HEALTH INSURANCE REVOLUTION

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INSURANCE REVOLUTION

Navigating the Game-Changing Power of REFERENCE-BASED PRICING for Group-Health Plans

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SENIOR ADVOCATES PRESS

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Published by **Senior Advocates Press,** Easton, PA

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ISBN: 978-0-578-32814-0

Edited and designed by Jason Liller/Liller Creative

www.LillerCreative.com

Designed and printed in the United States of America

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INTRODUCTION

When was the last time you visited a restaurant and ordered from a menu that included no pricing information? Would you hire someone to install flooring in your home without negotiating a price beforehand? Would you accept delivery of furniture and major appliances without looking at the price tags? How about buying a car? Would you just drive it off the lot and hope it's not too pricey?

Crazy, right? You would never do something like that. Or *would* you?

You probably already have. Every time someone has a medical procedure they submit to a system that treats the cost of treatment like it's a state secret. The facility charges whatever they think is appropriate and submits it to your insurance company, which translates to crippling premiums for you and your employer. It's a system that's at the heart of the well-publicized health-care issues that this country faces, with very real financial consequences for everyone.

It doesn't have to be like this. There is a revolutionary new way of dealing with health-care costs that breaks with tradition, that puts more control in the hands of individuals and employers, and that saves you and your boss money. This new way of doing things isn't a theory, it's not a proposal. It's available *right now*. Why doesn't anyone know about it? Because we've been *conditioned* to accept the health-care system as it is. It doesn't occur to us that medical supplies and procedures come with price tags, that

we could have a reasonable idea of how much procedures will cost beforehand, and that we (or our surrogates) can negotiate what we are willing to pay. Yet all of this is true.

What's this revolutionary new system called? It's called…

REFERENCE-BASED PRICING

Reference-based pricing takes the top-down approach of traditional health care, where the provider sends you a bill (calculated according to their own mysterious methods) and expects you to pay it, and flips it upside down so that you (or your employer) tell the health-care provider what you will pay (by referring to a price list—hence *reference-based pricing*). Under this system, your bill reflects negotiated rates that are established ahead of time and that are virtually always less than what you would have been billed under the old method. That translates to lower fees charged to your insurer and lower insurance

premiums for you and your employer. And there are no surprises.

Crazy, right? Imagine having that level of control over your health-care costs instead of having health-care costs dictated to you. Here's another thing: Reference-based pricing enables you to shop around and compare because—*surprise!*—some providers cost more than others. How would you know that if you didn't use reference-based pricing? You wouldn't.

And if it were up to the providers you wouldn't know about reference-based pricing because it's disruptive. And we all know how much entrenched business models like to be disrupted: *They don't*. Reference-based pricing is the undercurrent just below the surface, it's about to remake the landscape, and it has the potential to change the way we do health-care billing—the way we've *been* doing health-care billing—for the better. So forget all you know about how this

system has worked for the last sixty years. Purge your mind, retrain your brain, and prepare to embrace a brand-new method.

* * * * *

Sometimes, when I'm out with friends, I tell them enchanting tales of reference-based pricing and how it improves the lives of people and companies. When I'm done, my companions roll their eyes at me and say something like, "Rick, if you feel so strongly about this why don't you shut up and *do* something about it?"

Of course! *I'll write a book!* So here I am: Rick Solofsky, man of action, Medicare warrior, advocate of the aged, and reference-based pricing revolutionary, stepping boldly into the future with a powerful new method of controlling health-care costs. Armed only with passion, knowledge, a word processor, and a stack of charts, I'll guide us on an odyssey of disruptive new ideas at the end of which we'll discover

bright new horizons of significant cost-savings and patient autonomy.

Am I overselling it? Absolutely not. It's *that* cool. So strap yourself in and let's get started!

Chapter 1

THREE PLAN OPTIONS: FULLY INSURED, SELF-INSURED, AND HRA'S

Before we can get into the serious business of reference-based pricing, we need to take a look at the status quo: What kinds of health-insurance programs most Americans are using, how they work, what they cost, and their benefits and drawbacks. Let's start at the top: *Fully insured* health plans and *self-insured* (or *self-funded*)

health plans. These are the most common types of employer-sponsored plans, and one of them is a lot more common than the other. Let's take a look.

Fully insured health plans: If you have health insurance through your job (or through your spouse's job), and the company employs less than a hundred people, then you probably have a fully insured plan. Here's how it works: Your employer contracts with an insurance provider and pays a premium for an annually renewable policy. In exchange, the provider agrees to pay covered medical expenses for participating employees. Premiums are based upon the number of employees and the agreed-upon level of coverage. Employees are responsible for the typical deductibles and co-pays.

