CHANGING MEDICAL REIMBURSEMENT, ONE PLAN AT A TIME

EXECUTIVE SUMMARY

The purchase of medical goods and services by health plans in no way resembles any other business transaction in American commerce. This article will illustrate this reality with specific examples. Further, the article will show that this simple fact has caused a spiraling and unsustainable inflation rate in medical costs. ELAP presents a solution that results in dramatic and immediate savings that is achievable at a rate of $150,000 per 100 covered employees, in year one, as well as a long term stabilizing effect on self-funded health plans.

ELAP's solution hinges upon the willingness of the executive leadership at any given company to see the problem and address it. Consider this remark by the current Governor of Florida, Rick Scott—formerly the CEO of Fortune 100 HCA (Hospital Corporation of America, NYSE: HCA). "How many businesses do you know that want to cut their revenues in half? That's why the healthcare industry won't fix the healthcare industry," said Scott. Now examine the players in the industry, not only the medical providers, such as hospitals and doctors, but also the prescription drug manufacturers, the name brand insurance companies, the PPO networks, and pharmacy benefit managers. Who in this picture is financially motivated to assist in decreasing plan costs? None of them! Even many brokers are compensated purely on commission. No player in the status quo delivery of healthcare is rewarded for reducing your costs.

A self-funded health plan is the perfect agent to effect change and seize control of healthcare spending. All a plan sponsor must do is embrace this simple solution, which is to move toward paying for medical goods and services in the same manner that the corporation buys everything else—with transparency and upfront knowledge of the cost. ELAP makes this a reality.

PROBLEMS, PART 1 | THE COMPLETELY UNSUSTAINABLE MEDICAL INFLATION RATE

Independent healthcare analyst Brian Klepper calls this "our most serious national concern." He cites a 2011 RAND study that calculated that four of every five dollars of (American) household income growth is now absorbed by healthcare.

Uwe E. Reinhardt, Ph.D. is an economics professor at Princeton University. He cites the 2013 Milliman Medical Index, which states that "the average cost of healthcare of a typical American family of four under age 65, and insured through an employer-sponsored preferred provider plan (PPO), is now $22,000, up from about $10,000 a decade earlier. It is a staggering amount… when compared with the distribution of family income in the United States, with a median income of $50,000 to $60,000."

The inflation rate of healthcare is also staggering. Milliman calculates the average cost of family plan coverage increased by 220% in a mere 10 years. Furthermore, the average family plan cost is 37% to 44% of median U.S. family income. In other words, the average U.S. family is spending almost half its money on health coverage

How did we get here?

PROBLEMS, PART 2 RELYING ON NETWORK "DISCOUNTS"

Historically, it has been common practice for American health plans to pay medical claims based on a "percentage off billed charges." Exhibit A reflects a simple mathematical reality based on two patients with identical treatment needs who choose to go to two different hospitals. This example was highlighted in a 2006 Self-Insurance Institute of America discussion paper.

