Smart Practices

for Addressing High Claims Costs

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Employee Benefit Adviser

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Polling Question

What is the highest claim you have seen with a self-funded employer?

- o $1 million
- o $2 million
- o $5 million
- o More

Smart Practice:
Awareness

Know What's Happening in the Market

The ACA hasn't gone away.

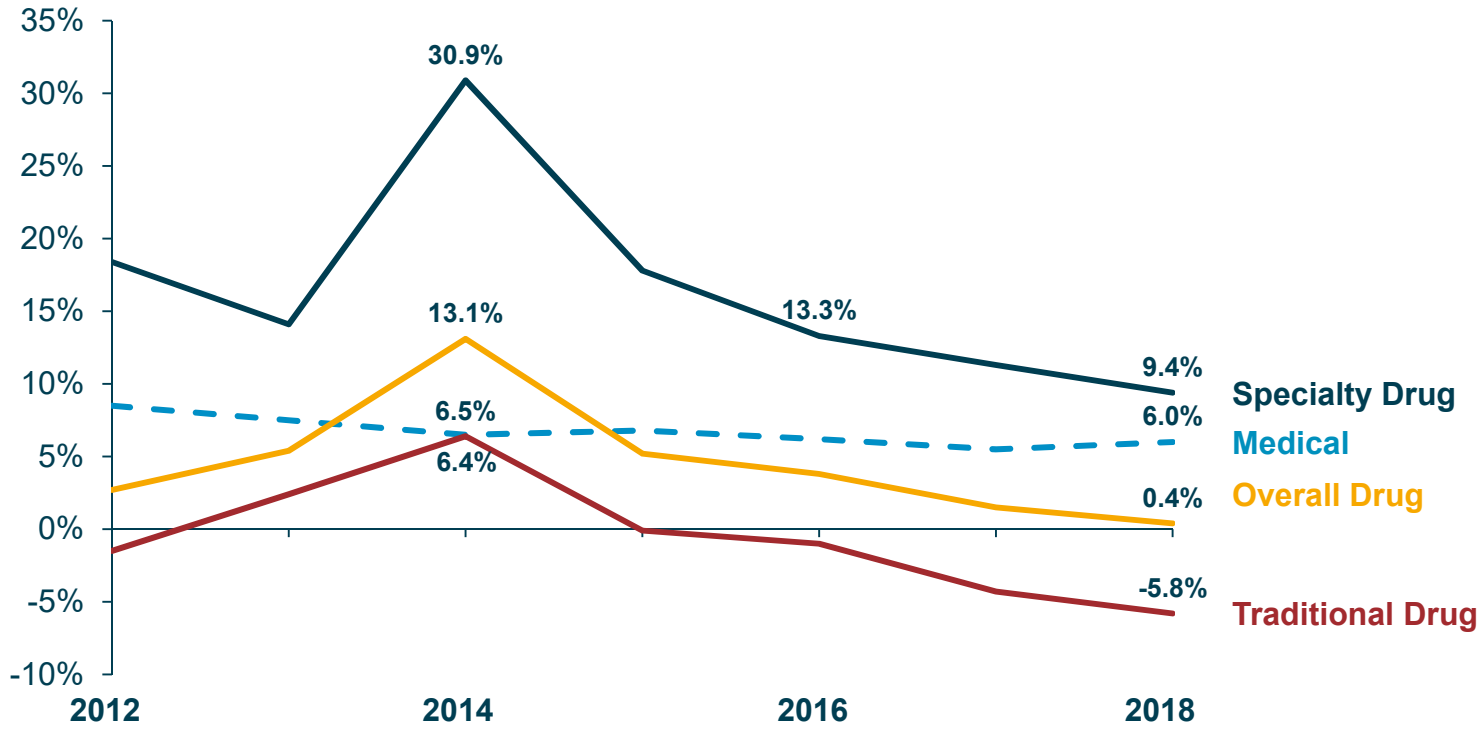
There are increases in the frequency and severity of Stop Loss claims.