In other words, a fully insured plan is the standard, traditional health insurance plan that most of us know and love. The major drawback

is eternally skyrocketing health-care costs. Remember that fully insured plans are contracted on an annual basis meaning that, just like the landlord raising the rent, the insurance provider can increase the premium every year. And believe me, they almost certainly will, sometimes so much that your employer has to scramble to figure out how to continue to provide your insurance benefit. It's a challenging situation and one that, for many smaller companies, threatens to become unsustainable.

Self-insured health plans are typically found in companies that have over a hundred employees. In a self-insured plan, the employer bypasses the fully insured concept and sets up their health plan with creative deductibles, copays, and out-of-pocket maximums. Self-insurance also requires the employer to self-administer the plan which, with a larger company, could involve the creation of an entire department along with all of the attendant expenses and headaches. It also

might require purchasing stop-loss insurance to cover medical expenses that exceed a certain limit, which highlights the chief drawback of self-insurance: the risk of the employees' medical expenses exceeding the employer's ability to pay. That's why these plans are also sometimes known as *partially self-insured plans with stop-loss coverage*, because the employer may take out a stop-loss insurance policy which reimburses them for expenses that exceed agreed-upon norms.

The primary benefit of a self-insured plan is that it can, in the short run, be less expensive than paying commercial premiums, but because of the reasons outlined above, self-insured plans are pretty rare in companies with a hundred or fewer employees. They are more popular in companies that have over a hundred employees because the volume of employees makes it easier to spread the risk of claims, but the key to success is this: the good health of the employee group. If

everyone is in reasonably good health, the company will pay lower premiums. If it's an older group, or if there are a lot of people with diabetes or serious heart issues, etcetera, the premiums will climb. (This is in contrast to fully insured plans where it is illegal to ask the employees to take health surveys). This is a great reason to encourage employees to make healthy lifestyle choices. This is why some companies reward staff for doing things like joining gyms: It saves the company money. Good employee health also makes the next health-care option more affordable …

Health-Reimbursement Arrangements (HRA): Health-reimbursement arrangements are a third way, and there are a number of ways to do them, but they boil down to this: The employer offers a high-deductible plan and reimburses the employee for most of the paid deductible. This concept offers great savings up front, but great uncertainty about the expenses yet to come. It

also places more responsibility on the shoulders of the employees, which is a mixed bag. Some people will welcome that, others won't. Either way, one thing's for sure: Regardless of the industry, few rank-and-file employees are healthcare experts.

A version of this type of plan is also common with companies that have fully insured plans with high deductibles. Essentially, the employer says, "We'll take out this insurance policy for our employees, but we're going to select the plan with the *highest deductible* and then reimburse the employees for any (or for an agreed upon level) of expenses that aren't covered by the insurance plan." The high deductible significantly reduces the employer's premium, and the employer hopes that the savings will be greater than any employee-incurred fees that aren't covered by the policy. It's a gamble for sure, and it assumes one thing: Most employees use health insurance for inexpensive, routine things and that

the typical health-insurance premiums are far more costly than the benefits used by the employees. It's a safe bet. In most companies, only twenty percent of covered individuals ever activate high-cost services, meaning that the company doesn't pay out much in reimbursements.

Each of these three methods of financing health care comes with its own set of benefits and drawbacks, but there is one drawback they all have in common: They prevent employees from truly holding the cards when it comes to making decisions about their own health care. They are always at the whim of the health-care providers, and always paying whatever prices they set. Next we'll take a look at just how much an employee can expect to pay.

Chapter 2

PAYING FOR IT: DEDUCTIBLES, CO-PAYS, AND OTHER FUN WAYS TO SPEND YOUR DOUGH

Health insurance provides a way for us to manage the often exorbitant costs of health care on a personal level, but the bottom line for most of us is the bottom line: *What am I responsible for? How much do I have to pay?*

If you've graduated into adulthood and have held a typical corporate job then you've probably had some experience with each of the following concepts, and unless you're paying a bill you probably think about them as little as possible, so let's take a minute to break them down because they're all important to keep in mind as we move forward.

Premiums: This is the big one. Premiums are the fees (usually monthly) that you pay to the insurance company in exchange for their promise to pay your medical bills (or at least some of them; see below). The premiums paid by large numbers of healthy plan participants are a major source of the fund pool that allows health-insurance companies to pay the medical bills of those who need care. Health-insurance premiums have famously become more and more expensive in recent years, to the brink of unaffordability. They've become a dominant issue in national policy discussions, and if you think the premiums

you pay as part of a company-sponsored health plan are high, just imagine what your employer pays.

Co-Pays: A co-pay is a fixed fee that you pay for common services, like routine doctor's visits, and for prescriptions. The fees don't change regardless of the actual cost of the service or drug; they always stay the same, so in that sense it's a bargain. It also lowers your premium: Plans that don't require co-pays cost more on the front end.