EXHIBIT A

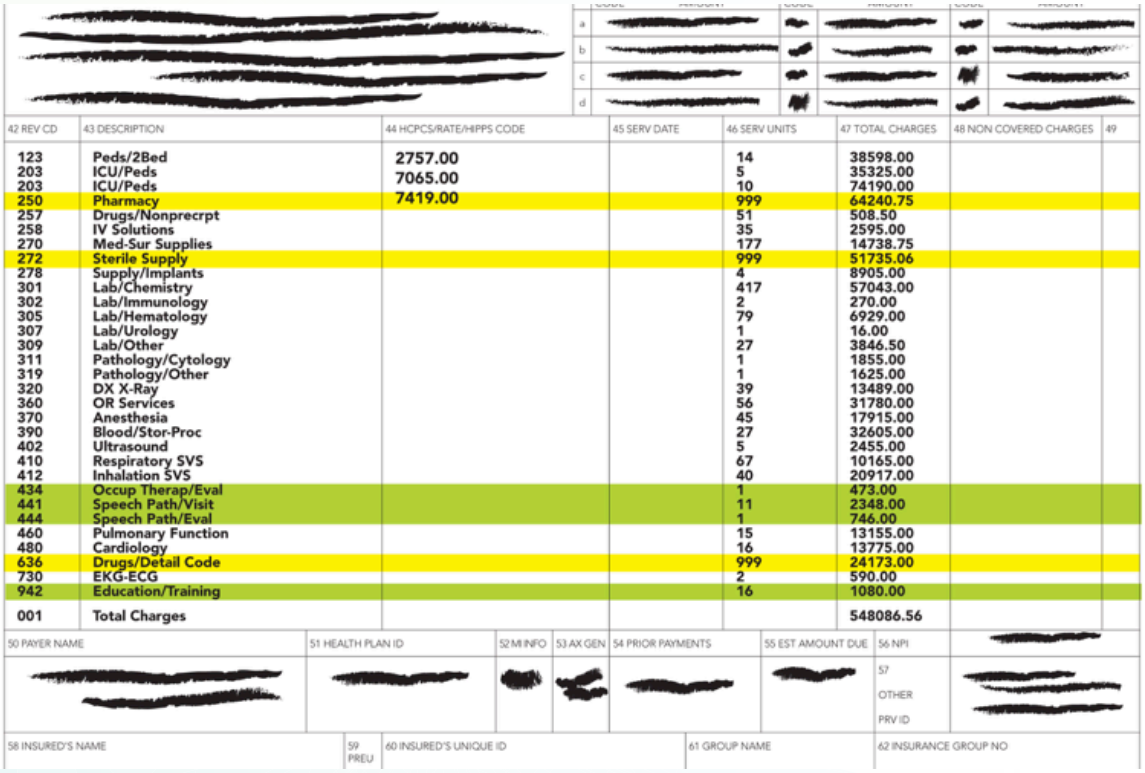
	HOSPITAL A	HOSPITAL B
Billed Charge	**$15,000**	**$10,000**
PPO Discount	**40%**	**20%**
PPO Allowable	**$9,000**	**$8,000**

Exhibit A makes the obvious point that the "best discount" is not necessarily the best deal. This exposes a notoriously common flaw. Content with receiving a percentage off discount, hardly anyone ever poses the question: A percent off what price? Consider an even more troubling reality - the single largest item in this example was $7,200 for a CT scan. Publicly available information revealed that Medicare would pay $225 for the same CT scan. This is not an extreme example, but instead reflects business as usual in hospital billing across America. Given such pricing, what is the true value of such a PPO discount?

PROBLEMS, PART 3 THE AMBIGUOUS PRICING SYSTEM

Hospital bills are not rationally related to hospital costs. Glenn Melnick, Ph.D., a professor of health economics at the University of Southern California reports, "How do hospitals set prices? They set prices to maximize revenue, and they raise prices as much as they can—all the research supports that." To illustrate the irrational nature of hospital billing, consider Exhibit B, an actual hospital bill redacted to protect patient privacy

EXHIBIT B



42 REV CD	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES	49
123	Peds/2Bed	2757.00		14	38598.00		
203	ICU/Peds	7065.00		5	35325.00		
203	ICU/Peds	7419.00		10	74190.00		
250	Pharmacy			999	64240.75		
257	Drugs/Nonprecrpt			51	508.50		
258	IV Solutions			35	2595.00		
270	Med-Sur Supplies			177	14738.75		
272	Sterile Supply			999	51735.06		
278	Supply/Implants			4	8905.00		
301	Lab/Chemistry			417	57043.00		
302	Lab/Immunology			2	270.00		
305	Lab/Hematology			79	6929.00		
307	Lab/Urology			1	16.00		
309	Lab/Other			27	3846.50		
311	Pathology/Cytology			1	1855.00		
319	Pathology/Other			1	1625.00		
320	DX X-Ray			39	13489.00		
360	OR Services			56	31780.00		
370	Anesthesia			45	17915.00		
390	Blood/Stor-Proc			27	32605.00		
402	Ultrasound			5	2455.00		
410	Respiratory SVS			67	10165.00		
412	Inhalation SVS			40	20917.00		
434	Occup Therap/Eval			1	473.00		
441	Speech Path/Visit			11	2348.00		
444	Speech Path/Eval			1	746.00		
460	Pulmonary Function			15	13155.00		
480	Cardiology			16	13775.00		
636	Drugs/Detail Code			999	24173.00		
730	EKG-ECG			2	590.00		
942	Education/Training			16	1080.00		
001	Total Charges				548086.56		

Note the following from Exhibit B, as follows:

- The total billed charge is $548,000+, yet it is neatly summarized on only one page. There are no itemized charges.
- Notice REV CDs (Revenue Codes) – 250 Pharmacy, 272 Sterile Supply, 636 (High Cost) Drugs/Detail Code.
    - o The quantity in each (SERV UNITS) is listed as 999.
    - o Not only is it merely a summary bill, but the hospital cannot even correctly summarize the charges because its "quantity" cell is limited to 3-digits.
    - o The sub-total billed for the 2,998+ unknown items in these same three Revenue Codes is just over $140,000.

