Healthcare's Great Transformation

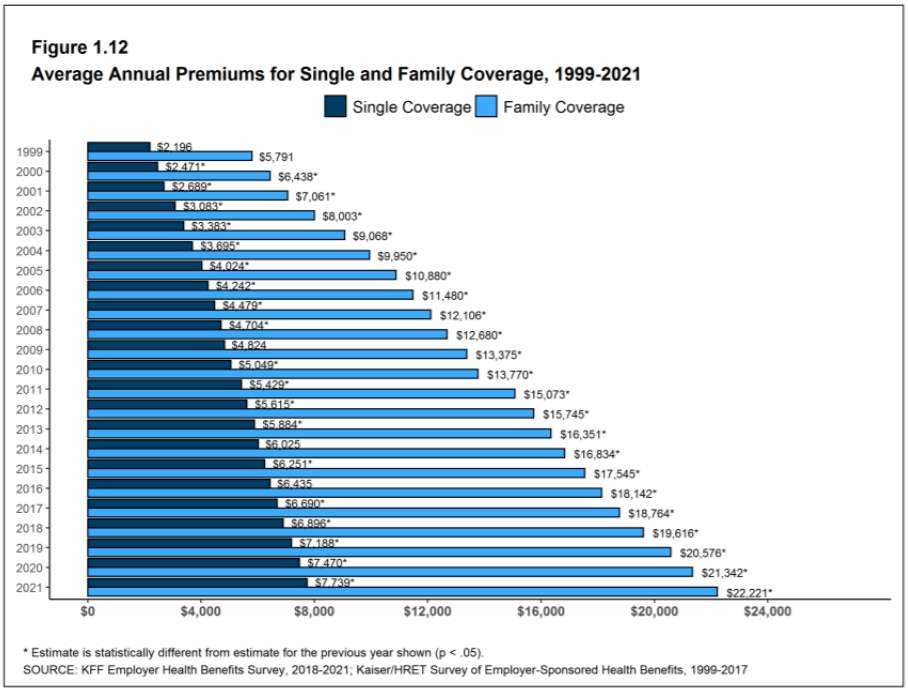
The pandemic has forced every person, company and industry to reassess what they do and how they do it. And while life as we knew it has changed and transformed, many 'great' (fill in the blank) and consequential events have fixed their place in history. In healthcare, it's the Great Transformation and the confluence of an unsustainable cost trajectory, pricing transparency laws and emerging, restorative fixes to the healthcare supply chain are reshuffling the deck by the invisible hand of the market and power is about to shift from the classes to the masses. Healthcare's Great Transformation belongs to the consumer—and here's how employers can take what is rightfully theirs: Control.

It's a health plan, not a health guess

It's customary to call a health insurance policy a 'health plan', but many employers do not have the luxury of planning because they lack the claims information needed to plan. Before you can use your claims information as a strategic asset, you must first acquire it. Even if you think you are getting your data, I suspect many companies are not getting a level of claims detail that is actionable.

This chapter is for employers that are interested in the positive attributes of change that having your healthcare claims data will provide not only your company, but your employees, their family members and ultimately your community. When your company saves money with using their claims data to optimize the structure and management of your health plan, the money saved can be better spent on increased wages, lower employee health insurance contributions or business expansion—all changes that will positively impact your community. The journey to better your company and impact your community starts with obtaining the right healthcare claims data.

Having access to your claims data is the difference between controlling your expense or continuing to be subject to the health insurance premium increases that the current system dictates—and in the past 22 years, the system has dictated single and family premium increases of 252% and 284%, respectively. How do you take back control of an expense that, in any other category on the income statement, would undergo much scrutiny, oversight and strategic planning? Know the frequency and occurrence of claims on a level of detail that allows you to manage this expense category that ranks # 2 or # 3 on your income statement.



Whether your company's health plan is fully insured or self-funded, your claims data is pivotal as it will ultimately determine your ability to guide the various ways you can control your overall healthcare spend. In other words, be in control or be controlled.

Before I go any further, I want to be clear that I am criticizing practices, not people. In my 24 years in the employee benefits industry, I have met hundreds of wonderful, very well-meaning people in every capacity of the supply chain—it's just that there's an acceptance that one line item on your income statement, and one of the largest, can't be managed. If you get nothing else from this chapter, consider that one simple rule of business: "If you pay, you should have a say" applies to healthcare too.

