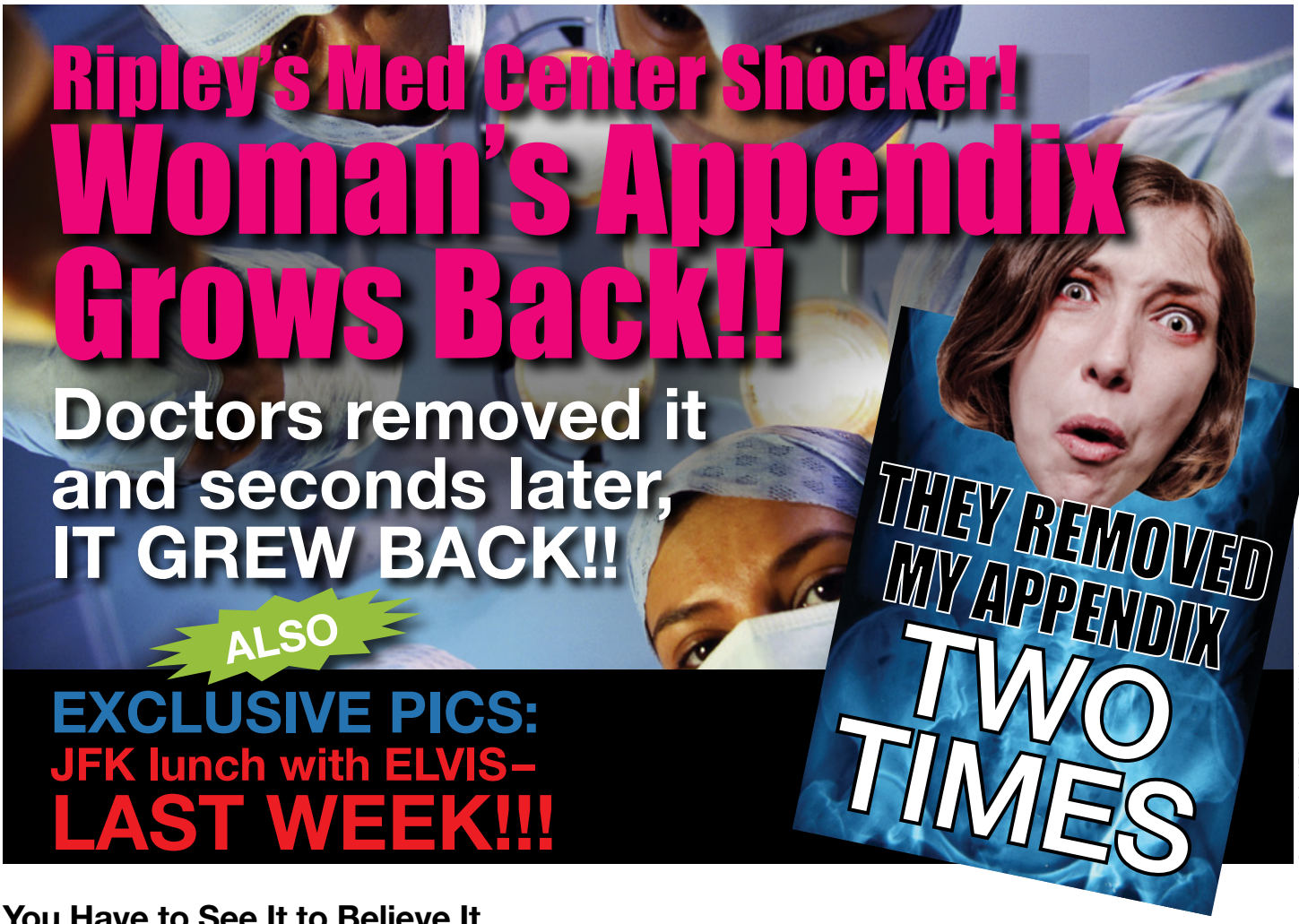

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Tax Code Changes Could Fuel ERC Growth

The use of enterprise risk captives (ERCs) may continue to swell among smaller and midsize companies searching for more diverse risk exposure, noted a panel discussion on the topic. One driving factor involves recent tax code changes that increased the annual premium limit to $2.2 million and imposed some ownership restrictions to qualify for the 831(b) tax election.

ERCs appeal to privately held firms that roll their uninsured or prohibitively expensive risks into an insurance company small enough to take that election, explained Jeff Simpson, a partner at Gordon, Fournaris & Mammarella, PA who served as moderator of the session, which was entitled "The Evolving Use of Enterprise Risk Captives."

Early on in the ERC evolution, there would be many cases where lower deductibles were covered – a trend that largely disappeared and then returned, noted Patrick Theriault, managing director of Strategic Risk Solutions, Inc. One explanation was that the IRS began asking to review those particular ERC claims. "We expect looking at deductibles again next year with increasing premiums as a way to bring more premium to these captives," he predicted.

While the IRS has long been skeptical of captives, there could be confusion surrounding its oversight. For example, Theriault recalls how a tax attorney specializing in the captive business asked IRS officials in one meeting their definition of business insurance risk, but the room went quiet. In another case, he heard that a line-by-line IRS review of what constituted a business risk vs. insurance risk "made no sense whatsoever."

His larger point is a pressing need for guidance, adding that "it's going to seem sometimes a little bit of tail-wagging-the-dog in terms of responding to the IRS, but that's the reality of the world, and we're seeing a little bit of that going on in the industry."

