




**THE
PHIA
GROUP** EMPOWERING PLANS



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What We Love About Self-Funding in 2019



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Today's Speakers



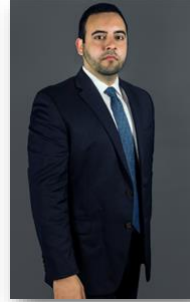
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A Special Shout-Out!

Special Shout-Out to Cristy Gupton

of



Cristy is an avid fan of our webinars and podcasts!

Thanks for listening!



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Faces of Phia



Ashley Turco, Director of Compliance – Ashley leads The Phia Group's internal compliance and risk management program. Ashley ensures conformity within The Phia Group's information security management system by overseeing all communications. In addition, Ashley works diligently to maintain The Phia Group's certifications, both in ISO 27001 and SOC 1 Type 2.

Lisa Tangney, Controller – Lisa is responsible for all financial transactions within The Phia Group. Lisa oversees the accounting department to ensure accurate and timely payments are made to our clients. In addition to keeping payments secure, Lisa makes certain that her department is always available to answer questions and assist clients.

Christine Sands, Business Analyst – Christine works to define software enhancements relating to The Phia Group's case management system. The Phia Group's employees look to Christine for assistance in identifying and measuring process improvement opportunities within departmental workflows. In addition to bridging the gap between the software development team and users, Christine also assists with data validation during client implementations.



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Overview

- Problem, Purpose, Process
- Last Month's PGC FAQs
- Political Update
- What We Love About Self-Funding
 - Customization
 - Cost-Containment
 - Systemic Change!



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Problem, Purpose, Process

The Problem – Health Care Costs Too Much and The Price is Increasing; Employers are Forced to Offset Costs Through Higher Co-Pays and Deductibles

Our Purpose – To Make Health Benefits Affordable for Employers and Employees

Why? – Because Hard Working Americans Deserve Access to High Quality, Affordable Healthcare



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Last Month's PGC FAQs

- How do OOP limits affect balance-billing?
 - OOP reached = allowable benefits paid at 100%
 - **Allowable** benefits
 - This does *not* mean the plan has to pay 100% of all balance-bills!
- How do we correctly apply a self-inflicted injury exclusion?
 - HIPAA's "source of injury" rule (domestic violence, medical condition)
 - Ex. Stomach pumping of patient with alcohol abuse disorder
 - Most likely can't exclude the emergent stomach pumping claim – but can possibly exclude claims for DWI (alcoholism may have forced him to *drink*, but it did not force him to *drive*)
- Direct Primary Care coverage: how does it integrate with an HDHP?
 - HSA eligibility requires coverage under *only* an HDHP – DPC could count as "other coverage"
 - In the plan (requires the patient to be responsible for the *full cost of care* until the deductible is met) vs. outside the plan (DPC provides potentially more than "excepted benefits," so the ACA may consider it a separate health plan; can be "other coverage")



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The State of the Healthcare Union



On February 5, President Donald J. Trump delivered his second State of the Union address before a joint session of Congress.



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The State of the Healthcare Union

- Prescription drug prices
- Price transparency / end to “surprise” billing
- Nationwide paid family leave
- Protections for people with pre-existing conditions
- Repeal of the ACA’s individual mandate
- Right to Try legislation
- Deregulation

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Drug Prices Top the List

• The Rhetoric

- Problems of free loading & price transparency
- PBMs portrayed as the shadowy middlemen
- Trump has called out Big Pharma directly



• The Action

- \$150 billion in yearly rebates → Trump proposed a ban on them for Medicare Part D
- Medicare Negotiation and Competitive Licensing Act → allow Medicare to negotiate drug prices with possibly of stripping patents
 - Bipartisan support, Democrats control powerful committees
- Johnson & Johnson will be the first drug maker to list the price of its prescription drugs in television ads

• The Impact on Self-Funded Plans

- The end of PBM rebates in the Medicare system would have ripple effects in the commercial sector
- Could establish a benchmark for pricing drugs based on Medicare



