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Navigating the Maze

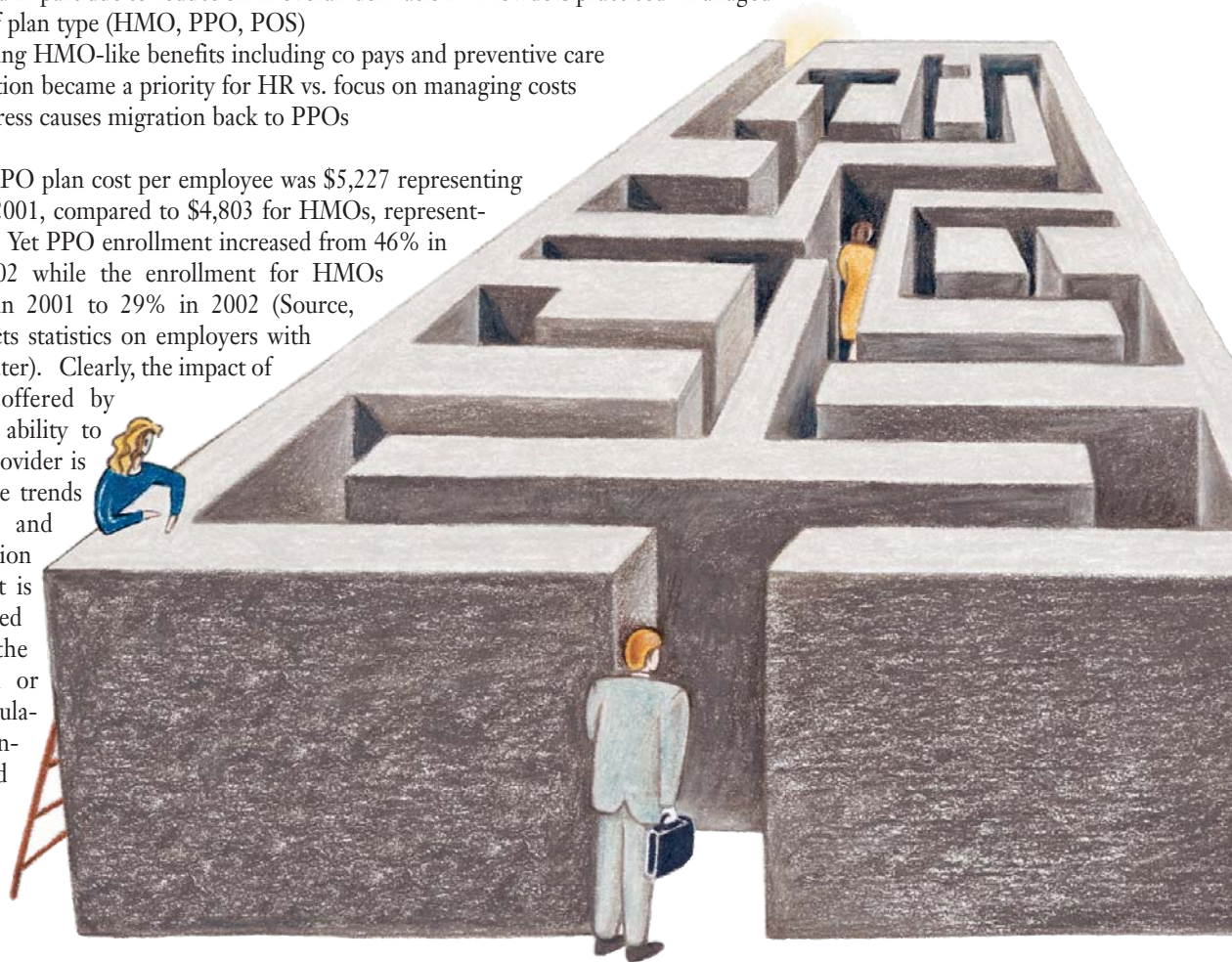
The Challenge of Selecting the Right PPO(s) for Self-Insured Organizations

By Corte Iarossi

Preferred Provider Organizations (PPOs) have become the cornerstone of most health benefits programs across the country. PPOs are typically offered as the standard benefit plan, or as an option within an employer's suite of benefits programs. Today, PPOs typically account for the majority of employee lives, followed by an ever decreasing indemnity population and a relatively stable HMO membership. As many of us have observed over the past 15 years, PPOs have experienced significant growth in popularity for several reasons;