Pharmaceutical advancements, approvals and costs are on the rise.

Everyone's seeking more control of outcomes.

Stop Loss protection is needed by self-funded groups now more than ever.

Prescription Drug and Medical Trend (2012-2018)



Note: Drug trends are for commercial prescription drug benefits; medical trend includes medical services and prescription drugs and is based on commercial insurers' large group plans and large self-insured business.

Source: Behind the Numbers: 2019, PwC, Express Scripts 2012-2018 Drug Trend Report.

Presenter: Mark Lawrence

Growing Interest in Managing Benefit Costs

Employer-sponsored health insurance premiums have **risen dramatically** in the last 20 years.[1]

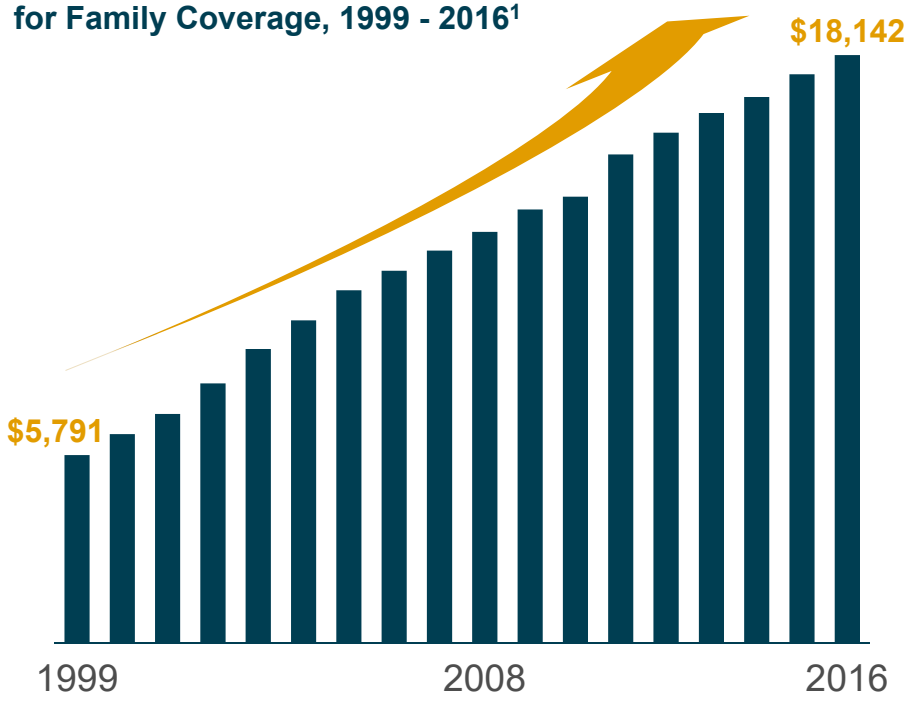
The rising costs are not attributed to overuse, but rather to the **high price of care** in the U.S.[1]

Payers do not know if they are paying a fair price because details regarding PPO discounts **are not openly shared…**

… and hospital charges have been considered to be egregious.

"Decades of research show that hospital prices vary drastically and have little to do with the quality of services."[2]

Average Employer Health Insurance Premiums for Family Coverage, 1999 - 2016[1]



[1] *Economic Policy Institute, The Unfinished Business of Health Reform, October 10, 2018.*
[2] *https://www.modernhealthcare.com/hospitals/setting-bar-hospital-prices.*

Presenter: Dom Palmieri

What's Behind the Growing Costs?

- Higher Price of Health Care
- \+ Continued Influence of ACA Requirements
- \+ High-Cost Pharmaceuticals
- \+ Inflated Billing
- \+ Fraud
- \+ New Technology & Advancements
- \+ Provider Consolidation
- \+ Increasing Chronic Illness

= $$$

Presenter: Mark Lawrence

Managing the Unpredictable

Not all claims can be anticipated, but they may be able to be better managed should they arise.