If you currently do not have actionable claims data from your healthcare spend, the reasons can range from a simple not asking the right questions to a more complicated reason that your health carrier claims to own the claims data and is unwilling to share at a level that provides you with information to question their decisions with managing your spend. To further complicate the claims acquisition issue, the insurer, as the claims administrator and the party with the financial risk, is typically deemed the primary "owner of claims data." As a covered entity under HIPAA, the insurer is restricted regarding the circumstances under which it can share claims information with the employer, and as a business with a profit motive, the insurer is often reluctant to share that data with the employer for other reasons. Nonetheless, ERISA places on the "Plan Administrator," which is typically the employer (or a group of employees designated by the employer), a fiduciary duty to oversee the insurer and ensure that its actions are prudent and taken in the best interest of plan participants and fiduciaries (employees). The Plan Administrator has an obligation to act as a safeguard to assure that plan assets are protected, used prudently, and delivered in the best interest of the plan members. There are compelling arguments that employers need to protect themselves and take a proactive approach to being a best-interest fiduciary of the assets that plan members are contributing (i.e., employee contributions for their share of premiums), but employers are finding it difficult to fulfill their obligation in the absence of access to claims data. Sure, employers believe they are doing their best to design the best-interest health plan, but without data, it's a guess.

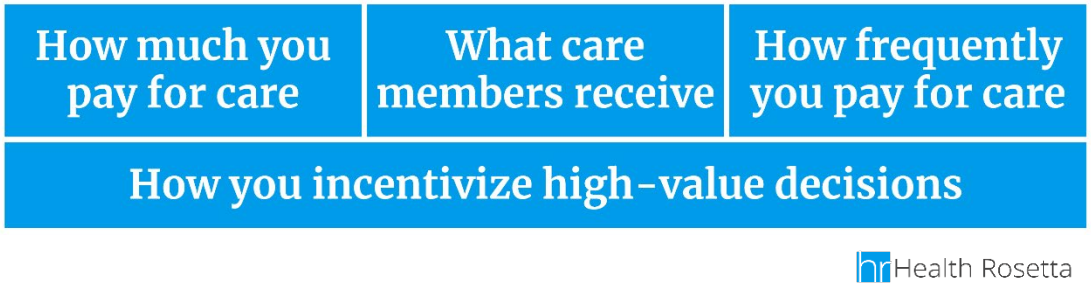
Data is also a key element in the determination if self-funding is right for your company and to provide you with a negotiating position at renewal. If you do not have access to your claims data, there are modern risk assessments that use vast amounts of consumer data who can create a risk profile for your population to further assess if self-funding is right for your company.

You can't manage what you can't measure

The Affordable Care Act gave authority to the states to redefine small group as 1 - 100 employees and depending on the number of employees your company has and the state where your business was incorporated, you may have some restrictions on self-funding. For example, in New York it is prohibited to sell stop loss insurance into the small group (1 – 100 employee) market.

The remainder of this chapter will focus on large groups (100+ employees) that should have access to their claims data for the asking, as the larger the company, the more influence to be wielded at the health care claims data negotiating table (in a perfect world). Companies have more power than they realize and there are tools that exist today to empower you to take control your total healthcare spend. It's cliché, but true: Knowledge is power and you can't manage what you can't measure.

When You Know:



You will be able to take control of your healthcare spend.

Healthcare Claims Needed & Why

Claims Data Category	Importance
Medical claims paid by diagnostic category, providers & facilities	This will tell you how much you spend for healthcare and where the money is spent. Historical data will identify patterns and trends to interrupt the occurrence and frequency of claims, where possible. You will also want to benchmark the care venue to ensure it's a high value one. Health analytic software programs are available to compare your claims data with a larger population to interpret and identify risks of undiagnosed health issues so you can be proactive and build wellness and other intervention programs to support your at-risk populations.
Prescription drug claims detailed by specific drug and pharmacy	Pharmacy Benefit Managers (PBMs) that are not carrier embedded may be the most cost effective. Transparent PBMs work on a fixed fee vs. per fill cost. Drug rebates from the pharmaceutical companies need to be disclosed and returned to your company.
Members using in network & out of network providers, facilities and pharmacies	To identify and set contracts with providers, facilities and pharmacies with the highest value of care and the best cost.
Members Utilizing Wellness and Preventive Care Benefits	To identify educational programs that engage and incentivize members to maintain and protect their health.
Denied Claims	Identify claim problems early and protect both your employees and your company from cost uncertainties.