As further demonstration of the pervasive nature of this method of hospital billing, the form used in Exhibit B is actually called a "Universal Bill" or "UB" in the hospital billing industry.

- Notice Revenue Codes 434 (Occupational Therapy), 441 (Speech Pathology Visit), 444 (Speech Pathology Evaluation), and 942 (Education/Training). The sub-total for all four is less than $5,000. That may seem reasonable until you consider:
    - o This summary hospital bill is for treatment of a baby born 2-months premature.
    - o Did this baby really receive speech therapy, occupational therapy, education?
- Now compare this entire summary bill to an invoice from a typical national builder supply company. Focus only on Rev Code 272. Suppose the company printed an invoice that read, "272, Framing and Lumber Supplies, Q=999, $51,735.06."
    - o A typical American business or consumer paying this bill would have to wonder how many 2x4's did I get, 2x6's, 2x8's, 2x10's, pieces of plywood, pieces of molding, etc.?

- The PPO discount for this claim was 20%, and the hospital expected payment of 80% with no questions asked. When challenged, the PPO supported the hospital's position.

WHOSE FAULT IS THIS?

The costly and unsustainable practice of irrational hospital billing has finally gained much needed public attention. TIME Magazine led the way with its March 4, 2013 issue, devoted entirely to one subject. The title, "Why Medical Bills Are Killing Us," says it all. Respected publications such as *The New York Times*, *The Wall Street Journal*, and *FORTUNE Magazine* followed suit, excoriating medical providers, drug makers, etc., for irrational, egregious, and predatory pricing.

Insurance companies, PPOs, PBMs and facilities perpetuate this irrational pricing. They commonly enter contracts with "no audit" and "no notice of a change in payment terms" provisions. Finally, various states exacerbate the problems with "clean claim" and "prompt pay" laws that require fast payment of hospital claims that disincentivize close inspection of hospital bills through late payment penalties

But a clear-eyed look in the mirror—and again using the summary claim in Exhibit B as an example—would force an employer to contemplate these questions:

- What manager in any business or any industry would pay any other type of vendor bill in this manner?
- If that manager did routinely pay bills in this manner, how much longer would that manager have a job?

This moves Professor Reinhardt to observe, "American employers have arguably become the sloppiest purchasers of healthcare anywhere in the world. For more than half a century, employers have passively paid just about every healthcare bill that has been put before them, with few questions asked. So far, businesses have not displayed much appetite for galvanizing on this issue," says Mr. Klepper.

THE ELAP SOLUTION

In the November 2012 issue of *WIRED*, former Intel CEO and Chairman Andy Grove wrote a very compelling article. He wrote that if the federal government would pass a Medical Freedom of Information Act, it could do for medical pricing what Oklahoma Senator Mike Maroney's 1958 MSRP (manufacturer's suggested retail price) law did for car buyers. It brought transparency, understanding and true competition among auto dealers.

If your company pays too much in healthcare costs and you are tired of waiting on industry, government, or erstwhile outside help, then ponder heeding the words of James Robinson, Ph.D., professor of health policy at the University of California, Berkeley, "The only way to pay less for healthcare—is to pay less for healthcare."

ELAP—in strict adherence with ERISA and other laws governing fiduciary duties—gives you the opportunity to do just that. A self-funded plan document is a lawful and flexible contract, and one with terms that the plan fiduciary exclusively controls. It is the perfect vehicle to rein in healthcare claims costs. Make no mistake; claims are the overwhelming driver of the cost of operating a health benefit plan. The dollar value of claims increases in direct proportion to charges by medical providers.