Knowledge and awareness enable the development of targeted tactics.

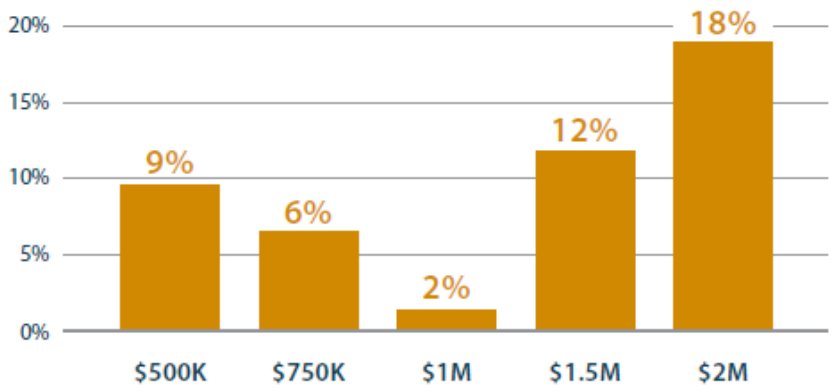
Stop Loss carriers must delve into the details to deliver the right coverage.

What HM Is Seeing with Large Claims

Claims Incidence Per 100,000 Employees

UW Year	$500K	$750K	$1M	$1.5M	$2M
2014	37.3	14.0	7.3	2.2	0.9
2015	37.1	13.8	6.3	2.3	1.0
2016	45.4	15.9	6.9	2.3	1.1
2017	50.3	16.9	8.0	3.0	1.4
2018	51.9	18.0	8.0	3.4	1.7

Average Annual Percentage Increase in Claims Incidence Per 100,000 Employees (UW Years 2014 – 2018)



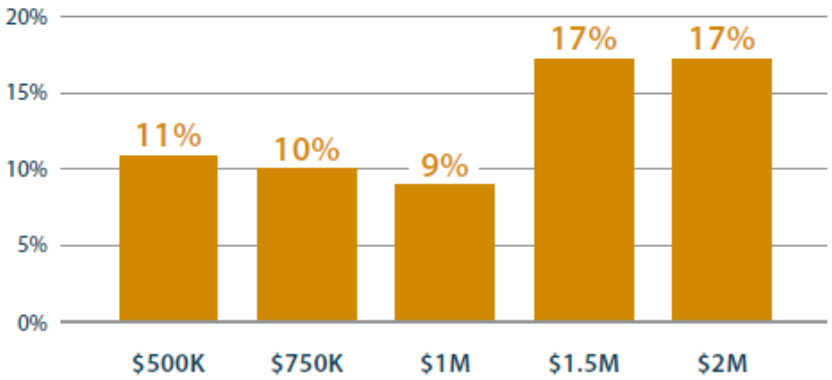
Source: HM Insurance Group internal analysis as of 12/31/18; UW years 2017-2018 are immature and projected; costs are expected to increase.

What HM Is Seeing with Large Claims

Cost Per Employee Per Month (First Dollar Claim Amounts)

UW Year	$500K	$750K	$1M	$1.5M	$2M
2014	$9.52	$4.78	$2.89	$1.17	$0.56
2015	$8.71	$4.51	$2.64	$1.09	$0.48
2016	$11.07	$5.05	$2.81	$1.27	$0.59
2017	$12.83	$6.21	$3.68	$1.71	$0.83
2018	$14.51	$7.06	$4.02	$2.15	$1.06

Average Annual Percentage Increase in Cost Per Employee Per Month (UW Years 2014 – 2018)



Source: HM Insurance Group internal analysis as of 12/31/18; UW years 2017-2018 are immature and projected; costs are expected to increase.

What HM Is Seeing with Large Claims

Top Diagnosis Categories

Percentage of first dollar claims more than $1,000,000 for that category.

