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Keeping Costs Down on Self-Funded Health Care Plans

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In the era of health care reform, one of the most significant issues everyone is facing is increasing costs. Yet organizations that have 50 or more employees can control expenses—while maintaining valuable health care options for employees—through proper design and administration of a self-funded plan.

Indeed, these days more employers are turning to self-funding options for their health care plans—not only to reduce their premium expenses but also to manage their cash flow and gain control over their benefit dollars. According to a 2011 survey conducted by the Kaiser Family Foundation, 60 percent of covered workers in US companies are in plans that are partly or completely self-funded, with that figure jumping to 96 percent for employees in US companies with 5,000 or more workers.

Cost and Risk Rest with the Employer

It's important to note that self-funded plans aren't insurance. Health care costs are paid from the employer's own pocket as the medical costs are incurred, and the employer assumes the financial risk of providing health care benefits to employees. Contrast that with fully insured coverage, in which medical costs are paid as a fixed premium to an insurance carrier, with the carrier bearing the financial responsibility for the costs of enrollees' medical claims.

Self-funded employers typically set up a special trust fund to ear-

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LETTERS TO THE EDITOR

If you have questions or suggestions regarding the News and its contents, please reply to dpeel@wahcnews.com.

Letter from the Publisher and Editor

Dear Reader,

We periodically report health plan financial results based on publicly available data. We compile high level figures in a spreadsheet and send it to health plan representatives with a request to confirm the accuracy of their figures. We also ask for comments on their plan's results. We are in the middle of this process now and will report the results in mid April.

We go through this laborious and tedious process with extra effort to achieve buy-in from plan representatives because the figures are distributed to over 10,000 Washington Healthcare News Readers.

In this year's report, we will give credit to the plans that took the time to confirm their figures. We truly appreciate the effort given by these plan representatives.

If you have received our request to confirm figures in our spreadsheet, and to comment on your plan's financial results, please respond as soon as indicated in our request. There have been several occasions where plans were reporting wrong figures to governmental entities and only learned of this when they received our spreadsheet. Your prompt confirmation will not only help the Washington Healthcare News with our financial reporting but will also assure your numbers are accurate. Until next month,

David Peel, Publisher and Editor

Washington Healthcare News 2012 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2012	Hospitals	December 1, 2011	December 26, 2011
February 2012	ASCs	January 3, 2012	January 30, 2012
March 2012	Hospitals	February 1, 2012	February 27, 2012
April 2012	Insurance	March 1, 2012	March 26, 2012
May 2012	Clinics	April 1, 2012	April 30, 2012
June 2012	Human Resources	May 1, 2012	May 28, 2012
July 2012	Hospitals	June 1, 2012	June 25, 2012
August 2012	Hospitals	July 2, 2012	July 30, 2012
September 2012	Clinics	August 1, 2012	August 27, 2012
October 2012	Human Resources	September 3, 2012	September 24, 2012
November 2012	Hospitals	October 1, 2012	October 29, 2012
December 2012	Clinics	November 1, 2012	November 26, 2012

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mark money (corporate and employee contributions) to pay claims as they're incurred, and the employer usually purchases stop-loss insurance to protect the plan from catastrophic losses. Self-funding means assuming a bigger role in employee health management and taking over the paperwork and other services an insurance company normally provides.

For most businesses, focusing on growing revenue often supersedes managing medical claims expenses. As such, the majority of self-funded employers rely on third-party administrators or insurers to administer their benefits.

Make Sure Your Plan Is Working for You

The largest expense in any employee health care benefit plan is the claims cost. In fact, for many businesses, health care claims are among the highest unaudited expenses in the entire organization. So how do you know whether your third-party administrator is helping you keep costs down and drive greater efficiency?

An administrative claims review offers the best opportunity to create accountability, measure performance, and establish processes for continuous quality improvement. Performing such a review of your administrator will not only fulfill your fiduciary responsibility as a plan sponsor but also help you evaluate whether your claims are being paid correctly and in accordance with the plan's intended benefit provisions.

An administrative performance review gauges the administrator's ability to pay claims accurately and efficiently by measuring the financial, payment, and procedural accuracy levels of claims against industry-wide standards. Based on our experience, administrators fail to meet industry-standard financial and payment accuracy measures 60 percent of the time.