Deductibles: The deductible is the aggregate amount you're expected to pay, exclusive of co-pays, for medical procedures before your insurance kicks in. If your plan has a five thousand-dollar deductible, your policy won't pay a cent for your heart surgery until you've spend five thousand dollars of your own money. Policies can have widely varying deductibles, anywhere from nothing (which would be a colossally

expensive plan) to several thousand dollars. In general, the higher the deductible, the lower the premium. Many people understandably opt for the higher deductible to save money up front, but that comes with some risk: If you or a member of your family needs an expensive medical procedure you could be forced to cough up some big bucks before your insurance kicks in to cover it. Keep this in mind; it's important later.

Deductibles are paid in aggregate, meaning if you spent two thousand dollars in January and three thousand dollars in June then you will have satisfied your annual deductible, and they are annual: They reset to zero on your plan's anniversary date.

One more thing: Deductibles generally do not apply to the costs of routine visits and procedures. Why? Routine visits and procedures help keep you healthy, therefore reducing the chances

of the insurance company having to pay up, which they don't want to do any more than we do.

Co-Insurance: Even after satisfying your plan's annual deductible you may still be responsible for a portion of any costs for non-routine procedures and is usually expressed as a percentage instead of a fixed dollar amount (as is the case with co-pays). Like most other things, co-insurance is negotiable, but you'll have to pay more now if you want to pay less later.

Out-of-Pocket Maximum: Here's the light at the end of the tunnel: Your policy limits the total dollar amount that you are required to pay in any given policy year. The maximum is usually higher than the deductible, so you'll always be responsible for that, but when your maximum is reached the insurance company will pay for everything until the policy anniversary at which point everything resents and you once again have a deductible and an out-of-pocket

maximum. So if you have a $2,500 deductible and a $5,000 out-of-pocket maximum, once you've paid $5,000 in deductibles, co-pays, and co-insurance fees you'll be financially off the hook until the policy anniversary.

These are all of the ways that you have to make financial contributions to your health insurance plan. Next, we'll take a quick look at the three primary ways that health-care plans are administered.

Chapter 3

THREE EXCITING OPTIONS: PPO HMO FFS

For most of us, the world of healthcare insurance boils down to three exciting options: health maintenance organizations (HMO), preferred provider organizations (PPO), and, rarely, fee-for-service policies (FFS). Okay, maybe they're not that exciting, but at least they get the job done. These are the three programs that are the day-to-day reality for millions of Americans and they represent the system that we hope to move

beyond. Before we get on with the main subject of this book—reference-based pricing—we should do a quick review of what they are and how they work.

Health Maintenance Organizations (HMOs): These are typically the least-expensive plans which, naturally, makes them attractive since few things speak louder than dollars and cents. The trouble with HMOs is that they come bundled with a whole bunch of restrictions on which doctors you can see and when. You'll have to select your primary-care physician (PCP) from a list that the HMO provides. Want to see someone not on the list? Get out your checkbook because the HMO won't pay a dime. Want to see a specialist? You'll need a referral from your PCP before you can even make an appointment. You'll receive the care you need, but it may not be the care you want.

Preferred Provider Organizations (PPOs): These plans are more expensive but provide a great deal more freedom. You can choose a "preferred" or "in-network" healthcare provider from a list that is typically much more extensive than the HMO provider lists are, and your policies will generally cover the costs at a pretty reasonable level. You can even use "out-of-network" healthcare providers which will cost more out-of-pocket, but at least you have the option. You also won't need a referral to see a specialist. If you need to see a dermatologist, just pick one from the preferred provider list and make the appointment. On the other hand, as I said, PPO plans can have higher premiums and higher deductibles than HMOs, which can make them less attractive at the outset. You often have the option to accept a high-deductible plan in exchange for a lower premium, but that's a gamble: You're paying less up front in the hope that you're never faced with a situation—probably at the worst

possible time—where you might actually be forced to pay those high deductibles.

Fee-for-Service (FFS) policies: Increasingly uncommon, and entirely unavailable in some areas, fee-for-service policies are simple reimbursement plans: You go to the doctor, you pay the bill, and the insurance company reimburses you (although copays and deductibles still apply). This type of plan offers tremendous freedom, but the initial financial obligation can be enormous because you are responsible for one hundred percent of expenses up front. Fee-for-service policies are also high-premium plans, so you get walloped on the front end *and* the back end. If you're fabulously wealthy this may be the plan for you (if it's even offered where you live). But—and this is just a hunch—if you're fabulously wealthy you probably don't spend a great deal of time thinking about your medical expenses.

As I said, each of these three policy programs will get the job done. Summarize each type and tie it up with an emphasis on the drawbacks of each one. Each one of them will get you the healthcare you need, but each also comes with a significant disadvantage. We sacrifice freedom or we sacrifice money and we accept our fate because, until now, we haven't known that there's a better option available.