In brief, ELAP Services, LLC will serve your plan as a co-fiduciary, with duties and obligations explicitly spelled out within your plan document. ELAP will oversee the installation of rational healthcare payment metrics into your plan. These metrics are based on the actual cost to provide a service. A hospital's cost structure is publicly available information, updated annually, and based on reports executed and signed by hospital CFOs and filed with the federal government. Medicare, among other things, is the only national and recognized "benchmark" available to evaluate any medical bill. Medicare-plus and cost-plus formulas are primary. They become the basis of claims coverage and payment by the plan. Together, we become prudent stewards of the hard earned dollars that you and your covered employees contribute to the health plan. ELAP explicitly fulfills the fiduciary obligations owed to the plan members under the applicable law.

In the ELAP Audit Program, year one savings are substantial. They typically measure $150,000 per 100 covered employees. As specific examples:

- An auto dealer whose plan went from a six-figure deficit to a seven-figure surplus in two years.
- A chain of barbeque restaurants dropped costs significantly in year one and has been level—no increases—for seven straight years.
- A municipality that saw its Standard & Poor's bond ratings climb three levels in the year after adopting the ELAP model. As published by S&P on December 24, 2013, the city "…raised its long-term grade to 'A-' from 'BBB-' …The outlook is stable. The rating change is based on …our view of the city's return to structural balance as a result of significant cost reductions, primarily in employee benefits."

For support, we acquired and utilize the most notable pricing engine and rules database available in the market today. It is the state-of-the-art Medicare-based content and decision support tool.

We founded and pioneered this approach, more than eight years ago. We have audited tens of thousands of medical bills, and our plan-clients have adjudicated and paid them in accordance with this methodology. Attorneys have defended our program and won cases in both state and federal courts, establishing new case law that has become precedent in other jurisdictions and in subsequent actions.

A federal judge in Georgia ruled in favor of ELAP (and the Plan and TPA) and wrote in his opinion, "…the question presented in this action, however, is not simply whether the (hospital's) charges were 'reasonable' or 'customary,' but the issue is whether they were covered under the Plan." The case is

NO. 4:11-CV-15 (CDL), IN THE U.S. DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA -- http://www.elapservices.com/sites/default/files/Order%20Granting%20Defendants-msj_0.pdf – Please visit this link to read the Order in its entirety.

Changing the American medical reimbursement model is a tall order, however, ELAP is delivering viable change and legitimate savings, one self-funded plan at a time.

NOTES

[i]Klepper, Brian. "Why Only Business Can Save America from Health Care." Weblog post. The Health Care Blog. 25 Mar. 2013. Web.

[ii]Ibid.

[iii]Reinhardt, Uwe E. "The Culprit Behind High U.S. Health Care Prices." Weblog post. Economix. The New York Times, 7 June 2013. Web.

[iv]"The PPO Value Proposition." Self-Insurance Institute of America (SIIA) (2006). Web.

[v]Rosenthal, Elisabeth. "As Hospital Prices Soar, a Single Stitch Tops $50." The New York Times. 2 Dec. 2013. Print.

[vi]Reinhardt, Uwe E. "The Culprit Behind High U.S. Health Care Prices." Weblog post. Economix. The New York Times, 7 June 2013. Web.

[vii]Klepper, Brian. "Why Only Business Can Save America from Health Care." Weblog post. The Health Care Blog. 25 Mar. 2013. Web.

[viii]Rosenthal, Elisabeth. "As Hospital Prices Soar, a Single Stitch Tops $50." The New York Times. 2 Dec. 2013. Print

Managing Healthcare Costs

A Transformative Solution

Moving healthcare forward

elap services

Managing Healthcare Costs

A Transformative Solution

Healthcare pricing varies widely and has a direct effect on the bottom line for businesses nationwide. While employers are in the driver's seat when it comes to business operations, managing healthcare costs can be an elusive exception. Traditional health plan approaches present several challenges, but alternative cost-containment solutions are within reach.

In the United States, the traditional Preferred Provider Organization (PPO) model is the most popular form of health coverage on employer-sponsored health plans. Introduced in the 1980s, PPOs were quickly adopted and became the mainstream solution. Simultaneously, the cost of healthcare has skyrocketed and is driving increases in insurance premiums, according to the United States Bureau of Labor Statistics.[1]

195%

The increase in consumer prices for inpatient healthcare services since 1997. Outpatient services have gone up 200%.[1]

THE PPO BANDWAGON

By offering broad access to seemingly affordable healthcare, PPOs promised to be the answer for employers looking to provide healthcare coverage to over 150 million American workers. A PPO gives discounts to subscribers for healthcare services obtained from an approved network of medical doctors, hospitals and other healthcare providers. Members have the option to seek care within or outside the network, helping to explain the easy acceptance and continued appeal among employers.