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Federal Paid Family Leave

• Background

- U.S. is only developed country w/o federally-mandated paid family leave (FMLA is unpaid)
- 35% of ERs offer paid maternity leave: 29% offer paid paternity leave
- Issue has bipartisan support, especially in the House, and is important to Ivanka Trump

• Impact on Self-Funded Health Plans

- Continuation of coverage
- Providing paid sick time to EEs has many benefits to the workforce



• A Plan Is Being Drafted

- Tax Cuts & Jobs Act included a pilot program
- President announced that his budget will include a plan
- *"I am working with the White House to develop a sustainable paid family leave plan that will give parents the flexibility they need to raise a family."* Senator Bill Cassidy (R-LA)



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Notable Mentions

- **Rhetoric Has Shifted**
 - Administration has declared regulatory victory
 - The 2018 midterms forced the WH to embrace parts of the ACA
 - Republicans widely support maintaining protections for those with pre-existing conditions → likely to see legislative action here
- **Ongoing ACA Lawsuit**
 - Despite Texas v. United States (N.D. Tex. 2018) ruling, employers & plan sponsors must comply to comply with the ACA until trial court proceedings and appellate review are complete
- **2020**
 - Healthcare will be a major issue
 - Protecting the ACA will be paramount
 - Medicare for All?
- Another government shutdown looming?



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What We Love: Customization

Self-funding lets you utilize programs like...

- Medical (and Rx) tourism: domestic & international
- Direct contracts, narrow networks, Direct Primary Care



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What We Love: Customization

Ability to integrate Direct Primary Care!

- Saves the health plan money
- Saves members money
- Ability to call, text, email a doctor that you've actually met before
- Members feel like VIPs



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What We Love: Customization

Don't ignore the data!

- Know the spend for stop-loss quotes
- Negotiate better contracts and/or explore carve-outs
- Fraud, waste, abuse
- Customize benefits based on needs, trends, expectations



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What We Love: Customization

- Who is your employee base?
 - Do they smoke? Skydive? Drink and drive?
 - Are they generally healthy?
 - Is the focus on maintenance or accidents (or both)?
- Coverage options: individual, spouse, families, retirees, or more
- Network options: PPO, EPO, RBP, OON RBP....
 - Options for working *with* providers rather than fighting
- Options for dialysis, cancer, hemophilia, and more



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What We Love: Customization

Don't ignore the data!

- Identify “preferred” providers (feel free to copy Phia’s example!)
- Push notifications to members regarding their plan, benefits, incentives, steerage, etc.



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What We Love: Customization

- Employee Incentives!
 - Birthing costs & “diapers & wipes”
 - Shopping around for DME or other equipment
 - Generic drugs
- Copays, deductibles, coinsurance
 - Can also tie into incentives
- Generally good access to claims data, for even more customization options
 - But, ASO vs. TPA still a factor



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What We Love: Cost-Containment

Design your own SPD!

Recent example: “Wilderness Therapy”

- Strong definition of “residential treatment facility” helped court dismiss lawsuit against plan
 - <https://goo.gl/5nf5FU>
- Network options: *lots* of ‘em
- Rx, specialty drugs, orphan drugs
 - FDA considering drugs to help children quit vaping
 - <https://goo.gl/LwynVo>



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What We Love: Customization

Assistance is always available!

- Appeals & various fiduciary duties
- Plan Drafting
- Subrogation & overpayments
- Claim negotiation & direct contracting
- Compliance & consulting



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What We Love: Cost-Containment



Most Expensive Chronic Diseases

- Cardiovascular diseases
- Smoking-related issues
- Cancer
- Diabetes
- Obesity

Most Expensive Procedures

- On average, transplants are some of the most expensive procedures
 - Heart, lung, bone marrow, liver
- Open heart surgery
- NICU admissions

Most Common Carve-Outs

- Dialysis!
- Specialty drugs
- Implants
- Air ambulance
- Oncology
- Hemophilia



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What We Love: Cost-Containment