In addition to validating current performance metrics, results from an administrative performance review can serve as a benchmark for establishing or renegotiating performance guarantees between employers and plan administrators.

These reviews can also help you:

- Recognize claims payment errors and recover identified overpayments
- Discover process or systemic

issues impacting optimal administrative performance

- Identify compliance needs in relation to contracts and procedures
- Identify exceptions to standard cost-control procedures in the processing of claims
- Confirm performance metrics that are often self-reported by the administrator

The Best Defense Is a Good Offense

For your organization to remain competitive, you must address and manage its health care costs. With claims costs representing the largest expense component of an employee health care benefit plan, it simply doesn't make sense to assume that your claims administration process is operating exactly the way it should. Getting out in front of the issue, with regular administrative performance reviews, can help you verify that you're getting the most from your health care expenditures.

William Norris has consulted with some of the largest HMOs and capitated payers in the country and provided extensive support in the areas of claims administration, revenue recovery, IS implementation, operations redesign, and process improvement. He can be reached at (949) 623-4172 or william.norris@mossadams.com.

Francis Orejudos has over nine years of experience serving managed care organizations. He has led payer initiatives related to claims auditing, contracting, operational assessments, and business process redesign. He can be reached at (949) 221-4033 or francis.orejudos@mossadams.

Pharmacy Carve-In: The Benefit of Integrated Benefits

By Pamela Wells, ASA
Senior Actuarial Analyst
Premera Blue Cross

and

By Daniel Ness
Actuarial Analyst I
Premera Blue Cross

Introduction

Over the past decade, pharmacy costs have exhibited a trend exceeding that of either medical benefits or general inflation. Pharmacy is generally only 20 percent of the total claim cost, yet it garners a lot of attention. In an effort to control costs, many employers have been lured into "carving out" their pharmacy from their medical coverage. By carving out, they obtain benefits for drug coverage through a stand-alone Pharmacy Benefit Manager (PBM) instead of receiving integrated medical and pharmacy benefits through the same carrier.

To examine this further, Premera Blue Cross recently conducted an actuarial analysis to study the difference in cost between integrated plans and plans that carve out pharmacy from medical benefits. Our study shows that although carving out to a separate PBM may save money on the pharmacy benefit alone, the impact of higher medical costs without an integrated benefit dwarf those pharmacy savings.

Results

On average the medical claims costs for our two sets were statistically different, varying between 3.0% and 11.8%, with a mean of 7.5% higher medical claims for the Carved-Out set. As shown in Table 1 (top of page 7) even a theoretical 15% savings on pharmacy benefits through a carve-out would still result in a higher total claim cost. Under this scenario, *employer groups could save approximately 2.2% by integrating their pharmacy and medical benefits*.

The most important driver of this cost difference may be due to the design of Premera's preferred formulary, which is based on a combination of cost and clinical characteristics. Many drugs are on the preferred tier even though they contribute to higher pharmacy cost, because they are expected to be offset by lower medical costs. By taking a holistic view of overall treatment methodology, Premera helps control costs in a responsible way.

The cost difference may also be partially due to more effective care management programs, where integrated pharmacy data allows more rapid identification of those members who would benefit from engagement. These programs use pharmacy information to reduce adverse drug interactions, coordinate the care of complex cases, and avoid omissions of needed care. Integration of pharmacy and medical data could potentially provide more accurate and thorough information for both members and providers, leading to better overall health outcomes.

Methodology

We began our study with both medical and pharmacy claims incurred by Washington-based self-funded large employer groups between 1/1/08 and 12/31/10, with no lapse in coverage during that time period, then defined the following cohorts:

- Those with integrated medical and pharmacy benefits during the entire period (Integrated)
- Those that provided only medical benefits through Premera during the entire period

