CHAPTER 8

PPO NETWORKS DELIVER VALUE—AND OTHER FLAWED ASSUMPTIONS THAT CRUSH YOUR BUDGET

"Your assumptions are your windows on the world. Scrub them off every once in a while, or the light won't come in." – Isaac Asimov

Albert Einstein famously said, "We can't solve problems by using the same kind of thinking we used when we created them." Yet, this is exactly what health care does over and over. Baked into our thinking about health benefits administration are many assumptions that turn out to be flawed on deeper examination—at best outdated, at worst outrageous.

Here are three flawed assumptions that are doing you serious harm.

1. Your broker works for you*

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* *There are certainly some excellent brokers that do their best for employers, but the overwhelming majority have undisclosed conflicts of interest that favor insurance carriers. In this book, the term benefits consultant or advisor refers to people who provide a broader range of services and expertise than simply signing up clients on behalf of a carrier. Many of them bring a more sophisticated brand of professionalism to their clients. See Chapter 13 – 7 habits for a more complete treatment of this critical subject.*

2. Insurance carriers want to drive down costs and PPO networks deliver the best pricing available
3. Auto-adjudication of claims is always good

Together, these assumptions may seem minor, but together they add up to significant costs and damage to your bottom line, your employees' bottom line, and your employees' health. Luckily, knowing about them is half the battle to counter acting them.

Flawed Assumption #1: Your Broker Works for You

Organizations often treat brokers as buyers' agents, but the reality is that their financial incentives typically make them sellers' agents for your insurance carrier and other health benefits vendors. Benefits consulting is a $22 billion industry, and insurance companies are the source for much of that revenue.[99] According to industry veterans, over 90 percent of the compensation models for brokers conflict with your objectives, because their income increases as overall per capita health care spending increases. In a proper model, one would expect exactly the opposite: Compensation should *decrease* as low-value spending increases. Over the last few decades of consistent health care spending increases, status quo brokers have won big while employers and their employees have lost.

Most disturbing is that brokers generally don't disclose a significant portion of their compensation. For example, insurance carriers and other vendors work to retain clients by tying broker commission and bonus programs to the total business the broker places with the carrier, not just your business. Brokers typically must clear a specific threshold of business each year to get these bonuses. Y*our business is just one piece of the total, but keeping it with the same carrier can boost the broker's total compensation by 50 percent or more.* Because this compensation isn't specific to you, status quo brokers will often claim they've disclosed fees and commissions. But they are actually only disclosing your *account-specific*

fees and commissions that may not even be the most significant piece of their overall compensation.

Another way insurance carriers enforce loyalty is a clause in broker contracts that let carriers drop brokers on 30-day notice. If a broker gets over half of their entire compensation from a specific carrier—a common situation that can include annuity-type compensation built up over years—you can imagine how potent that threat is. Forward-looking brokers have sent me letters from insurance carriers saying they'd be "fired" when they spoke the truth about egregious practices the carrier was inflicting on the broker's clients. This makes clear that the carriers view brokers as a quasi-employee they can fire at will. In other words, they are working for the carrier, not your organization.

Flawed Assumption #2: Insurance Carriers Want to Drive Down Costs and PPO Networks Deliver the Best Pricing

Much of pricing in health care is set as a percentage of Medicare pricing. Why? Because Medicare uses a rigorous process to develop pricing that takes into account actual hospital costs (which are often inflated, but we cover that elsewhere) and market variances. The average PPO network pricing is 2.6 times Medicare rates or, as it is often called, "260 percent of Medicare." While there are some markets where average commercial payer pricing is lower, there are many more where the number is significantly greater—as high as 1,000 percent of Medicare in some places.[100]

To get a deeper perspective, I spoke with Mike Dendy, an industry veteran with deep health care cost management experience. Dendy was previously chairman/CEO of HPS Paradigm Administrators, an independent third-party administrator (TPA) services company that manages both private- and public-sector plans. Before that, he was the head of community health system business at Memorial Hospital in Savannah, Georgia.

Dendy's company managed a large volume of claims. On average, he says they found that hospitals bill services (called gross billed charges) at about 550 percent of Medicare and that the major insurance carrier PPO network discounts are approximately 50 percent off those prices.

"It is amazing how little employers know about what they pay. I met with a Fortune 100 company that has 110,000 U.S.-based employees and asked their human resources vice president how much they were paying for health care relative to the Medicare benchmark. He had no clue and was flabbergasted when I gave him the answer. The BUCAs [Blue Cross, UnitedHealthcare, Cigna, and Aetna] hide that information, of course."

In comparison, employers who properly manage their health care spend will often pay roughly 150 percent of Medicare rates. Their logic is that the government has arrived at a price that would enable health care organizations to sustain themselves, so hospitals should be willing to limit themselves to a 50 percent premium on top of that. Some will accept 120 percent or less.