Type	Claim Number	Status of Claim	Received	Incurred	Plan ID	Effective			
External ID:									
DGN	DGN Description	ICD	Year	UND/GRP	Network	Claim Source	Pat. Acct.		
Z38	Liveborn infant	Z38.31	2017						
Benefit	From DOS	Unit	Charge Amt	Disallowed	Deductible	Percent	Payment	Paid To	
121	01/24/2017	83	763800.00	152760.00	.00	100	611040.00	PRV	
123	01/24/2017	1	25390.73	20460.53	.00	100	4930.20	PRV	
110	01/24/2017	0	76911.94	.00	.00	100	76911.94	PRV	
Totals:			866102.67	173220.53	0.00		692882.14		
Adjustments:			0.00	COB Adjustments:	0.00	Withhold:	0.00	Total:	0.00
Assignment	Tax ID	Employee/Patient - Provider	Payment Type	CHK/TRN ID	Status/Date	Payment			
Patient						.00			
Provider						692882.14			
Total:						692882.14			

ICD Z38.31: Live twin C-section, billed at **\$866,102**



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What We Love: Cost-Containment

Negotiation potential: agreement to pay **\$510,000**

Savings of **\$350,000**

Double the network discount



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What We Love: Cost-Containment

Level-funding

- Many different programs offered by many different TPAs and stop-loss carriers
- Just like “U&C,” there’s no universal definition of level-funding
- Notes:
 - Typically requires stop-loss advanced funding, so carrier must be on board
 - No plan changes needed in SPD!
 - Claims must still be paid – even if stop-loss denies funding
 - So, make sure you’re allying with good stop-loss partners
 - *Always* good advice

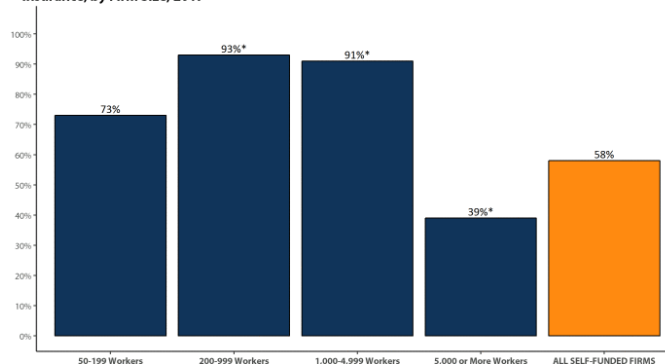


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What We Love: Cost-Containment

Stop-loss: is it right for you? (Spoiler alert: probably*)

Figure 10.7
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance, by Firm Size, 2017



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
NOTE: Figure includes covered workers enrolled in partially or completely self-funded plans. For definitions of self-funded and fully insured plans, see the introduction to Section 10.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

* Possible exceptions include hospitals, casinos, and eccentric billionaires



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What We Love: Cost-Containment

Stop-loss Options

- TPA vs. ASO
- Lower deductible, higher premium
- “Specialty” programs like level-funding
- Plenty of RBP stop-loss options

But remember... you usually get what you pay for!



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What We Love: Cost-Containment

- MEWAs and Association Health Plans
 - The ability to self-fund may be worth it, even if you have to deal with state law
- Options in subrogation and overpayment recovery such as offsetting future claims
 - But watch out for cross-plan offsets...
 - *Peterson v. UnitedHealth Group, Inc.*
- Ability to vet and use (and term) vendors
 - Not getting bang for your buck? Make changes!



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What We Love: Systemic Change

- Self-funding promotes vendor and provider transparency!
- The fact that the employer's money is at risk means all parties involved are more interested in containing costs
- Stark difference from the fully-insured world, where a flat premium means no one questions costs on the back-end
- RBP, especially, is changing the industry
 - Even legislatures are getting on board the RBP train
 - That either wouldn't happen or would be much slower to evolve in the fully-insured world
- 1/1/19: CMS rule requires hospitals to publicly post charges online in a machine-readable format on annual basis



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