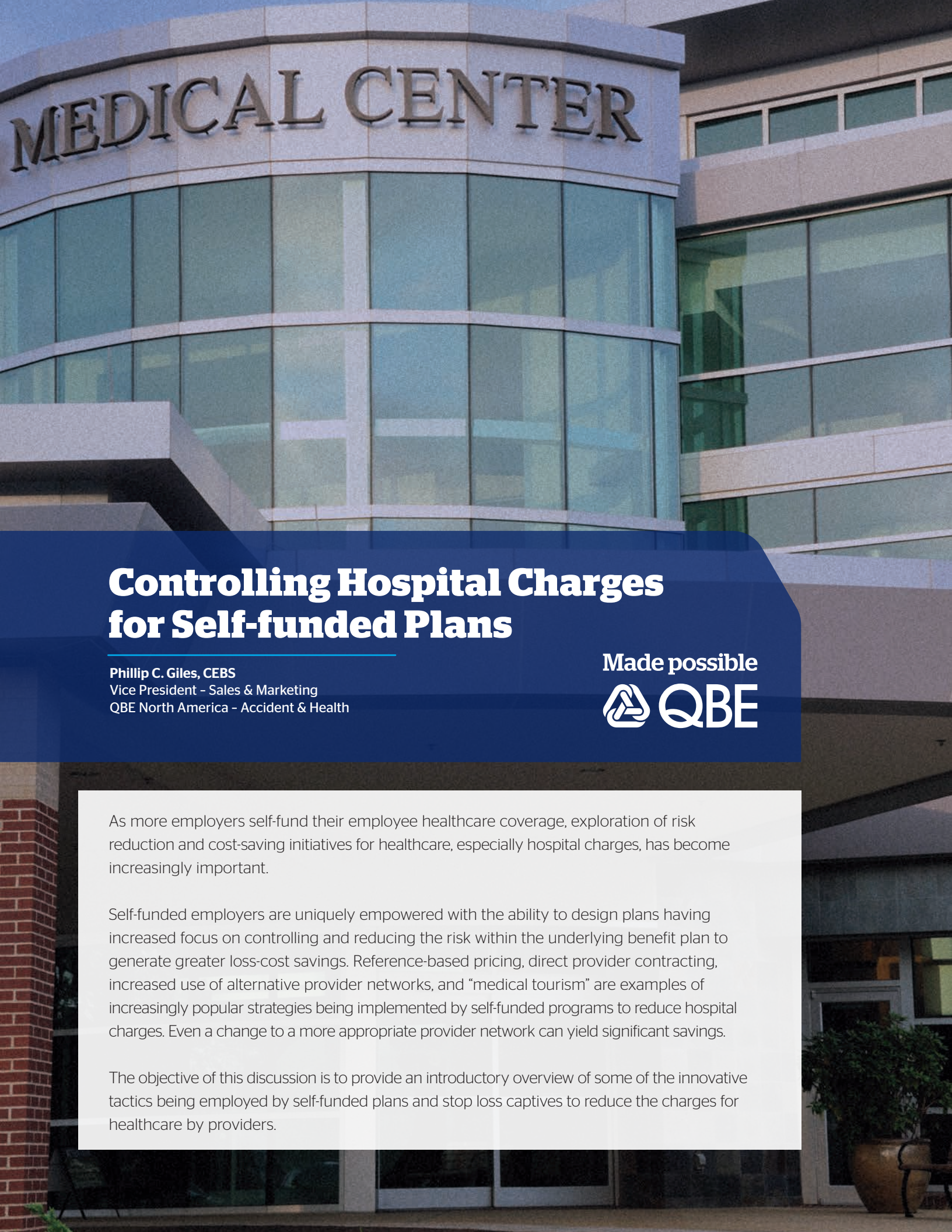

Controlling Hospital Charges for Self-funded Plans

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As more employers self-fund their employee healthcare coverage, exploration of risk reduction and cost-saving initiatives for healthcare, especially hospital charges, has become increasingly important.

Self-funded employers are uniquely empowered with the ability to design plans having increased focus on controlling and reducing the risk within the underlying benefit plan to generate greater loss-cost savings. Reference-based pricing, direct provider contracting, increased use of alternative provider networks, and "medical tourism" are examples of increasingly popular strategies being implemented by self-funded programs to reduce hospital charges. Even a change to a more appropriate provider network can yield significant savings.

The objective of this discussion is to provide an introductory overview of some of the innovative tactics being employed by self-funded plans and stop loss captives to reduce the charges for healthcare by providers.