Chapter 4

UCR: USUAL, CUSTOMARY, AND REASONABLE

Reasonable is not a word that springs to mind when we think about medical bills, but it's an important component of what insurers use to determine how much they're willing to pay for a medical procedure. *Usual, customary,* and *reasonable* are three ways of saying almost, but not quite, the same thing:

- **Usual:** Is this the fee providers are usually charging?
- **Customary:** Is this the fee that providers ought to be charging?
- **Reasonable:** Does the fee make sense in the context of the provider's costs?

For every medical procedure that's covered by a given policy, the insurer has determined a price range that it considers to be within the bounds of what's usual, customary, and reasonable. Oh, and there's one more thing: These price ranges are determined regionally. Getting your tonsils yanked out will likely cost you more in Manhattan than it will in Peoria and insurers make adjustments accordingly.

Here's how all of this affects *you:* If your provider charges fees that exceed what your insurer considers usual, customary, and reasonable you may be charged for the difference and have to pay it out of pocket. That's not a fun surprise.

How do you avoid this? The easy way, and the way that most people do it, is to use providers that are *in network*. Your insurer has a list of approved providers that are known to charge fees that fall within your insurer's definition of usual, customary, and reasonable. These are the insurer's network of providers. You are, of course, free to use other providers, known as *out of network*, but you run the risk of significant charges that your provider might have covered if you had stayed within their network.

The real significance of usual, customary, and reasonable fees within the context of reference-based pricing, though, comes down to this: Medicare has its own list of usual, customary, and reasonable fees which is published and available to providers, insurers, and the public at large. Medicare-participating providers have agreed to accept whatever fees Medicare has decided are usual, customary, and reasonable (excluding co-insurance, co-pays, and deductibles) as full

payment for any listed procedure. The existence of this list, and the provider's agreement to abide by it, is a central piece of reference-based pricing. *It tells us what providers are willing to accept as payment*, which is a valuable piece of intelligence in the war for affordable health-care coverage. If a provider thinks that a thousand dollars is reasonable compensation for a given procedure, why should anyone pay more than that? Why indeed.

Keep this in mind. We'll come back to it after we put a few more pieces in place.

Chapter 5

SELF-INSURED OR LEVEL FUNDED?

There are two ways to fund a self-insured plan. We touched on the plan itself earlier:

Self-insured health plans *are typically found in companies that have over a hundred employees. In a self-insured plan, the employer bypasses the fully insured concept and sets up their own health plan with creative deductibles, copays, and out-of-pocket maximums. Self-insurance also*

requires the employer to self-administer the plan which, with a larger company, could involve the creation of an entire department along with all of the attendant expenses and headaches (although hiring a third-party administrator, or TPI, to run the plan is an option). It also might require purchasing stop-loss insurance to cover medical expenses that exceed a certain limit, which highlights the chief drawback of self-insurance: the risk of the employees' medical expenses exceeding the employer's ability to pay. That's why these plans are also sometimes known as partially self-insured plans with stop-loss coverage, because the employer may take out a stop-loss insurance policy which reimburses them for expenses that exceed agreed-upon norms.

The primary benefit of a self-insured plan is that it can, in the short run, be less expensive than paying commercial premiums, but because of the reasons outlined above, self-insured plans are pretty rare in companies with a hundred or

fewer employees. They are more popular in companies that have over a hundred employees because the volume of employees makes it easier to spread the risk of claims, but the key to success is this: the good health of the employee group. If everyone is in reasonably good health, the company will pay lower premiums. If it's an older group, or if there are a lot of people with diabetes or serious heart issues, etcetera, the premiums will climb. (This is in contrast to fully insured plans where it is illegal to ask the employees to take health surveys). This is a great reason to encourage employees to make healthy lifestyle choices, and it's why some companies reward staff for doing things like joining gyms: Good employee health saves the company money.

Self-insured plans are where reference-based pricing can come into play, so before we get into that we need to drill down just a little bit more into the funding options available to

employers for self-insurance plans, specifically *self-funding* versus *level-funding*.

In *self-funded* plans the employer simply pays the medical bills of the employees. This can be great if no one has any significant health issues, but throw in a heart attack and a cancer diagnosis and the employer is suddenly looking at some potentially crippling sky-high bills that hadn't been factored into the budget.

With self-funded plans, past experience is just about the only information you can use to guide budget-making. How could anyone know how much to allocate to employee health care when there's no way of predicting what might happen over the course of a calendar year? It can't be done. The best you can do is make educated guesses based upon typical preventative care (routine doctor's visits, etc.), and the health history of the employees. Even the best planning based upon such sketchy criteria goes right out

the window when an otherwise healthy thirty-year-old has a stroke. You can't plan for that. No one can. Uncertainty is the great hazard of self-funded plans which is why companies that choose to go down this path often purchase stop-loss insurance as a hedge against the risks of un-anticipated catastrophic expenses.