	2014	2015	2016	2017	2018
#1	Neonatal **26%**	Cancer **21%**	Neonatal **20%**	Neonatal **22%**	Circulatory Diseases **17%**
#2	Cancer **15%**	Neonatal **19%**	Cancer **19%**	Cancer **20%**	Neonatal **15%**
#3	Circulatory Diseases **15%**	Circulatory Diseases **12%**	Circulatory Diseases **12%**	Blood Diseases **11%**	Cancer **13%**
#4	Injury & Poisoning **8%**	Injury & Poisoning **12%**	Injury & Poisoning **10%**	Injury & Poisoning **9%**	Injury & Poisoning **12%**
#5	Blood Diseases **8%**	Endocrine/ Metabolic Diseases **11%**	Blood Diseases **10%**	Respiratory Diseases **8%**	Respiratory Diseases **12%**

Source: HM Insurance Group internal analysis as of 12/31/18; UW years 2017-2018 are immature and projected.

Presenter: Dom Palmieri

The Nature of High-Cost Claims

Considering Known Risk vs. Unknown Risk in Underwriting

HM's January 2019 Claims

2 claims more than $2M
4 claims more than $1M
4 claims more than $800K

→ 5 babies
2 children in Children's Hospitals

Gene Therapy Drugs for Rare Conditions Are Driving Costs Higher

- Hemophilia
- Spinal Muscular Atrophy (SMA)

Information gathered from HM Insurance Group internal reports, February 2019.

Working to Better Control Costs

Turn Data into Insights

Understand Group Dynamics

Consider Regional Nuances

Enhance Risk Management

Smart Practice:
Cost Containment

Tactics to Consider for Containing Costs

- Employee Benefit Plan Design
- Vendor Intervention
- Manage the Potential for Excessive Provider Charges Upfront
  - Direct Contracting
  - Narrow Networks
  - Reference-Based Pricing

Plan Design

- Clarify Eligibility
- Provide In-Network Incentives
- Support Use of Case Management Services and Centers of Excellence
- Address High-Cost Services with Solutions
  - Clinical Trials/Experimental Treatment
  - Alternative Treatment Plans
  - Transplant Service Requirements
  - Genetic Testing
  - Pharmacy
  - Pre-authorization
- Include Language on the Unanticipated
  - Medical Errors/Never Events/Substandard Care
  - Assault and/or Participating in a Felony

To help prevent gaps in coverage, the Stop Loss protection should mirror the group's underlying plan document.

This is only a partial list of recommendations; many other areas can be addressed to help in containing costs.

Vendor Intervention

- Out-of-network Discount Negotiations
- Hospital Bill Review
- Repricing Services
- Centers of Excellence for Transplants
- Cancer Management Services
- Kidney Resource Management Services
- Neonatal Management Services
- Specialty Pharmacy Services

This is only a partial list of vendor services; other areas can be addressed to help in containing costs.