However, most employers play the PPO's discount game without question. There is a "wink, wink, nod, nod" exercise that insurance carriers and health providers go through to arrive at a baseline PPO network price, which allows carriers to say they "negotiated" a larger discount, say 52 percent. This makes it appear that the network can get you a better deal than you can on your own. Hey, I'll give you a 99 percent discount on anything if I get to choose the undiscounted price.

To add insult to injury, PPO networks charge access fees of $12-$20 per employee per month (PEPM) for what you might call the privilege of overpaying for health care services. Insurance carriers continue to insist to employers that their employees won't be able to see a doctor or be admitted to a hospital outside the PPO network relationship. This is every bit as ludicrous as it sounds. Care provider organizations are often eager to develop direct payment arrangements that are far better than typical PPO rates.

Flawed Assumption #3: Auto-Adjudication of Claims Is Always Good

Auto-adjudication is the term used to describe automatic payment of claims. Claims administrators will highlight one of three specific benefits of this system: Your employees won't be hassled with bills, it's a sign of efficiency, or it's based on sophisticated algorithms— typically all three. However, the best way to describe auto-adjudication is that you're giving another organization a blank check to withdraw money from your treasury based on minimal information that may or may not even be accurate.

Claims administrators from the largest national insurance companies to the smallest mom and pop shops essentially all follow the same process. They receive a useless Uniform Bill (UB) from a hospital as an invoice, deduct the PPO discount from the total price, then pay the claim.

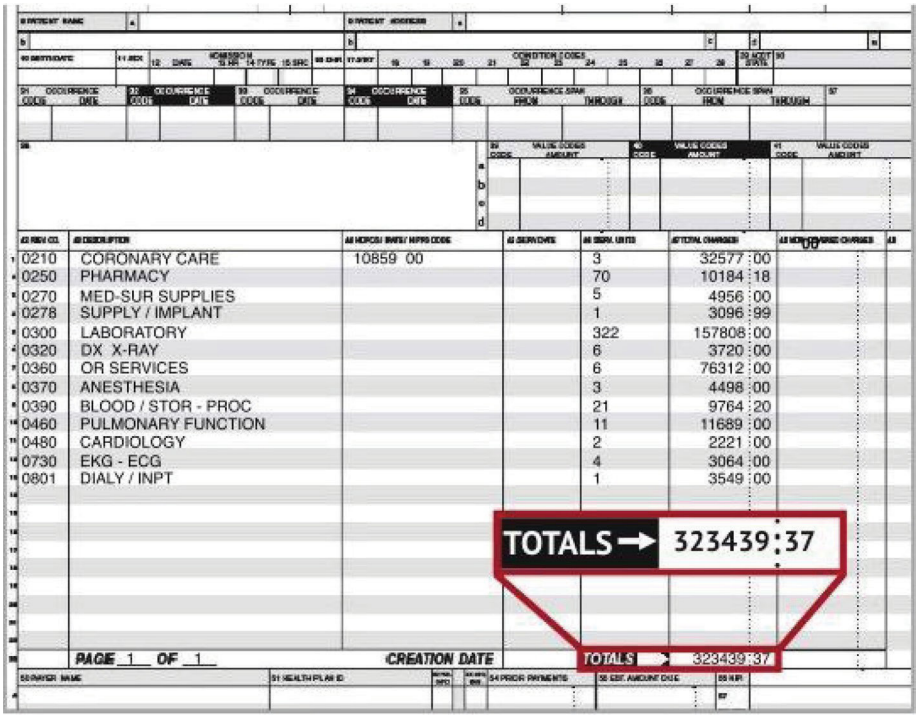
Figure 9 is an anonymized UB provided to me by Dendy for $323,000. This one-page UB represents the entire invoice submitted by the hospital on this claim. Note that 322 units of laboratory—completely unspecified—are billed at $157,808. No one in their right mind would ever accept such minimal detail if they're spending their own money. And yet the claims administrator in this case was prepared to write the check if AMPS had not intervened.

Further, BUCA administrators often charge $30 to $60 per employee per month (PEPM) to pay bills using this see-nothing, know-nothing method. Pretty good gig if you can get it. Large insurance carriers typically auto-adjudicate 90 percent or more of all claims.[101] Dendy's firm intervened on behalf of a Fortune 100 company on a hospital bill for well over $2 million. Even he was shocked to learn that the claims administrator was ready to pay on the basis of the single-page UB.

It's no surprise that claims administrators often have clauses in their agreements with employers that would only fly in health care. What's surprising is that so many employers are willing to sign them. For example, contracts stipulate that claims data is

proprietary and owned by the carrier, meaning you don't get to see your own claims data. Sometimes, they'll use HIPAA privacy as a smokescreen to prevent you from having your data analyzed by an outside party, an issue HIPAA effectively accommodates.

Second, claims administrators will insist on extremely limited claim audit clauses. One large company I'm aware of with more than two million claims per year had an audit clause that gave it the right to audit just 200 claims *of the administrator's choosing* and only on the carrier's premises. That's 0.01 percent of all claims for what is often a company's first or second largest expense after payroll.