Level-funded plans address these issues while still allowing the employer to self-insure. With level funding, the employer pays an un-changing (level) monthly fee into a reserve account to provide funds in the event of those un-anticipated catastrophic expenses. In other words, it's funding you can plan on, and a scheduled expenditure that can be included in a budget. Another plus is that level-funded plans are administered by an insurer with its own stop-loss policy, so if you overspend your fund, no worries: You're covered.

Because level-funded plans are administered by insurance companies, it also means that the employer isn't responsible for all of the paperwork, bookkeeping, and legal requirements that come with running a health-insurance program: The insurance company takes care of it. Make no mistake, though: Whether self-funded or level-funded, it's still *self-insurance*. Even with a level-funded plan, which is administered by a contracted insurance company, the employer is still insuring the employees independently as opposed to purchasing a policy from an insurer. This independence is what gives the employer the flexibility to take advantage of reference-based pricing, as we shall soon see.

Chapter 6

STOP-LOSS VS. REINSURANCE

Stop-loss insurance is a good idea for companies that self-insure. In fact, I'd go further than that: I wouldn't dream of self-insuring *without* a stop-loss policy. If there's a catastrophic healthcare claim in your company, a stop-loss could be the difference between a relatively easy experience and utter financial ruin. Let's assume that *utter financial ruin* isn't on your company's

agenda as we take a few moments to look a little more closely at stop-loss insurance.

First of all, let's clear up a common misconception: The terms *stop-loss insurance* and *reinsurance* are often used interchangeably. While they are similar in concept, they are not the same thing. Reinsurance is a type of policy that insures insurance companies—and *only* insurance companies—against excessive claims, also known as *shock claims* because when they happen they are totally unexpected, thereby shocking the claims experience. Reinsurance transfers some of the risk to another insurer, thereby reducing the potential burden of a cluster of major-claim events. Whether or not reinsurance companies take out their own reinsurance policies is a mystery to me, but the bottom line for you and me is this: Unless you're running an insurance company you will *not* be purchasing a reinsurance policy, but if you're self-insuring for employee health care, you might (and probably

should) purchase a stop-loss policy which, like reinsurance, helps protect you against the burden of excessive claims.

Stop-loss became more popular as the concept of health insurance evolved from one of only paying for expensive procedures to one that encompasses paying in whole or in part for a host of health-care related expenses. Like any other type of insurance, stop-loss requires a large pool of premium-paying participants in order to build a financial base of sufficient size to make any anticipated payouts.

Also like other types of insurance, stop-loss is available in a variety of coverage levels, and you'll pay more for coverage that kicks in at $100,000 than you will for coverage that kicks in at $250,000, so crunch your numbers, assess your risk tolerance, and choose wisely.

That's just common sense, but here's an aspect of stop-loss insurance that may not occur

to you until someone points it out: A carrier can specify which expenses will and will not be covered, and can exclude entire categories, like experimental treatments, from coverage. More importantly, a carrier can exclude individuals with specified known conditions, and drop employees from the policy who prove to be high risks. It's the classic insurance catch-22: You get the insurance to guard against claims, but if you use the policy you risk getting dropped (or having your premium raised). Which brings us back to another excellent point that's been raised before: Give your people incentives to stay healthy. It doesn't just save you money (and keep you insured), it enhances employee morale and productivity.

By all means, if you are self-insuring, or considering self-insurance, please give careful thought to stop-loss insurance to help absorb some of the potential impact of unexpected claims. And with that, we've put one more piece

of the puzzle together and reach into the box for the next one.

Chapter 7

GETTING FANCY: BOUTIQUE & CONCIERGE DOCTORS

Recent years have brought increasing complaints about access to routine health care. With appointments that have to be made months in advance, too much time spent in waiting rooms, and overburdened doctors who are forced to rush through appointments, it's no wonder people are getting fed up. Here's a surprise: The doctors are

fed up, too. Everyone wants a solution, and the one that many have settled on is *boutique doctors* or *concierge care*, which is two ways of describing doctors who see limited numbers of patience in exchange for a fee. Some even operate on a sort of subscription service where patients pay a fixed monthly amount in exchange for access to a doctor who has a freer schedule. You get more appointment slots, shorter wait times, and doctors who have ample time to spend with you every time you visit. Some even make house calls.

Because the practice of charging extra for access is largely unregulated, boutique doctors are able to provide endless combinations of services and fee structures. Check around your local area to see what's available and what the medical professionals in your region are able to provide in terms of added-fee services. And if you like your current doctor but are frustrated by wait times and rushed appointments, know this: Some doctors who follow the traditional path *also* offer

dedicated appointment slots to those who are willing to pay for such services, so it's worth asking. Remember, many doctors want the same things you do: shorter waits and unhurried time with patients.