The reality of the solution has turned out to be much different for most employers. At renewal each year, many employers face double-digit cost increases from their PPO. The rate hike, along with the inflexibility and lack of transparency of the model, leaves many employers feeling helpless.

Consider some hallmarks of traditional PPO plans:

Increasing Premiums for Employees: Since 2007, insurance premiums for family coverage have increased 55 percent, and in 2017, the average annual premium for employer-sponsored health insurance was $6,690 for single coverage and $18,764 for family coverage according to The Kaiser Family Foundation/Health Research & Educational Trust.[2]

Inability to Customize: There is limited to no customization of health plan design available with PPOs. Unlike any other business decision a company makes, PPOs offer limited flexibility for tailoring a health plan around a workforce's specific needs.

Limited Transparency: Every business understands how valuable data can support sound decision making. The only data PPOs provide is the percentage discounted off the charges for a medical service -- there is no data provided regarding the cost of performing the service. Businesses blindly pay for medical services without explanation, an unacceptable practice for any other business operational expense.

Lack of Insight into Health Plan Utilization: PPOs do not provide insight into how an employer's workforce is utilizing healthcare benefits, but there are many advantages when employers have an understanding of utilization. This type of insight empowers employers to optimize care for their employees while minimizing costs, and it can be a data source to drive wellness programs that promote a healthier workforce.

THE COST OF HEALTHCARE

The PPO model where employers pay for medical claims based on discounted billed charges demands further scrutiny. While a discount is helpful in controlling costs, the amount of the billed charges is almost always inflated, and oftentimes grossly. A hospital's charges and an insurance company's negotiated discount are arbitrary figures that can fluctuate widely within the same geographic area. In some instances, the provider's chargemaster contains billed charges marked up by as much as 2000 percent, raising the question if a 40 percent discount off inflated charges provides the best value for employees.

2000%

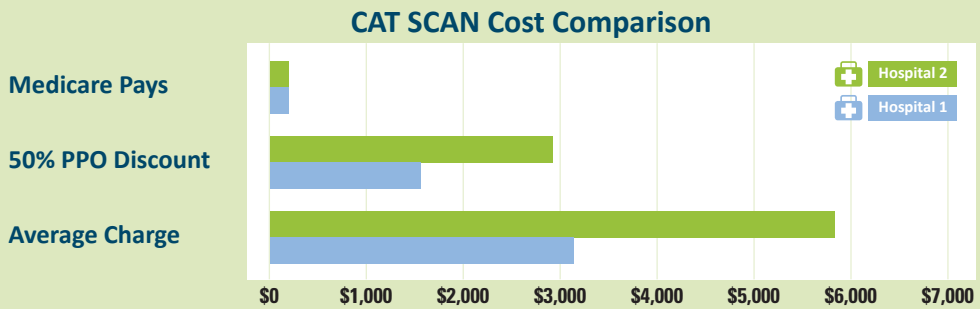
The markup on billed charges in some medical providers' chargemasters.

PPO Price Fluctuations for the Same Medical Service

An independent study conducted by Castlight Health, a San Francisco-based healthcare price transparency company, shows wide variations in PPO allowable amounts for common procedures that are sometimes five-fold within the same geographic area.[3] Additionally, the Centers for Medicare and Medicaid Services (CMS) gathers data from hospitals on the actual cost to deliver services. For employers interested in a better understanding of billed charges, the data can be compelling. The graphic shown below highlights pricing variations for a CAT scan in the U.S.