Reasons for not having actionable healthcare claims data:

1. Told by their insurance carrier, "We can't release that information due to HIPAA". Not so. The Health Insurance Portability & Accountability Act of 1996 was enacted to ensure the proper protection and proper dissemination of Protected Health Information (PHI), not the withholding of PHI. There's a process to ensure that PHI only makes it into the hands of those authorized to receive it, and those hands include those employees of the employer who are responsible for health plan administration and operations. HIPAA provides alternative procedures to allow for data share after de-identification—HIPAA was never enacted to block the free flow of information between insurers and Plan Administrators. See the next section for a general overview of the HIPAA requirements and process by which employers can get more extensive claims data (which includes PHI) from their insurers.
2. "Our system can't extract that information". Again, nope. There are over 10,000 medical Current Procedural Terminology (CPT) codes that need to be acknowledged in a given database for billing purposes, so logic would tell you that despite the sophistication of any system, if the system provides for codes for billing, it can provide for the reporting out of what was billed. There are data warehouse software systems that take raw data claim feeds and create meaningful intelligence that, coupled with the right claim mitigation vendors will provide the tools to manage your expense.
3. A few 50,000 ft. morsels of information leads to confusion as to what are the details of data that would move the needle towards managing the expense. The list of claims data categories needed and why in this chapter are meant to serve as a field guide as you begin your journey.
4. Unaware that such information is available for the asking.

If you meet resistance, push. Dig deeper and demand the information you need to provide the proper fiscal oversight to this top three business expense.

I will leave you with this thought as you consider your rights to your healthcare claims data if you are initially denied access: ***What vendor, if they were proud of their work for you, would withhold information?***

How Employers Can Get PHI from Their Insurers[1]

The type of claims data most useful to employers will typically involve PHI. While virtually every self-insured plan needs (and likely already has) access to PHI to administer the plan, fully-insured plans may not have access to PHI. To get access to PHI – the underlying data that can help employers make informed decisions as to their plan design and which strategic levers to use to manage their expense – employers generally need to make changes to their governing documents and operations. Those changes are required by HIPAA and are summarized below.

First, the employer's health plan document must be amended to comply with HIPAA's privacy and security rules. This amendment includes several components:

[1] Nothing in this chapter should be viewed as legal advice. Particularly with respect to HIPAA, I encourage you to consult with legal counsel about an employer's rights and obligations regarding PHI and the required documentation to enable you to handle PHI properly. Your benefit advisor can facilitate the process with an ERISA attorney.

A. The amendment must define the permitted and required uses of disclosures of PHI by the employer. 45 CFR §164.504(f)(2)(i). All uses of PHI are limited to "plan administration functions" performed by the employer. 45 CFR §164.504(f)(3)(i).

B. The amendment must provide that the plan will disclose PHI to the employer only after the plan receives the employer's written certification that the plan documents have been amended as required by HIPAA, and that the employer agrees to the various restrictions in the amendment (such as not using or disclosing PHI for employment-related actions). 45 CFR §164.504(f)(2)(ii).

C. The amendment must provide for adequate separation (a "firewall") between employees of the employer who will have access to PHI to perform plan administration functions, and all other employees who will not perform such functions. 45 CFR §164.504(f)(2)(iii). This requires designating specific employees who need access to PHI, restricting their access to the plan administration functions the employer performs for the plan, and providing a mechanism to address such employees' non-permitted uses and disclosures of PHI. 45 CFR §164.504(f)(2)(iii)

D. If the employer will have access to electronic PHI, the amendment must require the employer to (i) implement administrative, physical, and technical safeguards to protect PHI; (ii) ensure that the privacy firewall is supported by appropriate security measures; (iii) ensure that any agent or subcontractor who receives PHI implements appropriate security measures to protect the PHI; and (iv) report security incidents. 45 CFR §164.314(b)(2). Because almost all PHI is electronic now, these changes will be required for most employers.

Second, the employer must certify to the health plan, in writing, that the employer has amended the health plan document and agrees to the restrictions in the plan amendment. 45 CFR §164.504(f)(2)(ii). In other words, the certification is the key that unlocks the employer's access to PHI. Although the insurer cannot share PHI with the employer until it receives the employer's certification, most insurance companies have such certification forms at the ready. With such access, the employer becomes "hands-on" with respect to PHI, and therefore must comply with additional requirements under HIPAA's privacy and security rules, as further described below.

To comply with those rules, the employer must adopt HIPAA policies and procedures to govern the uses, disclosure, and protection of PHI. 45 CFR §164.308; 45 CFR §164.530. A detailed description of what is required is beyond the scope of this chapter. However, by way of example, the employer's policies and procedures must appoint a HIPAA privacy officer, provide for employee training on the privacy rules, and establish administrative, physical, and technical safeguards to protect PHI. 45 CFR §164.530(a)(1); 45 CFR §164.530(b)(1); 45 CFR §164.530(c)(1).