What does this have to do with self-insurance (and, ultimately, with reference-based pricing)? Most traditional insurance plans don't have provisions or options for boutique doctors or concierge care, and the doctors who offer this form of care exclusively will almost certainly be considered out-of-network. The option simply isn't offered, forcing you to pay one hundred percent out of your own pocket if you choose to use their services.

But here's the thing: While many think boutique medicine is the exclusive province of the rich and famous, it doesn't have to be. In fact, in spite of its reputation for being fabulously expensive, concierge care is often relatively

affordable, especially when the patient is the beneficiary of a custom-designed insurance plan that offers the coverage they need which, of course, is something that self-insurance can provide. Self-insurance offers the freedom to cover things that most traditional insurers exclude, things like boutique doctors. And self-insurance is made easier and more affordable through reference-based pricing.

Chapter 8

CRYSTAL CLEAR: HOSPITAL CHARGES "TRANSPARENCY"

Now it's time to backtrack to what I said in the very first paragraph of this book: When was the last time you visited a restaurant and ordered from a menu that had no prices? Would you hire someone to install flooring in your home without negotiating a price beforehand? Would you accept delivery of furniture and major appliances

without looking at the price tags? How about buying a car? Would you just drive it off the lot and hope it's not too pricey?

No sane person would do any of these things, yet when it comes to health care we've been forced to do *exactly* these things for years. Happily, that began to change in January 2021 when new price transparency requirements for hospitals, issued by the Centers for Medicare and Medicaid Services, came into effect requiring hospitals to disclose standard prices for three hundred *shoppable services* (services that patients can schedule in advance at times of their choosing), along with the lowest prices that they will accept from patients paying out of pocket.

As you might imagine, hospitals weren't thrilled with having to meet this new requirement. As they saw it, pricing any given procedure was far more difficult than simply putting a dollar amount on a chart. It meant disentangling and

analyzing a whole bundle of interwoven costs, such as administration, supplies, and payroll, to get to a meaningful bottom line. Even worse, the requirement to include lowest acceptable prices was sure to set off a race to the bottom as consumers flocked to the facilities that were most affordable. And it was one more thing hospitals had to do that, in their view, had nothing to do with their core mission of delivering health care.

But in the view of others it had *everything* to do with delivering health care. For the first time, the general public had access to what, until now, had been privileged information, a closely guarded secret. It was key intelligence that would finally allow consumers to make informed decisions about their own care, a development that would finally revolutionize an incredibly pricey industry, finally putting some control into the hands of consumers. Nothing would ever be the same.

Except, as it turns out, consumers have done very little with this new resource. Most don't know it exists. That may change (more information, including negotiated rates for *all* covered procedures and in-network costs for prescriptions, must be provided as of January 1st, 2022), but for now it's made little impact among the public.

One group that hasn't allowed this development to slip past them, though, is insurers. The inclusion of minimum-acceptable rates has given them a base from which to negotiate pricing. Crucially, it has empowered self-insured entities like never before. Now, instead of flailing in the dark, with all power in the hands of providers, the balance has shifted, giving self-insured companies the ability to intelligently build coverage plans for their employees in ways that save employers money while also ensuring that providers are fairly (and not exorbitantly) compensated.

Needless to say, this information, while valuable, may not make a great deal of difference to those who don't know what to do with it. Saying that consumers can use these new charts to make intelligent decisions isn't the same thing as actually having them in hand and making informed decisions about things that most of us don't fully understand. It takes a specialist to make the most of it and to do it correctly. Here's an example: The Internal Revenue Service, the Department of Labor, and the Centers for Medicare and Medicaid Services each has a position on this issue. Feel like tangling with them? Of course not, but don't worry: We have people who do that. Turn the page and see.

Chapter 9

RED TAPE: GOVERNMENT REGULATIONS, REQUIREMENTS, & GUIDELINES

We tend to have two contradictory opinions about government: It's either ruthless and efficient, plowing through everything in its way, or it's incompetent and ineffective, failing to accomplish even its most basic tasks without screwing things up. These are obviously extremes and, like most other things, the reality is somewhere

in the middle. When government seems incompetent I think it's often because government is badly coordinated: one piece of government establishes a rule or a regulation without coordinating with other pieces of government to make sure that everything works smoothly for the citizens who ultimately have to deal with the results.

When it comes to qualified health-insurance plans that wish to use hospital pricing transparency to their advantage, the government has done a pretty good job of ensuring that the various offices and departments are well coordinated. (According to the Department of Health and Human Services, a *qualified health-insurance plan* is one that is "certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act").