  -Those groups that did not provide pharmacy benefits

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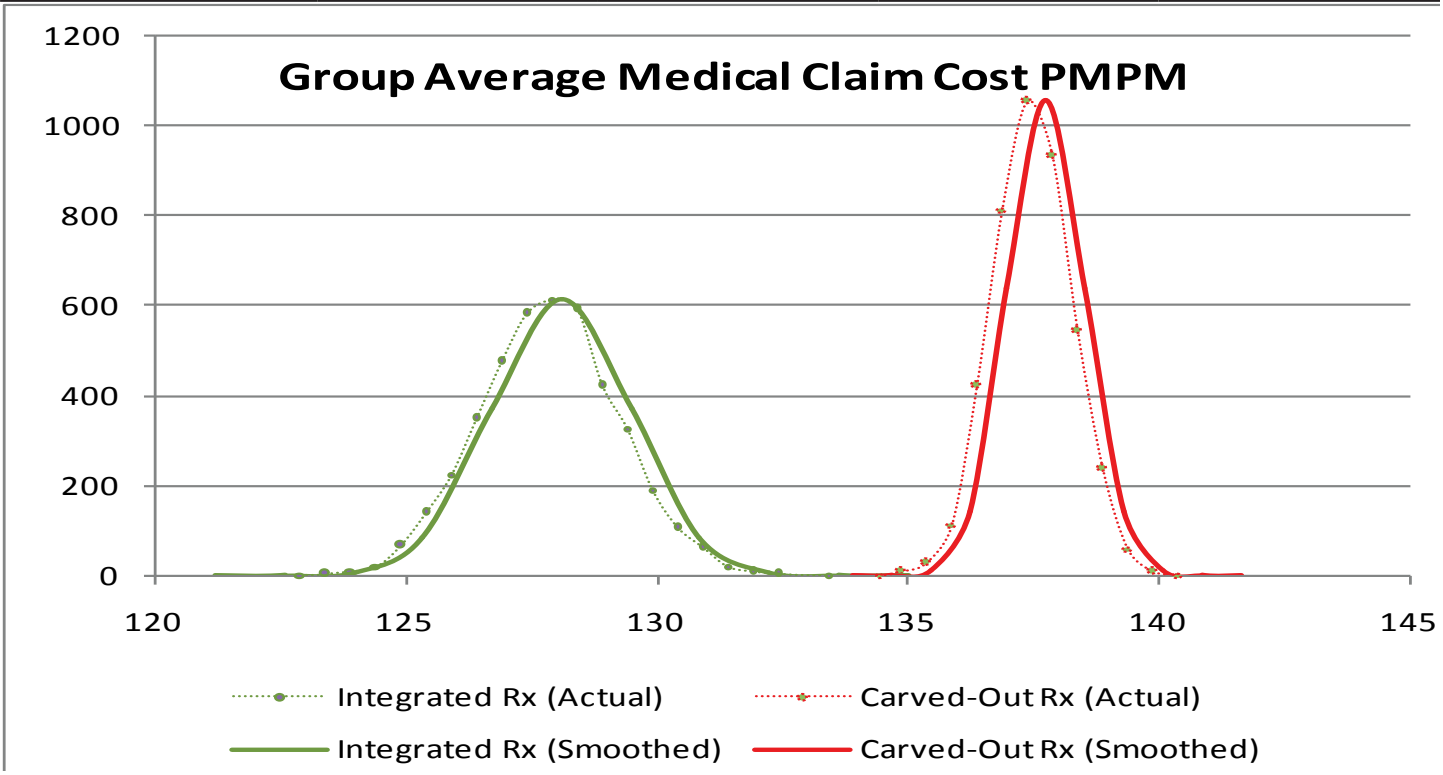
Table 1: Difference in Experience and Potential Savings				
	Carved-Out Rx	Integrated Rx	Additional Cost (PMPM)	
Medical	$137.76	$128.10	$9.66	7.5%
Rx	$34.19	$40.23	($6.03)	(15.0%)
Total	$171.96	$168.33	$3.63	2.2%



Sono Bello - Reinventing the Liposuction Wheel

By Michael Gellis, MD
Chief Medical Officer
Sono Bello

In 2008, the U.S. faced a rapidly decreasing market for liposuction due to the onset of the recession. Yet despite the grim outlook Sono Bello, a liposuction clinic performing surgery under awake local anesthesia, opened its doors for the first time. Since then, and 17,000 cases later, Sono Bello has grown to 12 locations nationwide across nine states. Sono Bello skillfully filled a niche, unidentified by competitors, by recasting a well-known product in a newer and more attractive light.