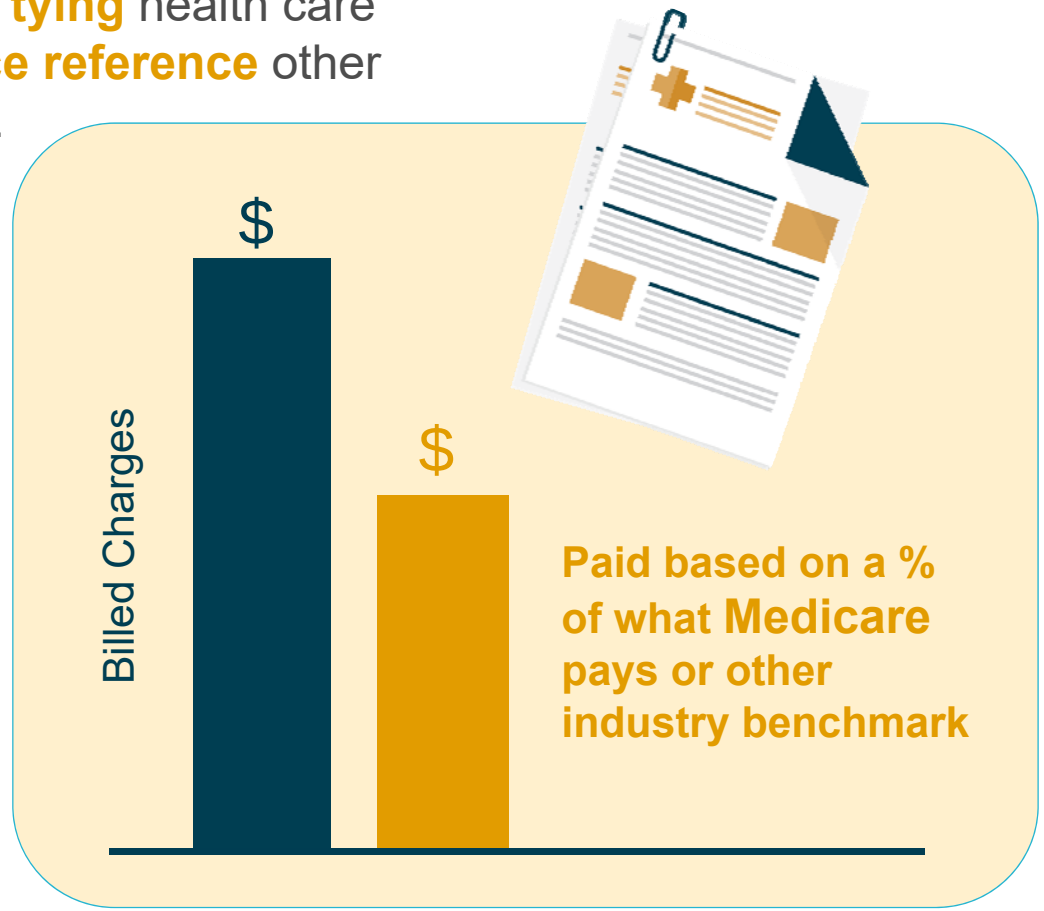
Smart Practice:
Reference-Based Pricing

What Is Reference-Based Pricing?

Reference-Based Pricing (RBP) is **tying** health care provider reimbursements **to a price reference** other than the facility's charge schedule.

It's a **tactic** that **Payers** of health care expenditures are employing to help **gain control of health care costs**.

Medicare reimbursement rates are the most commonly used price reference, although the hospital's CMS **cost report** or another industry benchmark also may be used.



Why Reference-Based Pricing May Be a Solution

Accepted

Most RBP plans are based on the Medicare reimbursement schedule, which is commonly used because it is a low-level reimbursement that **most providers are already accepting**.

Fair

Medicare reimbursements are adjusted based on geography and other factors, and **RBP reimbursements often include an additional margin of 20% or more**.

Transparent

The Medicare price schedule is publicly available and provides a **consistent starting point** – not a discount off of what may be an inflated charge.

PPO Pricing Compared to Medicare Plus Pricing

Simplified Cost Scenarios*

PPO Claim	
Billed/Charge amt.	$100k
PPO discount	($60k)
Reduced cost	$40k
Member deductible	($1k)
Plan pays	**$39k**

Medicare Plus Repricing	
~~Billed~~	~~$100k~~
Medicare pays	$20k
Plus 40% Medicare	$8k
Repricing fee	$4k
Reduced cost	$32k
Member deductible	$1k
Plan pays	**$31k**
Savings	**$8k**

Repricing fees vary from vendor to vendor and should be carefully considered when reviewing the overall benefits of reduced claims costs.

**Example is illustrative only.*

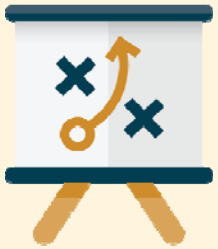
Polling Question

Do you currently work with Reference-Based Pricing plan(s)?