In 2020, the Internal Revenue Service, the Department of Labor, and the Centers for Medicare and Medicaid Services teamed up to establish some new rules for insurers. While this is an annoyance for insurance companies, it's a boon for consumers because the new rules require insurers to reveal in writing, on paper and online, all cost-sharing (co-insurance) information, including an estimate of the individual's co-insurance liability for covered items or services, AND disclose in-network provider-negotiated rates, historical out-of-network allowed amounts, and drug-pricing information, among a host of other things, upon request to participants, beneficiaries, enrollees, or their authorized representatives. It's a lot. The point of all of this is to create better-informed consumers and enable them to shop for services among health plans in the same way that they can shop for services among hospitals.

Which is great for the consumer, but a lot of work for the provider, and it's of paramount

importance for companies that self-insure because these requirements are *statutory:* They are required by law and failure to comply can result in penalties. Business owners deal with a *lot* of things that are of paramount importance. Keeping the government off your back is one that you'd probably rather not have on your agenda.

How can you make sure everything's done correctly, especially given that the requirements are likely to evolve and change (in fact, you can pretty much count on it)? Easy: Get help. Don't attempt to go it alone. Whatever money you think you'll save, or control you think you'll retain, doesn't outweigh the consequences of getting this wrong. You also owe it to your employees to get it *right*.

Stay tuned. I'll help you navigate the waters of health-care assistance in a bit. In the meantime, we're about to get to the part of the book that all of this has been leading up to.

Chapter 10

AND NOW FOR THE PART YOU'VE BEEN WAITING FOR: REFERENCE-BASED PRICING

So here we are, the part of the book we've all been waiting for, the part that ties everything together. Way back in the post-war world (we're talking about World War II here), employers began to do something wonderful and revolutionary: They offered *comprehensive employee*

benefits, including medical care. This was a time when taking a job at a company was often seen as a lifelong commitment, almost a marriage, and in exchange for your hard work and loyalty, the company promised to take care of you and your family just as if it were a loving parent.

But times change. A comprehensive, company-funded employee health insurance plan used to be affordable because medical and hospital bills used to be lower. Over the years, the cost of health insurance has climbed to the point that it's often a major corporate budget consideration. We've reached a point where many companies can simply no longer afford it. Just Think! Thirty to forty years ago, on a cash-flow chart of a business's Top ten costs, healthcare used to be eighth, ninth, or tenth. Nowadays, after payroll, healthcare costs are often second or third.

But if those days are gone, so too are the days of employers and insurers simply accepting

the prices offered by providers, and that's where reference-based pricing comes in. As we've said throughout this book, RBP provides a way for employers and employees to take greater control of their health care while paying lower rates for what they receive, a development that was largely made possible when the Centers for Medicare and Medicaid Services began to require providers to publish the actual cost basis of the services and procedures they provide. In the old days, insurers used to negotiate a discounted rate with providers; in other words, they might come to an agreement that the insurer would pay sixty percent of whatever the facility billed, so if MRI was billed at $5,800 the insurer would pay $2,320. That's a big savings, but it assumes that the facility's charges are usual, customary, and reasonable. Maybe they're not. Thanks to the requirement to publish the actual cost basis of procedures and services we now can negotiate *upward*, from the actual cost basis rather than

downward from an arbitrary price assigned by the provider. The markup on that $5,800 MRI looks pretty extreme when you know that the cost basis is only $700.

Medicare uses a series of formulas to determine the maximum amount that it will pay for any item on the list. Now, armed with the same information, self-insured employers and their plan administrators can do the same. For example, a plan administrator could set a standard of paying 150% of the cost basis of any given item on the list (which is more than Medicare will typically pay). Suddenly the bill for that $5,800 MRI with a cost basis of $700 is only $1,050. And a fifty-percent profit margin is pretty generous in most industries. Just ask your grocer.

Those numbers are purely speculative, but the point remains true: Employers and employees can realize significant savings while still allowing providers to make a decent profit. In 2014,

Montana's state government used reference-based pricing to renegotiate the way it works with hospitals. Armed with Medicare's cost list, Montana told the state's hospitals *what they would pay* for medical services and within two years the state was saving over fifteen million dollars annually. Once again, it's the opposite of the traditional top-down approach. A well-informed customer told the supplier what they were willing to pay based upon the cost figures that the supplier itself had provided, and now other states are looking into following Montana's example.

The cost figures also allow consumers to make more informed decisions about where to go when choosing the source of their healthcare, for the first time allowing informed comparisons between providers. RBP also eliminates the whole concept of a health-care network from the equation (no more worrying about whether or not your favorite doctor is in or out of network). A word of warning about shopping purely on the basis of

price: While price is important, so is quality. Just as in any other transaction, you often get what you pay for, so balance your cost analysis with the facility's reputation, success rates, and other metrics.

It's a revolutionary development for consumers and businesses, with particular significance for small and medium-sized businesses that self-insure. For the company, the constant stress and worry about how much next year's premiums will be can be put to rest. Precious time spent redesigning health plans to keep them affordable—while invariably curtailing benefits—can be spent on other important things, like making money. Your company's health-care program won't be entirely out-of-sight-out-of-mind, but it'll be the closest thing to it, allowing you to apply more focus and energy on your business.