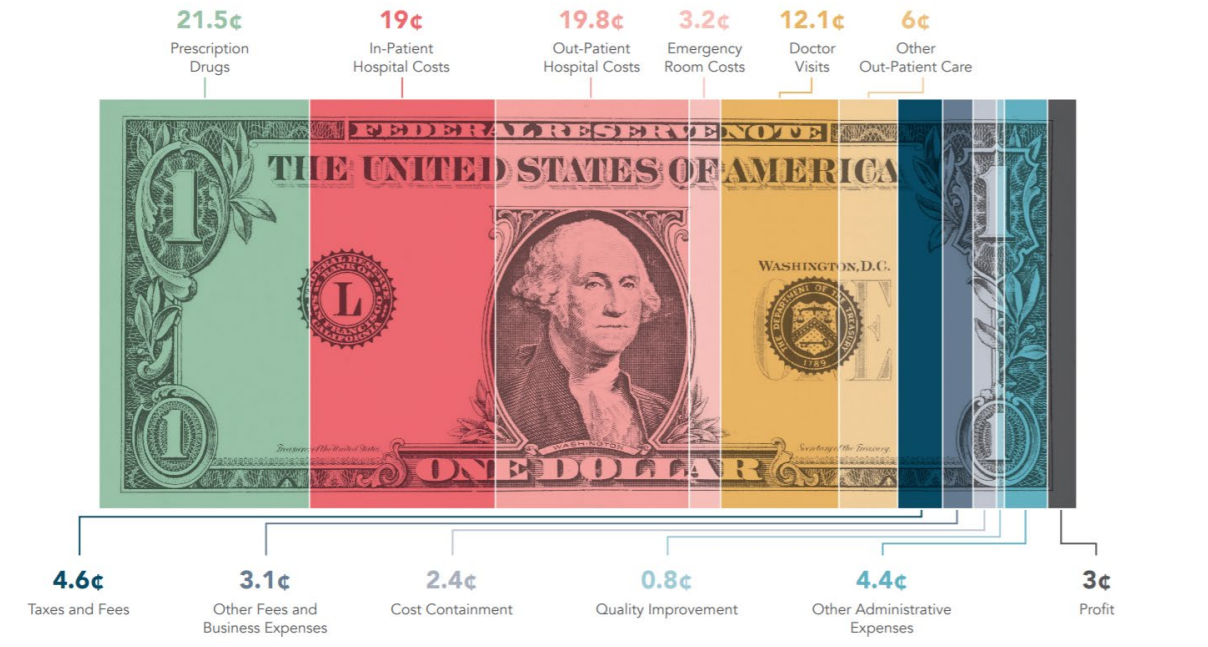
In addition, the employer will need to develop and maintain a separate "notice of privacy practices" that is distributed to plan participants, posted on the employer's benefits website, and available to plan participants upon request. 45 CFR §164.520(a)(2)(ii). The notice must describe the employer's uses and disclosures PHI and participants' rights, such as the right to inspect, amend, request additional restrictions on, a receive an accounting of disclosures of a participant's PHI. 45 CFR §164.520(b)(1)(iv).

An Alternative Perspective on Claims

Now that we have discussed why getting your health care claims data is important, let's look at an alternative assessment of where your claim dollars go…

According to AHIP, America's Health Insurance Plans (the national association of private US health insurers), "here is where your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone. Here is where your health care dollar really goes."

Posted by AHIP on November 12, 2020:



This data represents how commercial health plans spend your premiums. This data includes employer-provided coverage as well as coverage you purchase on your own. Data reflects averages for the 2016-18 benefit years. Percentages do not add up to 100% due to rounding.

AHIP Guiding Greater Health

While this graphic depicts a general understanding of where a health care dollar "really goes" (my emphasis), clearly it's more meaningful for each employer to know where *their* healthcare dollars are spent so that they can be the judge of whether or not the spend was value-based. This graphic is based on volume, not value—there's a difference.

A sample value-based health plan design strategy

When we talk about value, we are talking about the best venue of care in the healthcare supply chain. Even if you are fully insured and do not have the ability to select your vendors, there's a value plan design strategy you can adopt to create a corridor of self-funding to provide an opportunity to lower your total healthcare spend. The self-funded corridor is paired with a Health Reimbursement Arrangement (HRA) and a Medical Benefit Management (MBM) company to protect larger fee-for-service payments out of the employer HRA with a lower per employee per month (PEPM) cost.