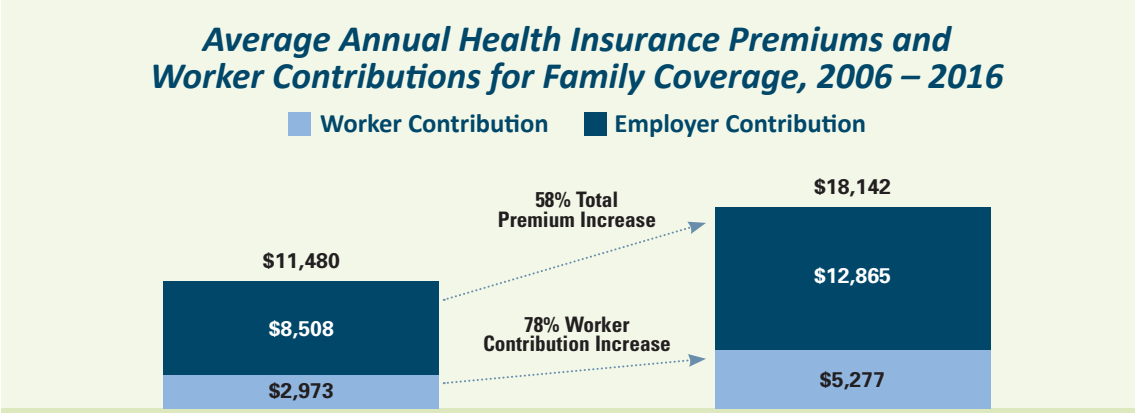
Sample Pricing Variations for CAT Scan

	Average Charge	50% PPO Discount	Medicare Pays
Hospital 1	$3,147	$1,573	$201
Hospital 2	$5,840	$2,920	$199



The Employer's Struggle

Employers choosing between a PPO or a High-Deductible Health Plan with Savings Option (HDHP/SO) are choosing between one high premium or another. Historically, premiums rise annually, and these increased costs must be either absorbed by the business or passed on to the employees, or both. On most health plans, the employer shoulders the financial burden. For businesses of any size, rising premiums and medical claims present a valid struggle.



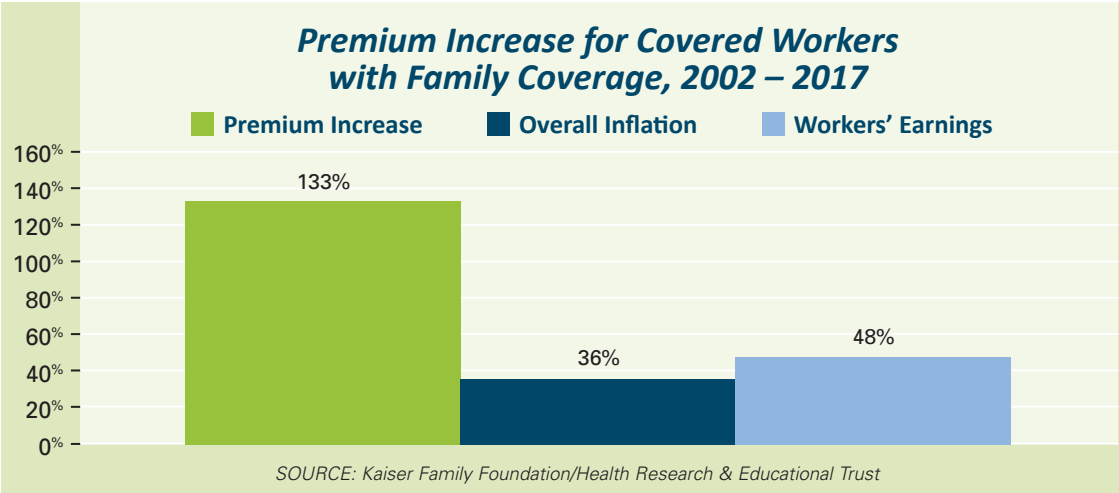
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2016.

The certainty of rising healthcare costs also represents the certainty of less resources to put back into an employer's business. It translates into less hiring of new employees, less competitiveness in their market space and reduced flexibility and resources for investing in growth initiatives.

The Employee's Reality

Once employers select their health plan options, then it's the employees turn to choose their healthcare coverage during open enrollment. The rate of annual premium increases noted in the Kaiser study have steadily surpassed the rate of wage increases and overall inflation.[2]

Beyond premiums, the deductible tiers and provider co-pays have also increased in the U.S. Since 2012, the percentage of covered workers with a general annual deductible of $1,000 or more for single coverage has grown from 34 percent to 51 percent in 2017.