- ▶ Health plan pricing pressures relaxed in late 1980 -1990s
- ▶ Patients focused on access to providers/ less willing to accept restrictions
- ▶ PPO costs dropped in part due to reduction in overall utilization - Providers practiced "managed care" regardless of plan type (HMO, PPO, POS)
- ▶ PPOs began offering HMO-like benefits including co pays and preventive care
- ▶ Employee satisfaction became a priority for HR vs. focus on managing costs
- ▶ Negative HMO press causes migration back to PPOs

In 2002 the average PPO plan cost per employee was \$5,227 representing a 15% increase over 2001, compared to \$4,803 for HMOs, representing a 15.3% increase. Yet PPO enrollment increased from 46% in 2001 to 50% in 2002 while the enrollment for HMOs dropped from 33% in 2001 to 29% in 2002 (Source, Foster Higgins, reflects statistics on employers with 500 employees or greater). Clearly, the impact of HMO-like benefits offered by most PPOs and the ability to seek care from any provider is still significant. If the trends continue into 2004, and there is every expectation that they will, then it is critical that self-insured employers choose the correct PPO option or options for their population to effectively manage cost increases and employee satisfaction.



Choosing your PPOs- “one size fits all” or “best of breed”?

Since PPOs are a key element to most self-insured employers’ benefit offerings how do you ensure you are getting the best value for your company and your employees? For example, employers with single locations have different needs from those of multi-state employers.

For single employer locations one PPO typically suffices. However, the challenge is determining the best option out of the multiple PPO offerings that may be available in your market. There are a number of tools that can be used to identify the best solution for access and savings.

- ▶ **Geo Access report;** an industry standard software used to match employee residences with provider locations. It is good for insuring there is coverage, but does not address if the providers included in network are the ones used by the employee population. This is typically a good starting point for analyzing PPO access options.
- ▶ **GPT/Revenue code analysis;** Often used in conjunction with a geographic analysis- allows the client to understand the contracted physician and hospital fees that would be paid for specific or highly utilized services- allows the client to gain some understanding of the potential cost savings offered by the PPO.
- ▶ **Detailed savings analysis;** This is a much more sophisticated and detailed approach to analyzing your specific utilization. It allows you to identify where the care is being provided and determine if the PPO has access to those key providers. But more importantly it enables you to see a realistic estimated of the savings that can be generated through the PPO’s contracts. The goal is to provide an “apples to apples” comparison of your existing savings vs. the savings that each PPO can generate based on similar utilization.
- ▶ **Provider credentialing process;** Most PPOs have a provider credentialing

process to insure a minimum level of quality of its physicians and hospitals, to include, but not limited to, confirmation of license, certifications, review of national practitioner data base, and patient feedback.

- ▶ **Who provides UM/CM;** This can have as big an impact on overall costs as the discounts provided by the PPO. The ability to effectively manage utilization can materially increase or decrease a plan’s costs. While many PPOs offer utilization management most do not require that you utilize their services. You are often better served using a company specializing in utilization management, case management, disease state management and demand management since that is their core competency and dominant focus.

Multi-state employers have additional considerations when making PPO network decisions. Certainly there is an advantage to working with one network for all employee locations. Most PPOs will focus on this strategy in their attempt to “up-sell” you on using their network in all areas where you have access needs. Unfortunately, this means that you will potentially be using a PPO not only where it has excellent coverage and savings, but also where its coverage and savings may be less attractive than other options in those markets. The reality is that one network typically cannot provide access to all the key providers for your employee population in each market and may not provide the best discounts to those providers. Consequently, we suggest you consider a “best of breed” approach to PPO access.

The “best of breed” approach has several advantages

- ▶ Allows you to choose the best PPO for coverage in each market that you have employees
- ▶ Enables you to choose PPOs that will provide deeper discounts in-network
- ▶ Reduces out-of-network claims because more key providers are in-network

- ▶ Enhances employee satisfaction through access to key providers and lower out-of-pocket costs

Challenges:

- ▶ Getting information for the purpose of doing a fair and thorough analysis of the network options
- ▶ Successfully analyzing all PPO data to make reasonable comparisons
- ▶ Requires multiple contracts and points of contact
- ▶ Typically results in varying fees for PPO access

How do you manage the selection process?

The good news is that there are a number of different resources, which can assist you in this process. I have listed several below along with some of the benefits or issues with which you should be aware.