0210	CORONARY CARE	10859 00	3	32577	00
0250	PHARMACY		70	10184	18
0270	MED-SUR SUPPLIES		5	4956	00
0278	SUPPLY / IMPLANT		1	3096	99
0300	LABORATORY		322	157808	00
0320	DX X-RAY		6	3720	00
0360	OR SERVICES		6	76312	00
0370	ANESTHESIA		3	4498	00
0390	BLOOD / STOR - PROC		21	9764	20
0460	PULMONARY FUNCTION		11	11689	00
0480	CARDIOLOGY		2	2221	00
0730	EKG - ECG		4	3064	00
0801	DIALY / INPT		1	3549	00

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Figure 9. Actual de-identified uniform bill provided by Dendy.

Limited audit clauses often reflect an agreement between insurance carriers and health care providers. The insurance carrier will sign a PPO agreement with a hospital that, absurdly,

doesn't allow the carrier itself to audit claims. The alleged reason is that it's all part of the give and take in negotiations, in which the carrier "demands" a certain discount in exchange for not auditing the claims they pay from that hospital.[102]

This dynamic is why transparent open networks featuring direct relationships between employers and hospitals have arisen (See Chapter 22 – Transparent Open Networks to learn more). By directly contracting with a health care provider, employers can secure significant savings. More direct, streamlined payment makes it valuable for high-value health care providers as well.

Key Take-aways

- Though benefits brokers sell themselves as advocates for the buyer, they are generally sales agents for insurance carriers.
- PPO networks, once a good idea, have become a core method for insurance carriers to ensure health care prices go up irrespective of underlying costs of health care services.
- Auto-adjudication of claims is rarely good.

CASE STUDY

CITY OF MILWAUKEE

John Torinus

City Slashes Health Care Costs by Improving Benefits

Because the economic pain of out-of-control medical costs is so high and Federal Government reforms are so slow, school districts, counties, and municipalities are moving on their own to find savings across the four major platforms for containing health care spending: self-insurance, consumer-driven incentives and disincentives, onsite proactive primary care, and value-based purchasing.

The City of Milwaukee, Wisconsin, with 6,500 employees, is one spectacular example. The city has held its health care costs *flat* for the last five years, stopping its previous hyper-inflationary trend of eight to nine percent annual increases. Milwaukee spent $139 million on health care in 2011 before switching over to a self-insured plan in 2012. Costs dropped to $102 million in 2012 and have stayed at about that level ever since—even in the face of six percent annual inflation for employer plans nationally over the same period.

If the old trend had continued, health costs for 2016 would have been about $200 million, double what they actually were.

Instead, the cost savings have had many additional positive ramifications: raises for county employees, no layoffs, flat employee premium contributions, better health outcomes for employees and their families, improved productivity, lower absenteeism, and less pressure to raise taxes.

Michael Brady, benefits manager, led this intelligent management approach in close collaboration with the mayor, city council, and unions. As with other enlightened group plans, there are many moving parts. Here's a sampling:

- An onsite wellness center and workplace clinic, headed by nurse practitioners, has sharply reduced hospital admissions. Onsite physical therapy was added last year. These services are free for employees and spouses.
- Relatively low deductibles (now $750 per single employee and $1,500 per family) were installed to create a consumer-friendly environment.
- Co-insurance was set at 10 percent for members who use UnitedHealthcare's Premium Provider program, which uses only doctors designated as top doctors by UnitedHealthcare. Co-insurance is 30 percent for providers outside that group. This tiered approach, aimed at improving health outcomes, is a form of value-based purchasing.
- Participants in the city's wellness program can earn $250 in a health account. Good progress has been made on hypertension and smoking (now 12 percent vs. U.S. average of 14 percent), but, as with other employers, there's not been as much traction on obesity. There have been some improvements on chronic disease management of diabetes. *
- A $200 ER copay has cut non-urgent ER visits by 300 per year.
- An intense program to reduce injuries, started in 2008, has resulted in a 70 percent drop in work hours lost to injury. The

** While workplace wellness programs typically have no or negative ROI (see Chapter 9-Wellness), approaches that use solid clinical evidence to address costly chronic illness and procedures without encouraging overtreatment are sometimes lumped into the same category as typical workplace wellness programs. However, they are highly different in goals, execution, and results.*

program has saved $10 million per year compared to the previous trend line.
- Milwaukee now spends about $15,000 per employee per year, well below the national average and not too far off the $13,000 at the best private companies.

Government entities are not known for bold innovation, so this track record is an eye-opener, especially in a unionized environment. "The results," said Brady, "are nothing short of amazing considering changes in the city's workforce demographics and the challenging environmental hazards that city employees regularly face."

These changes have taken place at the same time that the nation as a whole has experienced much more disappointing progress from federal reforms, e.g., much higher deductibles for plans sold on ACA exchanges, double-digit premium rises for employers in many states, and a cost to the Federal government of about $5,000 per subsidized plan member per year.

Clearly, most of the meaningful reform of the economic chaos from health care in this country is coming from self-insured employers, like the City of Milwaukee.

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