THE SELF-FUNDED CASE – BACK TO BASICS

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SELF-FUNDING – SO MANY TOYS IN THE SANDBOX

Not to criticize our industry, in the least, but if we are being honest, we should all agree that it takes thousands of "parts" to make this "car" run, so to speak. This fact has its positives. An industry chock full of numerous stakeholders does lead to incredible innovation, teamwork, healthy competition, creative solutions, and the general strength that comes with an industry steeped in camaraderie. Likewise, this reality of many stakeholders can also create confusion and distraction unless we are paying close attention and working to block out the noise. The typical self-funded case will likely have a list of stakeholders that include (in no particular order & I am sure to leave something / someone out):

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- A claim re-pricing solution provider
- A network
- A wrap network or wrap network alternative
- A claim negotiation solution and/or patient advocacy solution provider
- A data analytics platform
- A claims auditing solution provider
- A number of independent review organizations
- A subrogation and recovery solution provider
- And many, many, more…. (I felt the bullet points were becoming excessive – time to stop)

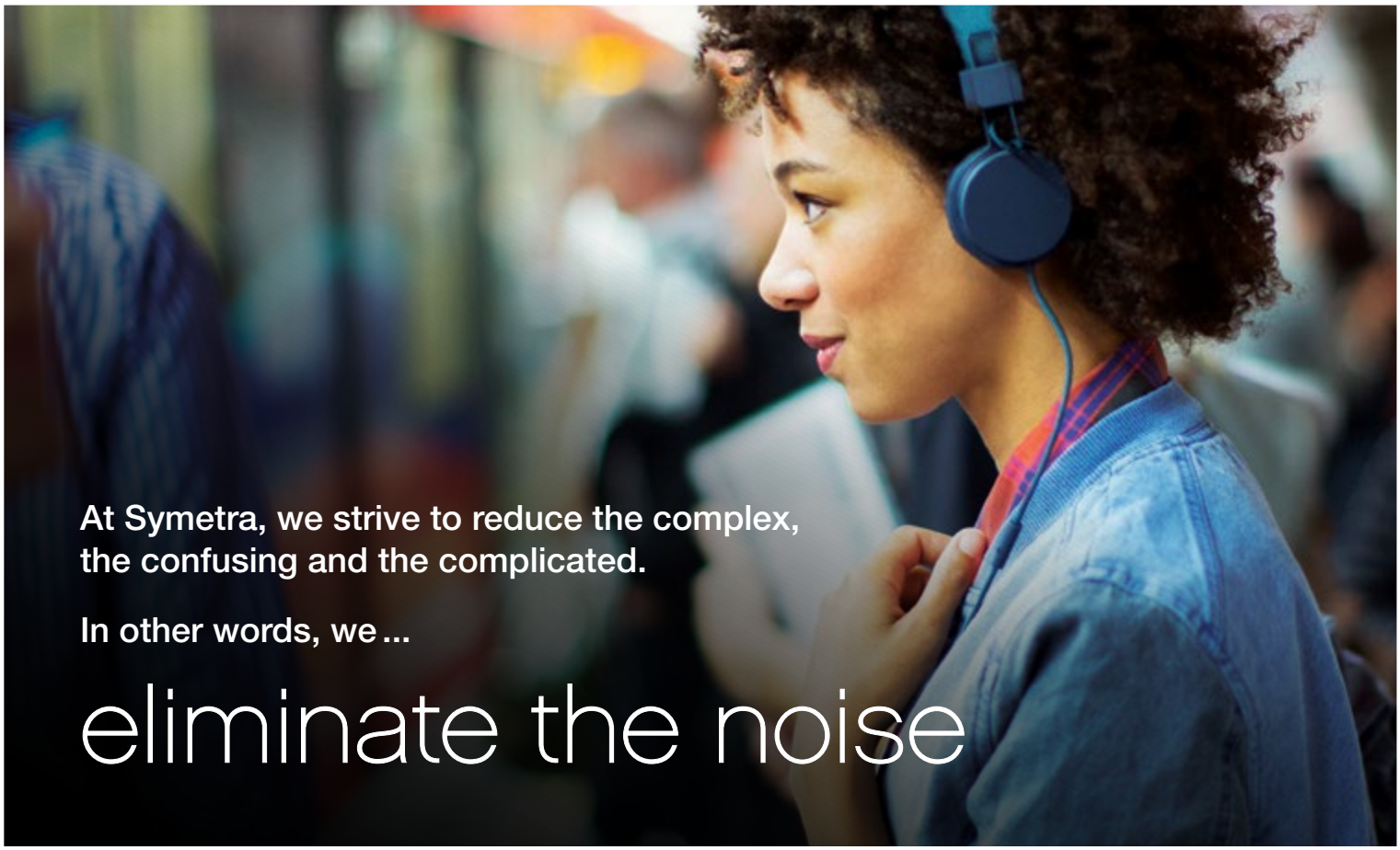
In short – there are many, many toys in this sandbox of self-funding.