Pricing Transparency: President Trump's Healthcare Legacy

President Trump issued an Executive Order in June 2019 demanding transparent prices in healthcare (https://www.nytimes.com/2019/06/24/upshot/health-care-price-transparency-trump.html). In November 2019, the Centers for Medicare and Medicaid Services (CMS) issued a final rule requiring hospitals to post clear, accessible pricing information online (Hospital Price Transparency Rule), beginning January 1, 2021. 84 Fed. Red. 65,524 (Nov. 29, 2019). The American Hospital Association filed a lawsuit in December 2019 to keep prices secret and lost on Tuesday, June 23, 2020 (https://www.nytimes.com/2020/06/23/upshot/hospitals-lost-price-transparency-lawsuit.html).

However, various federal agencies have stepped up efforts to increase transparency in healthcare. In November 2020, the Internal Revenue Service, Employee Benefits Security Administration, and CMS issued final rules requiring group health plans and health insurers to provide participants (via website or paper form) with cost-sharing information upon request, including an estimate of the individual's cost-share for items or services provided by a particular provider. 85 Fed. Reg. 72,158 (Nov. 11, 2020). This change takes effect for plan years beginning on or after January 1, 2023. The final rules also require plans and insurers to disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and drug-pricing information through a website so the public can understand healthcare pricing. This change takes effect for plan years beginning on or after January 1, 2022.

In the same vein, the Consolidated Appropriations Act, signed in late December 2020, requires health plans and insurers to provide advance explanations of benefits (EOBs) and online price comparison tools to allow patients to estimate the cost of different items and services. Pub. L. No. 116-260. These changes, which are separate from those discussed in the final rules above, take effect for plan years beginning on or after January 1, 2022.

In July 2021, CMS announced that hospital compliance with the Hospital Price Transparency Rule has been sporadic proposed modifications to the Civil Monetary Penalties (CMP), to take effect January 1, 2022, in order to increase compliance. Unfortunately, many believe that the CMPs are set at a level that are less than what the hospitals have to lose if they are forced to be transparent.

I believe that consumers (both employers and employees) should use the growing momentum towards health pricing transparency as a watershed moment to demand full transparency from all vendors in their health care supply chain, whether they use a bundled (fully-insured or self-funded with a carrier) or unbundled (self-funded without a carrier) approach to structuring their health plan. Not only will transparency provide you with the fiscal oversight of your top three business expense needs, it may help protect you from fiduciary duty claims under ERISA.

For updates on the developing price transparency laws, visit my website at www.benefitlink.net.

Who cares the most, wins

The business origin story that inspires me the most is from Sara Blakely (founder of Spanx): Rather than be intimidated by the established, status quo system of the hosiery manufacturing industry that existed 20 years ago, she said to herself, "I don't have the most experience, I don't have the most money, but I do care the most. And let me see what happens if I care the most". Caring the most worked out for Sara Blakely and I know it will work out for the employers and employees that care the most about the cost of their healthcare.

What's Next

My professional goal is to convene the healthcare consumer audience in Rochester, New York and lead employers and employees to create a Rochester Community Health Fund that is owned and controlled by those who pay for and use healthcare. I know that sounds ambitious, but "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that ever has" (Margaret Mead).

When I heard Dave Chase, Founder of Health Rosetta (www.healthrosetta.org) speak at the World Healthcare Congress in April of 2018, I knew I found a group of committed citizens that are changing the healthcare world. Health Rosetta's tagline says it all: "Healthcare is already fixed. Join us to replicate the fixes". Doesn't that make you want to know how they have fixed healthcare? Premiums keep rising double digits and most employers in my hometown are completely in the dark as to their healthcare claims and the power that comes from knowing such information. I believe that employers reading this that think they are getting a complete look at their claims information could still be getting a more granular view in order to take action and consider vendors outside of a carrier connection to identify stacks of hidden profit.

Final Thoughts

I am so fortunate to have built relationships with many talented professionals around the country that are mission-aligned to solve healthcare for the consumer (both employers and employees) in their region and share best practices. The cost containment strategies I have learned from Health Rosetta, Mitigate Partners and the NextGen Mastermind provide proof of concept with an impressive collection of employer case studies that I am happy to share with any employer who is concerned about their ability to pay for healthcare, curious how it might apply to them, and optimistic that healthcare's great transformation will provide them with the tools they need to be successful with managing their spend. The only barrier to your success will be obtaining your healthcare claims data—and don't be bashful about demanding it! If your request for your claims information is denied or your insurance carrier doesn't say yes, but doesn't say no, keep pushing (with this field guide as a reference) and if you get nowhere and feel powerless, **please remember who writes the check!**