A White Paper

Employer Health Alliance

October 2019

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Mesa County Medical Landscape

There are two hospitals in Mesa County – St. Mary's and Community Hospital that serve the constituents in Mesa County and other nearby counties on the Western Slope of Colorado. St. Mary's Hospital is a facility that delivers services for many complex cases while Community Hospital is a Short Term Acute Care Hospital.

Mesa County is also one of the highest cost counties, not only in the state of Colorado, but also in the United States.

The high and rising costs in Mesa County are primarily due to hospital charges. Overall, facility claims represent only about 1 out of 10 claims filed but represent approximately 60% of the total claim costs for a group. Rising prescription costs are also a major contributing factor, but by and large, physician claims are not.

Hospital Landscape

Hospitals have what is called a Chargemaster, which is a voluminous file of every service they offer patients when they come in the door, and what they will charge for that service. There are no rules, laws, regulations about what those charges can be – they can be whatever the hospital chooses. When an insurance company and PPO Network negotiate discounts, the discounts are based off the Chargemaster, or become what is known as billed charges.

Every hospital must report to the Centers for Medicare and Medicaid Services (CMS) an annual report that identifies their actual cost for services and their average charge for those services. It is this report that in turn, is the basis for their reimbursements from Medicare. Because taxpayers pay taxes to Medicare, it's public money going into Medicare, and it's public money coming back out to the hospitals, therefore the costs and charges are public information. The reports* have shown that the average charge for services are reimbursed to the two Mesa County hospitals at a rate between 300% and 700% of the amounts they receive from Medicare for the same services. What this means is patients are paying even more than 300% to 700% above the hospitals' actual

costs. In some instances, there are certain services being performed by these two hospitals that exceed 1200% of what they receive from Medicare.

*American Hospital Directory

Insurance Landscape

Historically, the predominate insurance company in Mesa County is Rocky Mountain Health Plans (Rocky). Traditionally, they have offered HMO, and PPO plans and within the last 20 years a self-funded plan through their third party administrator, CNIC.

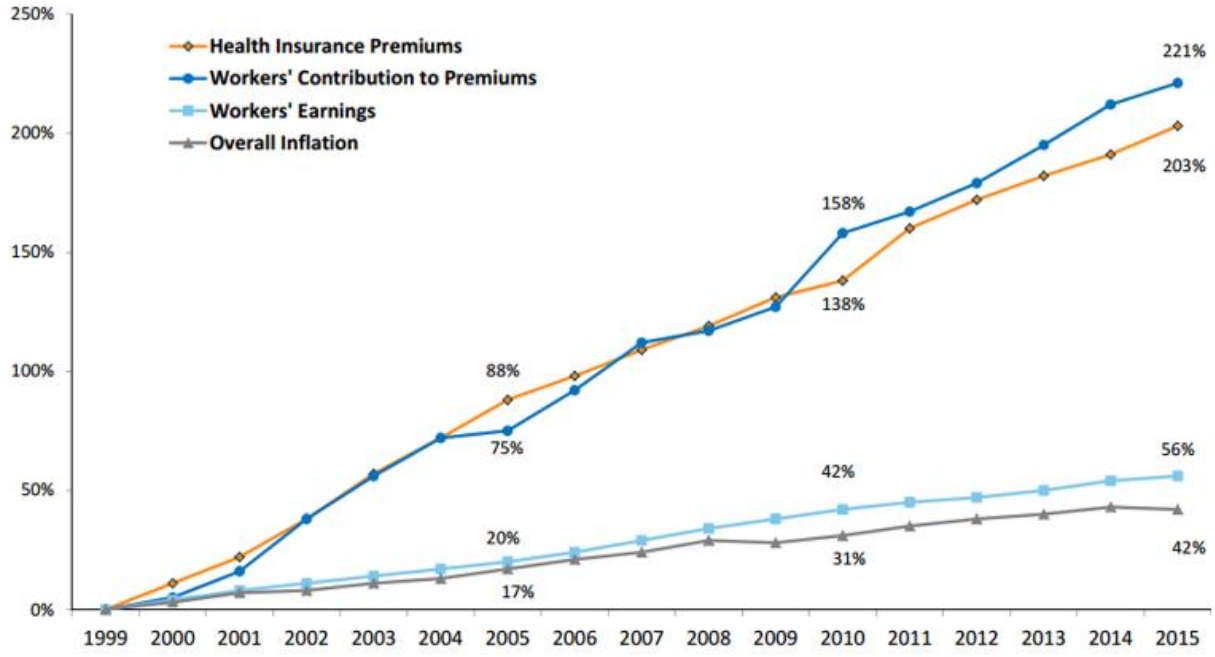
Rocky has also had sweetheart arrangements with the two hospitals in that they receive better discounts from the hospitals than any other of the competing health plans such as Anthem, CIGNA, United, Cofinity PPO network and others.