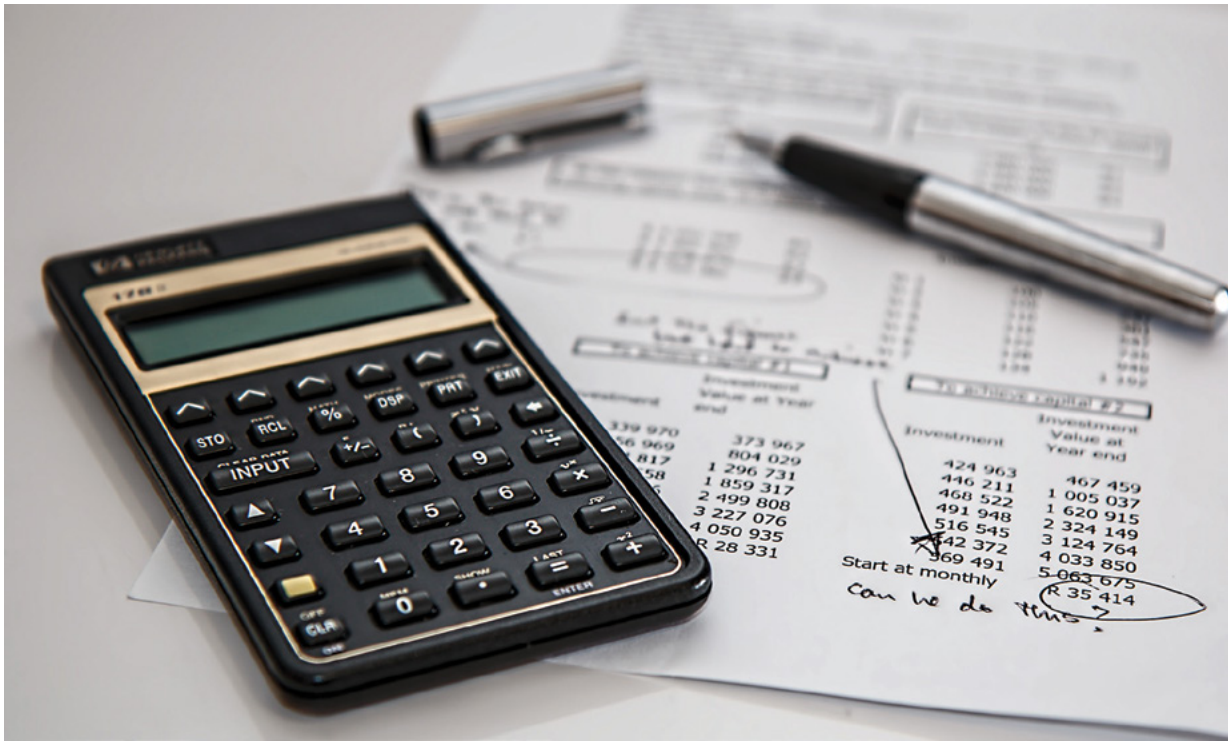
Gaining steam

While ERCs can be traced back to 2000, they didn't start to reach critical mass until 2010, Simpson said. There are now large public companies taking an interest in the arrangements, which are being integrated into traditional commercial insurance solutions.

A Marsh benchmarking survey analysis shows "interesting" growth patterns in nontraditional coverages from 2014 to 2015 in terms of employee benefits (nearly 143%) and supply chain (133%) purposes, observed Michael Serricchio, SVP at Marsh Captive Solutions.

Other such areas included cyber liability (30%), political risk (26%) and medical stop loss (nearly 14%). Leading traditional lines of coverage include general public third-party liability, property and workers' compensation or employers liability.

In terms of the means by which the insurance tax status for ERCs is achieved, he noted that the vast majority involve what's called a "brother/sister" approach (66%) compared with unrelated risk (25%) and a hybrid of those two arrangements (9%).



There's no cookie-cutter approach to captives, according to Theriault, who said there could be a dual-path solution in that "a group captive could fit well with a secondary ERC captive for all the P&C lines of business."

When addressing captive basics, several key points pertaining to the role of an ERC emphasized the need to have a disciplined, controlled formalized mechanism for self-insured risks, as well as a reasonable, smart, prudent and conservative philosophy. In terms of fund-retained corporate risk, ERCs insure predictable or high-frequency, and high severity or low-frequency claims.

Serricchio pegged the typical ERC captive cost at "somewhere between $40 and $90,000" to get the arrangement off the ground, including a feasibility study, implementation, government fees, actuarial work and legal advice. The process generally takes one to three months, he said. In terms of operational costs, he noted that it's less than $72,000 a year to run.

The latest Business Insurance Directory on captive managers and domiciles shows that Vermont leads the pack among domestic captives at 587, followed by Utah at 422 and Delaware at 333. Some U.S. regulators are keeping a close watch on these borders. There could be a self-procurement tax as high as 5% or 6% that's assessed on premiums paid to a captive located in a state other than where the company is based, according to Theriault, who noted that the additional cost could be significant.

There also are issues involving offshore domiciles to consider. For example, if an ERC is established in the Cayman Islands, Serricchio said there also would have to be a 953(d) tax election to make it a U.S. company for tax purposes.

As many as four years ago, Theriault noticed new captive managers or consultants entering the marketplace. Such activity has since slowed down, and if that trend continues, he believes some small managers could be acquired by bigger ones. He also has seen an uptick in RFPs from existing ERC captive owners who are considering a change in service provider for various reasons. About 40% of his clients are the result of takeovers in the small captive sector. ■

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