SOURCE: Kaiser Family Foundation/Health Research & Educational Trust

FAIR HEALTHCARE PRICING IS WITHIN REACH

Trading a PPO for an approach known as metric-based or reference-based pricing is a business-saving strategy that's readily available to employers. Many businesses striving to improve their cost management have taken the first step in that direction by adopting a self-funded or self-insured model for their health plan. According to data from the U.S. Department of Health and Human Services, more than 82 percent of employers with 500 or more employees are self-insured.[4] This includes large companies such as Federal Express, AT&T Corporation, and Marriott International to name a few.[5]

Taking self-funded health plans to the next level

Employers on self-funded health plans can make even greater strides in reducing their healthcare expenditure by using a reference-based pricing cost-containment solution. It's been identified as a top trend in 2017 by Wells Fargo, and it's recognized for its cost-saving benefits and transparent view into healthcare expenses.[6] Reference-based pricing empowers employers and enables them to transform their bottom line with costs savings upwards of 30 percent.

Up to 30%

Cost savings for employers who adopt a metric-based pricing solution.

How it Works

One of the most powerful benefits of reference-based pricing is how it restores control to employers and their employees. The health plan documentation plan defines pricing limits upon which claims will be paid, ensuring that fair prices are paid for medical services. A reference-based pricing solution is a bottom-up approach to healthcare charges that starts with the actual cost amount and adds a fair profit margin to calculate the bill. This is contrary to a PPO model, which starts at the top with a potentially inflated price from a facility's chargemaster and offers a discount.

Reference-based pricing restores information and control.

In a health plan that uses reference-based pricing, a common metric is used to determine payments. This can be the Medicare approved amount or the actual cost to deliver the service based on reported figures. A reasonable profit is added for fair and prompt reimbursement to the healthcare provider.

Other hallmarks of quality reference-based pricing solutions include:

Cost Savings: Beyond the savings gained from starting at cost and going up, self funded health plans are administered by a third party administrator (TPA) and oftentimes, those TPA's allow for plan customization that support cost containment goals.

Legal Advocacy: For employer health plans and their employee members, it's important to select a provider who provides expert legal backing.

Direct Relationships: Building bridges between employers and hospitals helps to make healthcare a community-centric solution that supports open dialogue between patients and providers. Establishing agreed upon reimbursement levels enables plan members to seek out community providers with confidence that their bills will be within claim limits.

TURNING THE TIDE — Transforming Your Business

The positive ripple effects of reference-based pricing can be transformative for any business. Businesses that have made the switch have saved money on their healthcare costs year over year, allowing their owners to invest funds back into the business.

The employees of these businesses also benefit. For those workers who have struggled with the financial burden of medical bills and healthcare costs that discouraged them from seeking treatment, the change is welcome.

EMPLOYER BENEFITS

- Attract new talent with rich benefit packages.
- Retain skilled employees.
- Invest savings into growth initiatives.
- Pass savings on to employees via reduced health plan premiums or other programs.

EMPLOYEE BENEFITS

- Reduced out-of-pocket healthcare expenses, including premiums, deductibles and copays.
- Access to quality, affordable healthcare services.

How ELAP Clients have Passed Savings along to their Employees

- a car dealership lowered deductibles for members
- an architectural consulting firm gave their employees a three-month "premium holiday"
- after one year, a client was able to increase their contributions to employees' 401k plans by 0.5%
- using their savings, an employer increased year-end bonus pools for employees

One of the most important focus areas of healthcare today is if costs are fair, reasonable, and sustainable for businesses, employees, families and the economy. Employers have the right to know what they're paying for healthcare -- those with a desire to take on this business expense astutely can enter the playing field of reference-based pricing.

ABOUT ELAP SERVICES

ELAP Services is a leading healthcare solution for self-funded employers across the U.S., offering unparalleled cost savings and advocacy services. ELAP's full-service program works in conjunction with a company's health plan to promote the responsible and sustainable management of healthcare costs.

Since 2007, ELAP has helped hundreds of organizations to reduce their total healthcare costs by up to 30 percent. Built upon the principles of federal benefit law (ERISA), ELAP's full-service solution encompasses hospital and provider claims auditing, plan design, and member advocacy and legal expertise, while emphasizing collaboration and strengthening partnerships within employer communities. ELAP builds meaningful connections with employers, members, and hospitals and health systems, to ensure a fair price for quality healthcare.

References

1. U.S. Bureau of Labor Statistics Spotlight on Statistics: A Look at Healthcare Spending, Employment, Pay, Benefits, and Prices, June 2016: https://www.bls.gov/spotlight/2016/a-look-at-healthcare-spending-employment-pay-benefits-and-prices/home.htm
2. The Kaiser Family Foundation/Health Research & Educational Trust 2017 Annual Employer Health Benefits Survey, September 2017: https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/
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