The public is hungry not only for outpatient surgery, but also for procedures done under awake local anesthesia. It's no surprise that people are generally concerned about procedures performed under general anesthesia. In fact, a recent study by John Starling III, MD published in the February 2012 issue of *Dermatology Times* revealed much higher mortality and morbidity figures for patients in Florida and Alabama who received liposuction and other cosmetic procedures performed under general anesthesia in an office setting. So, Sono Bello hit the mark when investing in the concept of awake liposuction.

There is also a perception, which is not scientifically grounded, that hospital procedures have a higher risk of infection, a greater chance of medication errors, and offer less privacy than those performed in an outpatient-clinic setting. Regardless of the facts, it is a quicker leap of faith for a patient to trust a smaller, warmer clinic than a larger, cold hospital. Recently hospitals have tried to overcome that stigma by placing their outpatient clinics on the periphery of the large mother hospital. For those of us who have been in private practice, we know it is often a hard sell to take patients to the hospital rather than an outpatient facility. There is a lot we can learn from that.

The meteoric rise and success of Sono Bello rests on many factors, the summation of which drives the company to future expansions, doubling its size in the next two to three years. First and foremost, the surgeons are among the best. To be hired, the surgeon must be a board-certified and board-eligible plastic surgeon or a fellowship-trained cosmetic surgeon. Second, every clinic is certified by the American Association of Ambulatory Health Care (AAAHC) thereby reaching the highest standards possible for safe outpatient local anesthesia surgery. Third, Sono Bello has rigid standards of quality control that put stringent systems in place to constantly monitor each clinic and every procedure. We collect patient satisfaction surveys and analyze the results to evaluate how each surgeon performs at each step of the patient encounter. Every clinic regiments face-to-face follow up with patients in addition to regular phone and email correspondence. Last, although we are proud of our patient referrals, Sono Bello financially budgets to achieve maximum marketing penetration in ways that respect the patient experience.

Now, back to the physician. It is not simple to perform liposuction on patients who are awake. Most plastic and cosmetic surgeons are trained to perform liposuction under general anesthesia. Our surgeons are specialists at awake liposuction. That is what patients want. Patients tell us they would prefer to have the procedure done while they are awake, while maintaining minimal discomfort. Our physicians are trained to do just that and after hundreds of cases

each, they deserve to be called experts in the specialty of awake liposuction.

Behind the scenes, Sono Bello has developed a strong administrative base which covers all aspects of any healthcare organization including risk managers, physician trainers, clinic practice managers, recruiters, financial officers, and many more. The chief medical officer functions as a safety officer and also collects data for research, interviews prospective physicians, troubleshoots, and represents the company in the media.

Not every cosmetic patient is always satisfied. Our internal surveys show that 95 percent are pleased with their results, which is very competitive with the national average. It is the 5 percent that require further review. Within the company we have a prescribed mechanism to take care of all patients and resolve instances when the patient (customer) expresses dissatisfaction. Issues are addressed immediately and decisively with thoughtful participation from all levels of administration and medical personnel who provide advice and counsel to manage any problem that arises. Small and large problems are treated with an equal sense of urgency. Internally, every person in the company is empowered to feel comfortable communicating with the CMO or Sono Bello's governing body about any concern.

When a company grows exponentially in bad economic times there should be lessons to learn. A previously unfulfilled niche was identified. Highly specialized and certified medical professionals must deliver safe and consistent surgical service. Follow-up care and consultation after the service should not be haphazard, but by prescription. The company should not hesitate to financially support the product with professional marketing. Quickly resolve patient dissatisfaction using decisive action that may involve counsel from an entire chain of command whose members are always reachable, accommodating, and personable.

Dr. Michael Gellis is a board-certified plastic surgeon. He was the previous chairman of plastic surgery, William Beaumont Hospital, Royal Oak, Michigan. He is an associate professor of surgery at Wayne State University School of Medicine. Presently he is the chief medical officer of Sono Bello, a national liposuction company.