- Yes and plan to continue
- Yes and plan to grow
- No but we are considering it in the near future
- No we have no interest

How Reference-Based Pricing Is Being Used

Specific Procedures



The plan states what it will pay for specific services.

Members are given a list of providers and their fees so they can shop for services. They may be responsible for amounts above the reference price.

Out-of-Network

Often negotiated by vendors on behalf of the plan after services are rendered.

The reference price is used to help determine reimbursement levels that are fair to both the provider and the payer.

PPO Replacement

PPO replacement models range from open access (where provider charges are repriced after services) to models that use direct provider contracts based on the reference price or a hybrid of the two.

PPO Replacement Models

Repricing

Facility only

or

Facility and professional claims

Wrap physician networks may be used when repricing facility only

Open Access

- There are **no provider contracts,** and members may go to any facility
- TPA works closely with repricing vendor
- Administrator sends claim to repricer
- Claim is payed at repriced amount
- Provider accepts the payment or pushes back and **may balance bill** the member

Direct Contract

- **Provider agrees in advance** to **accept** a certain reimbursement level
- Members are encouraged to use contracted facilities
- A narrow network is sometimes formed

Hybrid

- The Plan employs an open access type of arrangement, but also has some direct provider contracts with certain facilities or a wrap physician network to **avoid balance bill** issues

Presenter: Dom Palmieri

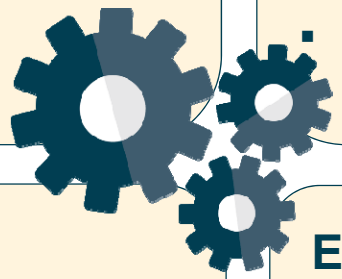
Working Together Is Key to Success

Repricing Vendor

- Ensure **plan documents** are consistent, support payment level and language is defensible
- Provide **member advocacy** services to defend reimbursements and help members obtain access if denied
- Provide **accurate** and **timely** claims repricing

Employer

- **Educate employees**
  - How the plan works
  - What to do if balanced billed or denied services
  - Importance of making timely co-payments
- Ensure **access** to plan **information**



Plan Administrator/Broker

- **Educate** employers on how the plan works and ensure they are **prepared** to handle feedback
- Assist in **communicating** to employees
- Support **member advocacy** efforts
- **Timely processing** of claims

Employees/Members

- **Learn** how the plan works
- Make co-payments and **report balance billing** issues timely

Roles of repricing vendor and plan administrator vary based on relationships

Managing the Risk of Balance Billing

Strong Member Advocacy

- Accessible central contact for members
- Trained staff to handle provider disputes on behalf of the member
- Sound explanations for the reimbursement amount
- Assistance in obtaining facility access if member is denied
- Support for handling collection and credit agency concerns
- Clarification for the member's financial obligation
- Well established processes for timely communications among concerned parties

Additional Measures Some Vendors and TPAs Take to Help Mitigate Balance Billing

- Maintain a **list of providers** who are known to accept the reimbursement and/or those that are known to push back
- Help establish **direct provider contracts**, including arrangements with **COEs** as needed
- Provide **plan information on ID cards**
- Approach **geographic locations** known to be problematic with caution
- **Explain reimbursement up front** at time of pre-certification

Finding the Right Balance

Cost Benefits

- **Reduction** in health **benefit spending** without taking away benefits or cost shifting to employees
- More predictable provider charges
- **Paying a fair price** for services rendered

Risks

- **Overall noise** or disruption/employer reputation
- Member being **balanced billed or denied access**
- Stop Loss **coverage gap** due to timing of provider disputes

Repricing vendors often analyze an employer's claim history to estimate savings and can provide historical statistics on provider acceptance.