The wizardry of chargemasters and the mystery of hospital pricing

There is virtually no regulation or consistency of healthcare charges in the United States. Healthcare systems have great leeway in determining procedural charges regardless of the actual cost. All hospitals maintain a "chargemaster" which is a hospital's comprehensive listing of all procedural charges and serves as the starting point for the billing charges that are assessed to the general public for treatment. With virtually no regulation of chargemasters, hospitals have nearly unbridled freedom to define prices. A recent study found that the average hospital had an overall charge-to-cost markup ratio of 4.32, meaning, the average hospital set a chargemaster price of $4.32 against a Medicare-allowable procedure cost of $1.00. Some specialty procedures had charge-to-cost markup ratios approaching 28.5. To maximize revenue, U.S. hospitals typically mark up prices more than 20-fold knowing that they will likely receive much less from commercial insurers based on negotiated discounts. The charges within the same facility can also differ greatly depending on the network agreement with each insurance carrier. As a result, different people with the same medical condition, who go to the same doctor in the same hospital, are likely to face completely different charges for the exact same treatment simply because they have different medical insurance cards. The actual cost of healthcare is largely irrelevant, as the insurance carrier will only respond to the pre-negotiated charge with the provider.

In many cases, the networks themselves are only concerned with demonstrating the "deepest discounts" from providers. Providers will charge different networks different prices that in turn receive different discounts. For example, a Blue Cross network could receive a 60% discount from billed charges and a competing Aetna network may only receive a 40% discount for the same procedure. However, the Aetna network may be charged only $5,000 for the procedure while the Blue Cross network is charged $7,500. Even though Blue Cross has the deeper discount off billed charges, the end cost is the same for both. In some cases, the "smaller discount" might even work out to a lower end price.

The key to realizing effective savings is being able to attain discounts in relation to the amount of the hospital's profit margin rather than relying solely on discounts from billed charges.

A progression of popular strategies

Each of the following initiatives represent increasingly effective strategies that can be implemented by self-funded employers to reduce the overall cost of hospital charges.

Employ the most appropriate PPO network

Many stop loss carriers actuarially evaluate provider networks and assign rate adjustment factors for the stop loss coverage based on the actual value of the network's discounts from

providers. The strength of any network will vary depending on its market presence in any geographic market location. Working with a stop loss carrier to help determine the most appropriate network based on actual discounts within geographic locations of the employee population can yield significant cost savings for the benefit plan.

Alternative Networks

Various network iterations have become more prominent since the implementation of ACA. Self-funded employers having larger concentrations of employees in specific locations can work locally to develop deep discount arrangements with select providers to develop "narrow" networks in return for increased or exclusive patient steerage from the employer. Narrow networks are most common in higher density population areas where provider selection, competition and the potential for leveraged discounting is strongest.

Some PPO networks will designate select providers (increased restriction for provider selection) within its existing network for deeper discounts. Commonly known as an exclusive provider organization (EPO) or a high-performance network, the focus of these arrangements is toward providing overall value in terms of qualitative care standards along with significant discounting. Provider-owned accountable care organizations (ACOs) and designated centers of excellence (COEs) for complex care treatments, such as organ transplants, cancers and difficult surgeries are forms of high-performance networks that focus on delivering improved patient outcomes along with procedural cost discounting. The combination of ensured quality and deeper discounting can result in substantial savings.

The value of the discounts needs to be commensurate with the restrictiveness of the network and the plan appropriateness of "carrot (reward) or stick (penalty)" incentives to employees.

These forms of restricted networks typically have up to two-thirds fewer providers than traditional networks. Alternative network plan design needs to encourage patient steerage, which is typically accomplished through multi-tiered plan structures. The different plan tiers typically increase out-of-pocket costs for the employee seeking non-emergency care outside of the network related to the selected tier. The most critical element to the success of an alternative network is not sacrificing the quality level of providers or care in favor of discounts. The value of the discounts needs to be commensurate with the restrictiveness of the network and the plan appropriateness of "carrot (reward) or stick (penalty)" incentives to employees.

Alternative treatment venues

Large hospital systems are typically the most assertive entities in terms of aggressive and opaque profit markups in the healthcare industry. Application of innovative means for reducing or even eliminating hospital charges through alternative treatment venues, such as physician-owned surgical centers and home healthcare treatments, can yield extraordinary savings for a self-insured employer. Switching a treatment venue from a hospital to an out-patient facility has become common for treatments such as dialysis and chemotherapy and can and routinely save as much as 50% for the treatment.

Case example

As a stop loss carrier, QBE was notified of a situation where a 22-year-old college student covered under his parent's policy needed infusion therapy. Upon review, QBEs medical risk management team determined that most of the expense related to the infusion regimen were associated with charges for administering the infusions in a hospital rather than the cost of the medicine itself. QBE arranged for the infusion to be done in the university's health facility by a professionally contracted infusion nurse rather than at the hospital. This essentially converted the claim to a level comparable with a home-based infusion which eliminated nearly all the hospital expenses including the related profit upcharges. The resulting savings was nearly 60%. It was also more convenient for the patient as he could be treated a block from his residence hall rather than miles away at the hospital.

Not only can this strategy significantly reduce the direct expenses incurred by the employer's plan by more than 50%, it will often prevent a claim from reaching the specific attachment of the stop loss coverage which will contribute to a positive and measurable impact at renewal of the medical stop loss policy.