SO…. HOW ABOUT, BACK TO BASICS?

As discussed, there are an incredible number of stakeholders in the self-funding sandbox. To reiterate, this is not necessarily a bad thing, but it can steer us away from the fundamental basics and core needs of our industry, which can lead us astray from the root goal. What is that goal? In short, most self-funded plan sponsors are going to tell you that they entered into the self-funded space for two reasons: (1) to bring the costs associated with their health plan down; and (2) to have the creative control needed to deliver top-notch health benefits to their employees and their families.

Not to take away from the importance of the newest healthcare-related iPhone app, or the newest, innovative methodology behind case management, but sometimes it is important to step back and focus on the basics of this complex, self-funded system. Whether from the outside looking in, or deeply involved in the self-funded industry, all viewers should agree that this industry – this system – is definitely a complex one, as noted by the copious bullet points listed above. To wade through the complex and try to identify the key roots of a successful self-funded case is not only a noble pursuit but should be a point of pride for all in this space. With the roots in place, all of the other, more complex solutions can fall into place and will do so with a much higher likelihood of success.

While like minds might rightly differ on the key elements that lead us toward the goals discussed above, I would list out the five most important roots that push the goals of driving down costs while delivering great benefits as follows:



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(1) A well-written and understandable plan document.

(2) A vested "benefits committee" or other decision-making body housed within the employer Plan Sponsor.

(3) An educated and empowered consultant.

(4) A partner-focused third-party administrator.

(5) A well-oiled subrogation and recovery platform.

THE ALL POWERFUL AND GOVERNING DOCUMENT

Without a plan document, what is a self-funded plan, truly? It is a nebulous financial instrument, or bizarre oral contract slightly memorialized by HR emails and broker notes that exists without clear guidance or application.

Yet this plan is still subject to incredible responsibility and liability. Needless to say, not only is having a plan document a good idea (if not required, depending on how you read the law) but it is an even better idea to have a well-written and understandable plan document. As discussed above, many plan sponsors become enamored with new and innovative solutions, ranging from specialty Rx cost control to a medical tourism program filled with plan member incentives.

These are wonderful solutions that may yield outstanding results – but what if the plan document does not properly support and outline the specialty Rx program? What if the plan document fails to provide clear instruction to the plan member on how he/she can take advantage of the beneficial medical tourism program? Not only does the plan sponsor run the risk of implementing benefit structures that may cause legal problems, since they are not outlined in the plan document, but the plan sponsor will most surely lose out on gaining the benefit of these innovative solutions.

Not to mention paying claims outside the terms of the plan's stop-loss policy. Without a well-written and understandable plan document, the it is pointless to pursue more complex solutions and the goals of cost containment and rich benefits will surely never be met.

THE HEART & THE BRAIN

Every employer plan sponsor should have a benefits committee in place, whether the committee is made up of 3 people or 15 people. Too many employers rely solely on the expertise of their consultant and "pass the buck," so to speak, when it comes to truly understanding the ins and outs of their self-funded plan. Not to say that relying on a consultant is a bad thing – that's why they exist!

However, as any expert will tell you, the expert's job is always easier when he/she is advising an educated consumer. An educated plan sponsor, backed by a benefits committee full of diverse knowledge and expertise, and advised by an industry expert consultant, is already leaps and bounds ahead of the rest when it comes to the ability to choose and implement solutions that will lead to cost savings and rich benefits. Not to mention, the committee can share the labor burdens associated with running a self-funded health plan. Like, working together to finalize that plan document!

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Additionally, a benefits committee increases the chances of a plan successfully implementing a complex solution. Let's use an out-of-network, reference-based pricing solution as a singular example. Such an innovative and disruptive program does not stand a chance if there is not employee / member buy in and understanding.

There will likely be balance billing and "scary" situations which will lead plan members to bring the noise, so to speak, directly to HR. This noise can quickly cause enough pain that the plan sponsor will choose to abandon an otherwise legitimate and beneficial program. But. What if a savvy, vested, and educated benefits committee existed, at the employer, plan sponsor level? Imagine the education and communication opportunities that could exist – imagine the opportunities to work with the plan members, ask critical questions of the vendor, and course correct when needed.