Presenter: Mark Lawrence

Key Considerations from a Stop Loss Carrier's Perspective

- The **TPA and repricing vendor are aligned** with clear expectations as to roles and responsibilities and have well established processes
- The **employer is educated** about how the plan works and is committed to educating employees
- The **employer is prepared** to handle employee questions and is able to tolerate potential disruption
- **Strong member advocacy services are in place** and have been communicated to employees
- The repricing methodology and **plan documents** are consistent and are based on sound principles, including clear provider explanations
- Expectations for **how long** a provider dispute may be negotiated and **notification requirements** are defined

Smart Practice:
Choose a Stop Loss Carrier That Pays Claims

Stop Loss Is Not a Commodity

A $3M or $4M claim could be financially disastrous for a business or public entity.

It is important to have the right coverage in place to help provide true financial protection.

The right Stop Loss carrier **pays claims** – and pays them **quickly** so the self-funded employer's business is not disrupted.

Million Dollar Babies

SITUATION

- Premature twins with NICU care
- Claims exceeding $2 million
- Covered under the self-funded plan of private college
- Stop Loss protection in place
- Group needed quick payment to protect financial stability

SOLUTION

- HM team knew swift turn-around was needed
- Worked closely with broker and group to quickly gather information
- Strong relationship/open communication allowed for swift movement
- More than **$2 million reimbursed** in **four business days**

Information gathered from HM Insurance Group internal reports, 2018.

High-Cost Hospital Services

SITUATION

- $1 million claim with a 40% discount off billed charges
- TPA felt cost was still too high
- Contacted hospital's revenue cycle manager for further reductions
- Told to contact the hospital's CFO, whom the TPA believed would either:
  - Decline the request as going beyond the already negotiated amount
  - State that the agreement was already in violation because the claim had not been paid within 30 days
  - Decline to even address the issue (which is what happened in this case)

SOLUTION

- TPA contacted HM
- Case was remitted to one of HM's partner cost containment vendors by the TPA
- Strong relationships with well-vetted vendors help to achieve savings
- Vendor reduced the bill, netting a **savings of $78,000 (7.8%)** in about a week
- TPA was surprised by the success because achieving such a positive outcome can be difficult in the current market

Information gathered from HM Insurance Group internal reports, 2018.

Reimbursement Management

SITUATION

- Educational trust on the East Coast had a unique situation – medical coverage was to be handled out of the Intermediate Unit (since they prepay their medical premium)
- Drug coverage was to be handled separately through each member school and later reconciled
- Many Stop Loss carriers were unable to handle the structure

SOLUTION

- HM assessed the situation, developed a plan and implemented a process that provides reimbursements throughout the plan year to the appropriate party
- Little to no work on the broker or educational trust
- Keeping payments separate allows other schools to join the Rx consortium for better overall discounts
- **Quicker reimbursement** since payment doesn't have to go through the Intermediate Unit

Information gathered from HM Insurance Group internal reports, 2018.

Traits of a Strong Stop Loss Carrier

- ✓ **Direct writer** – In-house decision-making responsibilities
- ✓ **Financially sound** – Well capitalized; excellent rating from A.M. Best
- ✓ **Stable** – Demonstrated market history with significant tenure and experienced leadership
- ✓ **Accurate** – Greater than 95% technical and financial accuracy in processing/paying claims with limited delays and denials
- ✓ **Contains costs** – Proven results and strong vendor relationships
- ✓ **Delivers a policy with solid protection** – Clearly articulated contract with limited exclusions
- ✓ **Demonstrates ACA expertise** – Understands health care reform legislation and obligations
- ✓ **Tailors plans to the group's needs** – Uses innovative programs to satisfy specialized needs balanced with appropriate risk management practices
- ✓ **Writes over multiple payers** – Provides seamless coverage that protects across plan variations

Closing Thoughts

Feel free to contact:
domenic.palmieri@hmig.com, mark.lawrence@hmig.com or marketing@hmig.com with any questions or requests for information.

This presentation will be available shortly in the Tools & Resources section of www.hmig.com and on the Employee Benefit Adviser website.

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