This pricing alone places Rocky in a most favorable position with employers as their rates have historically reflected this favorable treatment. There are no favored nation contracts in Mesa County with the two hospitals, which means the two hospitals do not have to give the same preferential discounts to other insurance companies. The hospitals can give their favorite insurance company better discounts to drive employers to use that insurance carrier.

The pricing arrangement that insurance companies have always had with hospitals is a discount off billed charges. The billed charges reflect each hospitals' Chargemaster as to what price the hospital wishes to charge for a particular service. These charges and the Chargemaster can change at any time. This effectively makes the negotiated PPO discount diluted if the prices continue to go up and the discount remains the same.

At the end of the day, when a hospital agrees to offer a PPO health plan or a self-funded employer a greater discount, this usually results in an increased hospital charge because the hospital can adjust their Chargemaster to cover the greater discount just offered, and then the plan or employer is really getting a "discount off of what"?

As healthcare costs continue to rise, the ability of an employee to afford either the insurance premiums, which come out of their paycheck, or the deductibles and copays when care is needed is of great concern. As you can see in the chart below, healthcare costs are rising at a significantly higher rate than employee wages.



According to Mercer**, healthcare costs are now $12,148 per employee per year and a recent study by Kaiser*** shows that the cost of a family is now $20,576 per year.

Insurance company programs' pricing requires one to peel back the onion. It's not about price, it's about cost. And in order to dissect the insurance companies' approach, one needs to understand how insurance companies arrive at their premium pricing.

When insurance companies look at the pricing for a particular group, they review the age/sex demographics, the geographic location, the SIC code or industry code for the company, the current plan of benefits offered, and the expected claims – using their manual book of business rates or a combination of actual claims experience and manual book of business rates. If the pricing for

facility claims are significantly greater in a particular geographic area, it's going to be reflective in their premiums quoted.

**2018 Mercer National Survey of Employer Sponsored Health Plans Report
***Kaiser Family Foundation 2019 Employer Health Benefits Survey

Employer Health Alliance

There have been a series of meetings and seminars over the years in Mesa County to educate employers about why their costs are rising so rapidly. Fully insured programs are created and rated such that an employer is pre-paying the expected claim cost and the cost of doing business. But when that group has lower costs than expected, the insurance company does not give a refund, but rather keeps that surplus and recalculates the rate for the upcoming year, including trend. If claim costs exceed the insurance company's expected costs, then an insurance company will raise the rates dramatically the following year to recoup the losses, and still add trend. It forces an employer into a no-win situation.

In 2014, a group of self-funded employers met to address the ever-increasing costs of medical insurance coupled with the ever-eroding benefit plans employers provided. The employers realized insurance companies and insurance brokers were motivated by their own self-interest and not that of the employer. The employer group felt they could leverage themselves to push for change. So, the decision of this group was to establish direct provider relationships and remove the middlemen.

The medical industry for years has talked about transparency in pricing and welcomed our employers to meet to discuss this. Those conversations ended in providers insisting the system of payment cannot be easily corrected but discussions should continue. After one year of talking without any positive progress in changing payment structures, the employer group felt the providers were stalling in hopes the employer group would just go away. Rather than accepting status quo, the employer group decided to meet directly with physician providers and establish their own provider contracts with actual transparency in pricing.

Every hospital provider receiving Medicare reimbursements must report their actual costs to the Centers for Medicare and Medicaid Services (CMS). This is the key to transparency. From this, contracts can be developed based on actual provider Cost Plus a reasonable profit (also called reference-based pricing) rather than fee for service or discount off charges. The latter systems are not based on any foundational rates therefore not offering consumers any transparency in pricing. This results in employers paying highly inflated rates.

Five years later, this has been a successful initiative with over one thousand (1,000) providers on the Western Slope working directly with the employer group. All contracts are based Cost Plus reimbursement. The physicians are excited to deal directly with the employers. This expedites payments to their offices and removes insurance company hassles. One physician provider practice has over sixty employees just to handle billing issues from insurance companies.

Employers realized they could no longer sustain absorbing double-digit increases and it wasn't acceptable for the providers and insurance companies to tell them they were working hard on reducing the costs of annual increases. The employers wanted to reduce their costs all together, not the rate of their annual increases. The employer group was successful and has saved upwards of 30% in claim costs each year through direct provider contracting based on Cost Plus payments. The table below shows employers' per employee per year (PEPY) costs over the last two years through the Employer Health Alliance. **The PEPY includes both employer and employee payments in the plan.**

	Employer A	Employer B	Employer C
2017 EHA PEPY	$5,615	$7,065	
2018 EHA PEPY	$10,505	$8,780	$5,686
2018 Costs if Didn't Join the Alliance *****	$12,185	$11,321	$9,809
MSEC Annual Cost per Employee	$13,628	$13,628	$13,628

Employer A had four catastrophic claims in 2018
*****PwC Health Research Institute (HRI)

The following table shows the same employers and their 2018 physician savings compared to their EHA fee and their related return on investment. Physician savings are achieved by contractual pricing versus billed charges.