Engage a consultant:

- ▶ Typically can provide detailed, unbiased analysis of your network options and make recommendations based on your goals
- ▶ May manage the relationships with the PPOs at cost or turn over to you for contracting and management
- ▶ Charge on fee basis

Work with a broker:

- ▶ Paid by networks so there is no cost to you
- ▶ May remain involved as resource as part of commission
- ▶ May not have systems to do effective analysis of all the data

Contract with a repricing organization;

- ▶ Many can provide detailed, unbiased analysis at no cost
- ▶ Some have ability to manage interface with PPOs & providers
- ▶ May provide access to all PPOs at one rate
- ▶ May charge a transaction fee
- ▶ Many can add networks to meet growth

- ▶ Some can provide options for discounting out-of-area/out-of-network claims

In the final analysis your best approach is to insure that your key providers (high volume providers currently being utilized by your population) are within the networks chosen and that you are getting the best savings possible (per diems, DRGs and case rates (global fees) for hospital providers and aggressive fee schedules or high discounts for physicians and ancillary providers). By offering PPOs that include these providers you are more assured of experiencing higher in-network utilization, resulting in a greater percentage of claims discounted. This can have a significant impact not only on your overall medical costs, but also on your stop-loss premiums from year to year.

Discounting those costly OON claims!

No matter how effective a job you do in your analysis process there WILL BE OUT-OF-NETWORK claims. Even the best network configuration can leave 10-30% out-of-network, depending on the location of your employees. The result is that a significant number of medical bills can be left undiscounted or, a Usual and Customary Rate (UCR) is applied resulting in the patient being responsible for the balance.

- ▶ EXAMPLE: 5,000 employee company with 80% in-network utilization can experience over \$6,000,000 in out-of-network medical bills per year

However, there is good news! There are options that can assist you in significantly reducing your costs associated with OON claims:

What to do:

- ▶ First, check with your Third Party Administrator (TPA), insurer or HMO to see if they offer out-of-network claim repricing solutions. If so, find out what percentage of your out-

of-network claims are being discounted and at what average savings.

- ▶ Second, if they are not offering this service or the savings are not satisfactory, there are companies that specialize in gaining discounts on these claims. Savings on \$6,000,000 in out-of-network billed charges can be as high as \$500,000 to \$1,000,000!

What to look for:

- ▶ Companies with several avenues for gaining discounts including Wrap PPO networks, Supplemental PPOs, negotiations and bill audit/recovery.
- ▶ Do they offer access to multiple Supplemental PPOs for repricing - *If one PPO is good isn't 5 or 10 even better?*
- ▶ Do they rank their Supplemental PPOs in each state by historical savings? *Are you getting the greatest savings possible, or using the network with the best fee to the vendor?*
- ▶ Do they handle all service issues related to the discounted claim, including provider inquiries - *or are you put in the middle between the provider, the PPO and your employee or insured?*
- ▶ Does the vendor have direct contracts with all the PPOs they are accessing, or are they using discounts for PPOs through another source? *No "silent or blind" PPOs which result in lost discounts!*
- ▶ Confirm the vendor's contract with the PPOs allow for supplemental discounts - *No "silent or blind" discounts that lead to lost savings and employee dissatisfaction.*
- ▶ Can they provide a detailed analysis of projected savings based on historical results - *or do they "guestimate" your savings?*
- ▶ Look at the percentage of out-of-network claims they are able to discount AS WELL AS average discount per claim - *High savings but a low success rate will not generate the total savings available to you.*
- ▶ Where are they successful - *If they are great in the northeast but all your employees are in the midwest- is the company your best solution?*
- ▶ Check for thresholds on negotiations - *many companies only negotiate on bills*

over a certain amount (e.g. over \$1,000 for physicians or \$5,000 for hospital) - you may be losing savings opportunities!

- ▶ Do they have HIPAA-compliant electronic solutions or real-time Internet access to facilitate repricing?
- ▶ Can they deliver average savings per discounted claim of 20% or higher?
- ▶ Is their average success for discounting OON claims 50% or higher?
- ▶ Do they price on percentage of savings basis (no savings, no cost)?
- ▶ Do they have a disaster recovery plan including third party hosting to protect your savings?

One of the best mechanisms to determine if the vendor can truly provide value and increased savings is through a detailed savings analysis. This allows the vendor to take actual claims from your organization and run an analysis against historical data to determine the estimated savings through their services. This is a powerful comparison that will tell you immediately if there are additional savings opportunities.

In the final analysis, there are no magical solutions for managing healthcare costs. However, we do know that through a wide range of services, including a focus on choosing the best PPO options in each market and discounting out-of-area/out-of-network claims, companies can yield significant savings and increase margins.

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