Direct Provider Delivery

As the concept of alternative treatment venues expands, a boutique industry is also being created by innovative providers that don't accept insurance and offer highly transparent, direct, upfront "package pricing" for complete episode treatment in specific facilities. Services are typically performed in physician-owned surgical facilities for non-emergency general, coronary, orthopedic, or bariatric surgical procedures, and common cancer treatments. Again, by eliminating the huge profit markups associated with hospitals and large healthcare systems, as well as the administrative costs associated with insurance management, these entities can offer all-inclusive treatment at much lower cost to a self-funded employer. A self-funded employer can pay an upfront "capped" price of $25K for a complete (all-care inclusive) hip replacement at an independent surgery center that would otherwise cost anywhere from $45K- $85K for typical hospital charges. Savings approaching 75% in comparison to typical hospital procedures are not uncommon from these boutique providers.

Medical Tourism

Medical Tourism in which the benefit plan will pay for employees and even a companion to travel to other lower cost venues, including different countries, for qualitatively comparable treatment is rapidly gaining popularity among self-funded plans.

Domestically, there are huge variances in the cost of care, not only from one state to another, but even one county to another. Some of the best facilities for care in the U.S., such as Cleveland Clinic or Johns Hopkins, can also be among the least expensive. The cost of the hip replacement, discussed earlier, can run $80K in a northern California hospital and $40K at a comparable facility in southern California, and maybe even $25K at an independent surgery center.

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Internationally, Cayman, Paris, Prague and Panama; each can all offer world-class medical care at less than half the cost of treatment in the U.S. The hip replacement that was reduced to $25K at the independent surgery center in the U.S. can be done for about $15K, including rehab, plus travel in Grand Cayman, Holland or France. The care is top-tier and the patient's self-funded employer will also cover travel and accommodation for the patient and a companion. Most plans will waive all out of pocket expenses, and some innovative plans will even refund a percentage of savings to employees as an added incentive for traveling for lower cost, but qualitatively equivalent, treatment. The savings to a self-funded employer can be substantial.

Referenced Based Pricing

In Reference Based Pricing (RBP), the healthcare plan sets the maximum amount it will cover for a particular health care service. RBP plans provide a more defined, or at least, a less ambiguous, fee structure by tying provider reimbursements to a specific reference point, such as a Medicare fee schedule, plus a defined margin. The margin usually ranges between 40% - 80%, e.g., Medicare + 60%. RBP plan design can also take the form of a defined benefit schedule. This type of schedule specifically defines the maximum dollar amount assigned by the benefit plan for each specific treatment or procedure. Many defined schedules will specifically target and limit high-margin hospital charges such as infusion and dialysis treatments, durable medical supplies, and multi-night hospitalizations. As self-funded plans have more plan design flexibility, RBP designs have become increasingly prevalent as a cost-containment strategy.

Application of "Big Data"

More data is now readily available throughout the universe than ever before. Larger self-funded employers, and those using captives, are increasingly accessing and mining large amounts of data to identify claim trends and large cost drivers within their benefit plan. Use of external data to analyze specific industry, geographic and demographic

trends for comparison with the employer's own data will help employers identify potential benefit plan modifications to address both claim frequency and severity.

The primary issue for data users is how to effectively distill huge amounts of data into useable information for predictive modeling. To succeed, the employer must start with clear objectives and know what specifically they are trying to measure. Data benchmarks could include: underwriting probability; specific claims trends; or qualitative outcome trends within specific geographic areas, diagnoses or even specific healthcare providers. The objective of the analysis needs to be clearly defined in order to know what formation needs to be extrapolated. The resulting data can be applied to the benefit plan design to determine and structure targeted cost containment strategies.

These are just a few overview-level examples of the progressive strategies that self-funded employers can exercise to reduce the cost of healthcare charges. Healthcare value is measured by two components, quality of care and price. The two components can be mutually exclusive. As mentioned earlier, there is a significant variation in hospital prices, even for the most common procedures. The expanding selection and availability of alternative provider networks and treatment venues, along with innovative platforms for enhanced consumerism will help self-funded employers reduce high costs associated with hospital charges. Hospitals and healthcare systems are facing cumulative pressure to publish their pricing structures and make them more accessible to consumers. Improved transparency empowers employers to adjust plan design strategy to provide improved healthcare value and broaden the opportunities for reducing the cost of healthcare delivery to employees.

About the Author

Phillip C. Giles, CEBS, is Vice President of Sales and Marketing for QBE North America's Accident and Health division, overseeing business development and strategic marketing initiatives, including medical stop loss captive production. He has 30 years of experience in Accident & Health and Property & Casualty alternative risk. He was named to *Captive Review's* "2016 Power 50" list of most influential individuals in the Captive Insurance Industry and was recognized as the Captive Professional of the Year at the 2017 U.S. Captive Awards.

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