A benefits committee, whether small or large, will move a plan closer to its goals of containing costs and delivering rich benefits, every time.

Likewise, it takes the industry expert consultant to advise this bought in committee and bring them the solutions and ideas that they may not be aware of, that they can then interpret and execute, on their own terms.

To repeat: the vested benefits committee plus the expert consultant = reduced plan costs and the implementation of solutions to drive rich benefit delivery.

THE PARTNER

A sophisticated plan sponsor, governed by a benefits committee and advised by an expert consultant, should next seek a true partner in its third-party administrator. Plan sponsors can sometimes fall victim to regionalism or sticker attraction (seeking out the lowest administrative fee), which may not always lead to the best payor partner for that particular plan.

Instead, plan sponsors and their consultants should begin by clearly understanding and defining their own needs and their own goals. They must do this first before trying to find the right payor partner.

Is the plan focused on a strong network? An in-house dialysis solution? Is a domestic call center presence important? What about reporting capabilities? What does the account management model look like and how involved will they be with enrollment meetings and finalizing the plan document? Will the payor listen to the plan's recommendations and needs regarding stop-loss? The list goes on.

Needless to say, combining a thoughtful benefits committee, with an expert consultant, and a true partner-oriented payor, will allow for a plan to truly innovate and successfully put solutions in place that will meet the plan's goals.

THE MONEY AT THE END OF THE CHAIN

In thinking on the goals of driving costs down while delivering great benefits, there is one area that provides a clear "win." Subrogation and recovery efforts.

Why is this the case? In efforts to contain costs, many plans go straight to the overly advertised, upfront, disruptive solutions that may drive costs down before costs are incurred. Many of these solutions have merit and bear fruit! But plan sponsors should not lose sight of the big recovery win that is available through a robust subrogation and recovery platform.

Especially now, where copious opportunities exist to seek the recovery of plan dollars on so many fronts.

Traditionally, most plans would focus their recovery efforts on the routine motor vehicle accident – the benchmark example of third-party liability. Anymore though, alongside these benchmark MVAs, plans should be considering other sources of third-party liability, such as torts, product recalls, and class actions. The list, and opportunities, go on.

Additionally, whether governed by ERISA or state law, or a combination of both, all self-funded plans are bound by some level of fiduciary duty. Instead of quoting federal or state law, the gist is this: plan fiduciaries must behave prudently with plan assets, which includes how the fiduciaries spend plan assets, don't spend plan assets, or get plan assets back!

To this end, it is easy for a plan sponsor to focus on asset expenditure and upfront plan savings, while forgetting about recovering dollars from a third party. This is understandable! Upfront expenses and upfront plan savings are exactly that, "upfront!"

But, the concept of chasing around a third party, sometimes for years, in an effort to return plan funds back to the plan – well, it is easy to see how this concept can fall by the wayside and become easily forgotten.

Yet, maximizing recovery efforts should be just as important to a plan fiduciary as the more routine, upfront savings and expenses that usually take priority.

Seeking to assure that subrogation and recovery efforts are maximized is an important obligation of every plan fiduciary. Not to mention, returning plan assets into the plan's coffers means costs can be kept down and the plan can reinvest those dollars in other areas that might lead to that richer, more robust health plan.

Goals met. ■

Tim serves as the Vice President of Sales and Marketing for The Phia Group, LLC. Prior to his current role, Tim served as a health care lawyer, staff attorney and lead PACE counsel for The Phia Group.

Before joining The Phia Group, Tim spent years functioning as in-house legal counsel for a third party administrator. Tim is well-versed in complex appeals, plan document interpretation, stop-loss conflict resolution; keeping abreast of regulatory demands, vendor contract disputes, provider negotiations, and many other issues unique to the self-funded industry.

Tim has spoken on a variety of industry topics at respected venues such as the Self-Insurance Institute of America ("SIIA"), the Society of Professional Benefit Administrators ("SPBA"), the Health Care Administrator's Association ("HCAA"), and the National Association of Health Underwriters ("NAHU"). Tim currently sits on the Board of Directors for HCAA as well. Prior to his time as a TPA's in-house counsel, Tim spent many years in private practice, successfully litigating many cases through full adjudication or to resolution through mediation or arbitration.

Tim received his Bachelor's Degree from The College of Idaho, prior to obtaining his Law Degree from The University of San Diego School of Law. Tim operates out of The Phia Group's western office in Boise, Idaho.