2018	Employer A	Employer B	Employer C
Savings from Physician Contracts	$77,312	$131,158	$17,440
EHA Annual Fee	$5,379	$8,322	$792
ROI	14.37:1	15.76:1	22.02:1

While direct contracting was a shift for the employers, additional positive outcomes were the employee awareness and financial gain they achieved. Employees are now active in their course of care. The money the employers saved has gone back into employee compensation and benefits programs as well as reinvested in the company's future.

A Partially Self-Funded Health Plan Exclusively for the Grand Valley

This is a turn key program that has all the various components assembled under one roof.

The formula for success is to first "unbundle" the health plan. This means that the plan is partially self-funded utilizing reinsurance to protect the plan from catastrophic claims and high frequency. Second, the traditional PPO contract must be removed from the plan. This is required so as not to pay the hospital per the PPO contract "discount off of what". This also permits employees to go to any hospital provider in the country that they want to because there is no network.

A qualified Third Party Administrator (TPA) is contracted with to provide all the administrative services that an insurance company would otherwise provide – claims payment, ID cards, plan documents, COBRA administration, etc. In addition, the TPA offers the services at a much lower cost than an insurance company.

Stop loss (reinsurance) coverage is also purchased to protect the plan from any catastrophic expenses that a member may have during the year and the overall expense of the plan for all members.

A Pharmacy Benefit Manager is also contracted with to provide prescription services.

To the member it doesn't appear any different than when they had an insurance company. The member still receives an ID card to present to the provider.

The beauty of the **partially self-funded plan** is that an employer only funds claims when they occur. They do not pre-pay monies to an insurance company or the third-party administrator. Cash flow savings is significant when control of the plan is given to the employer – not the insurance company.

With this **partially self-funded plan**, each employer has their own customized level of benefits and all separate contracts. The common denominator is EHA holds the contracts with providers.

The **partially self-funded plan** reimburses hospitals on a metric basis, not a discount like traditional PPOs. The metrics of payment are based upon the greater of their reported cost, plus a reasonable profit, or Medicare plus. Whether Cost Plus or Medicare Plus, in both situations this allows a hospital to be reimbursed at a fair and reasonable profit. It's *their* reported cost - not some fake number and it's *their* reported Medicare reimbursement from CMS - not a discount like traditional PPOs. If their reimbursement from Medicare doesn't cover their cost, which in some cases is true, the Cost Plus method is used. It's always the greater of the two.

Within the plan document, there is actual contractual language that states what the plan is going to pay. This is far different from a PPO "discount off of what". Employers cannot act as a responsible plan fiduciary when they don't know what the discounts are that the insurance company negotiates, and they don't know what the prices are from the hospital or other providers. ERISA requires plan fiduciaries to pay reasonable expenses. How can a fiduciary act responsibly when

they don't know what the expenses are? The employer is also using other people's money (employee contributions) to purchase the plan which creates a fiduciary liability.

Summary

If an employer is going to continue to work with insurance companies and their traditional PPOs, don't expect anything to change. PPOs may continue to negotiate deep discounts, but the provider base charges continue to go up.

Employers have to challenge the status quo because the status quo is not accomplishing anything to lower healthcare costs. Everyone can talk about transparency but if everybody is charging 500% of their cost what good is transparency? Everybody's grossly over-charging the consumer. Paying providers based upon metrics and/or direct contracting gives everyone a fair price and fair profit.

For more information regarding the partially self-funded health plan for the Grand Valley, please contact: Stefani A. Conley at 970-261-3025 or stefani@eha1.org.
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About the Authors

Stefani A. Conley • Executive Director, Employer Health Alliance
Stefani has been an executive in the health care environment for over twenty years. As a previous Human Resources executive, she has spear-headed initiatives such as employer owned clinics and moving to self-funded plans. She actively consults with employers on benefit solutions while partnering with providers to meet employer needs. Stefani has spoken frequently at conferences regarding the success of EHA.

Frank Stichter • President, Strategic Healthplan Consulting LLC
Frank serves the employee benefit needs of Colorado's Western Slope region, consulting on the identification and implementation of innovative and compelling savings opportunities for self-funded employers, rather than traditional cost shifting. He has over 35 years' experience working with public and private sector employers and their partially self-funded health plans. Frank earned the Managed Healthcare Professional (MHP) designation through the Health Insurance Association of America. He has spoken numerous times on the subjects of Self-Funding and Healthcare Risk Management programs at national conferences throughout the country and has written a variety of articles and position papers on these topics as well.