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-Those groups that provided pharmacy benefits through a separate carrier (Carve-Out)

- Those that provided some combination of coverage during the period

We focused on the difference in experience between Integrated and Carve-Out sets. We limited both sets to only members who were present with no lapse for the entire period. Members were then placed into categories based on the following characteristics:

- Gender
- Age
- Diagnosis of:
  - -Diabetes
  - -Coronary Artery Disease (CAD)
  - -Congestive Heart Failure (CHF)
  - -Chronic Obstructive Pulmonary Disease (COPD)
  - -Asthma
- Disease Management offered
- Health Status
- Deductible
- Coinsurance

In addition, we removed any claimants whose total claims exceeded $50,000 in any year. We then randomly selected the same number of members from each category for both the Integrated and Carve-Out sets, and examined their paid claims experience. We repeated this random selection 5,000 times, with a sample size of 13,489 each time. The method we used allowed us to achieve a near-perfect match between our groups.

Study Limitations

Although we have attempted to make our analysis as accurate as possible, some simplifications were necessary. To ensure a credible sample size, we considered only commonly occurring chronic conditions, and did not match on lower incidence or acute conditions. Additionally, we did not include out of pocket maximums and other small benefit differences as characteristics in our study.

The groups in our study had at least three full years under the same benefit structure, and are representative of the long-term effects that a carve-out has on medical costs. Employers should not expect to see an immediate change in their overall costs if their structure is changed. We estimate that the full effects may not be seen for three to five years after that change takes place.

Conclusion

Savings from a carve-out plan may seem beneficial on the surface, but the impact of such choices appears to be about 7.5% higher medical costs. This leads to a simple message: Employers should be cautious when evaluating offers to carve-out their drug coverage and not overlook the benefit of integrated benefits.

Pamela Wells is an Associate of the Society of Actuaries, and has spent the past seven years on the Actuarial Special Projects Team of Premera Blue Cross.

Daniel Ness is an honors graduate of Central Washington University with degrees in mathematics, economics, and German. He has spent the last year and a half working for the Actuarial Special Projects Team of Premera Blue Cross, ensuring data quality and helping analyze data.

Northwest Medical Group Alliance Members Receive Distinction as Better Performing Practices

Northwest Medical Group Alliance (NWMGA) would like to congratulate its Members recently recognized as Medical Group Management Association's Better Performing Practices:

Congratulations

- Edmonds Family Medicine
- Lakeshore Clinic
- The Polyclinic
- Walla Walla Clinic
- Woodcreek Pediatrics

About NWMGA:

NWMGA is owned and governed by many of Washington's largest, physician-owned, group practices. The role of the Alliance is to leverage purchasing volumes to reduce operating expenses and to promote information sharing in order to replicate successes and impart best practices.

Career Opportunities

Executive Director
Ashley House
(Enumclaw, WA)

Ashley House is a private, non-profit agency providing services for medically fragile children and their families. They have been providing this care since 1989.

Ashley House is licensed to operate group homes in Kent, Enumclaw, Brown's Point, Northshore, and Olympia.

Deering and Associates has been retained to recruit their new Executive Director.

Ashley House employs about 80 staff members.

This is an excellent opportunity for a seasoned Executive Director to provide leadership and direction in meeting the needs of medically fragile children and their families.

A Master's Degree is preferred with management experience in working with a healthcare or social service organization; working with children; home care experience, and dealing with the medical community.

Salary is open and negotiable and relocation will be considered.

For more information please contact:

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(888) 321-6016 (Toll Free)

Clinic Manager
Forks Community Hospital
(Forks, WA)

Live and work in the heart of the Olympic National Forest and the beautiful coastline of Washington State. The Clinic Manager oversees two clinics with a staff of approximately 45 with 15 direct reports. Works with physicians and allied heath professionals to maintain and improve support services. The Clinic Manager develops specialty programs and recruits physicians to provide services in the clinics as well as participating in providing surgical services for the hospital. Physicians and Mid levels are approximately 12 between both positions.

A degree in Health Care Management or closely related field or equivalent experience/education is required. Several years of experience in healthcare operations is also required. Rural clinic experience is preferred. Salary is open and negotiable. The position is open owing to the retirement of the current Clinic Manager.

For more information please contact:

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