For consumers it's unprecedented freedom and cost savings. It might require slightly more

homework at first, but people being more involved in their health-care decisions, instead of delegating that responsibility to faceless clerks in an office tower five hundred miles away, is a good and positive thing.

Reference-based pricing is gaining popularity throughout business and government, and while it's a very simple process in concept, implementing and running it takes a little work and know-how. There are also some common—and avoidable—problems and pitfalls that will give you a serious headache if you don't know what you're doing. That's where professional brokers and plan administrators come in. Someone who *does* know what they're going can assure you of a smooth transition and a flawlessly executed health-care plan that provides your company and its employees with a great program while saving serious money and avoiding the speedbumps and roadblocks that an experienced specialist knows how to avoid.

Chapter 11

GETTING HELP: PITFALLS AND HOW TO AVOID THEM

Reference-based pricing has many benefits for individuals and the companies that employ them, and like anything else with benefits there can also be pitfalls. These aren't necessarily downsides, or reasons why reference-based pricing (and self-insured plans) might not be as attractive as traditional plans. Rather, they are administrative issues that could cause problems in implementation and even potentially land someone in legal

trouble. In other words, after all the good stuff, this is the hard reality that has to be confronted and overcome. Ensuring smooth operation (and a smooth transition from the previous plan) is vitally important for maintaining employees' access to health care *and* employees' confidence in the company's leadership.

One of the keys to making sure that everything goes off without a hitch is to be aware of potential issues before they arise. While there are any number of little things that could come up on a case-by-case basis, there are three primary areas of concern that individuals and employers should be aware of . . .

1). Some Providers Won't Play Ball. While reference-based pricing has become increasingly common and popular, there are some providers that won't work with such alternative programs. This is, of course, their prerogative, and an employer could still choose to pay the provider's bill

as if it was a balance-bill situation (see below), but lacking an insurer to help carry the load is far from ideal. What this means for the individual is that, while reference-based pricing means that you don't have to worry about staying within a network, you might still find some providers that are significantly less attractive than others on a purely financial basis. It's always best to clear up something like this well ahead of time and avoid any nasty surprises or crushing disappointments later.

2). Some Providers Will Bill for Unpaid Balances. This is the dreaded "balance-billing" that we mentioned briefly earlier: Your insurer pays the reference-based fee and the provider attempts to collect the balance of what they feel they're owed according to their own pricing scale. It would be a tremendous understatement to say that receiving an unexpected five-figure bill can ruin your day. Companies rely upon insurers to take up the case when this happens, working with

the employer to insulate the member against owing potentially catastrophic amounts.

3). Some Employers May Have Difficulty Negotiating. Initiating a reference-based insurance program with your local health-care providers isn't necessarily a turnkey operation. It requires some meetings, some communication, and some back-and-forth about what each party expects of the other. This sounds challenging enough, but add in the fact that few smaller companies possess expertise in this area and it can seem insurmountable, especially when your little shop goes up against a colossal health-care conglomerate. It can be a little intimidating and, trust me, *they're counting on that*.

This is a tough one to deal with. Figuring out whether or not a provider will even accept reference-based pricing may be simple enough, but negotiating with a provider will likely take you into areas that are wholly outside of your

wheelhouse and that shouldn't be undertaken without some level of know-how and expertise.

And that's the solution: You need someone with know-how and expertise to guide you through the process and stand by your side as you navigate the ins and outs of a reference-based-pricing plan. There are brokers and consultants who have dedicated their professional lives to studying health-care insurance, learning how to avoid traps, how to maximize benefits, and how to do all the detail-oriented administrative work so that you're free to do what you do best: run your business.

But I thought this was supposed to save me money! You mean I have to pay someone to run this? You don't *have* to pay someone to run it, but I strongly recommend that you do. You will thank yourself a thousand times if you do. As far as saving money is concerned, the money you pay someone broker a plan and act as its

custodian will almost certainly be a fraction of what you would pay to maintain a traditional health-insurance plan. And for that fractional payment you will say goodbye to the worry and the work and the stress and the sleepless nights that can come with insurance administration because you'll have recourse to someone who can take on those burdens and handle them without you ever having to do more than make a phone call.

In fact, once you have help, there's very little reason not to at least explore reference-based pricing as the solution to your company's health-care future. It's made a world of difference for thousands of companies, saving them money that can be put to better use and freeing them from the yearly agony of having to renegotiate painfully expensive insurance plans that threaten to spiral beyond the realm of affordability. It can do the same for you. You only need to take the first step.

Chapter 12

PHARMACY BENEFIT MANAGERS: NOT ALL ARE CREATED EQUAL!

In the vast, baffling world of healthcare there is one important concept whose role is too often overlooked: It's a contract known as the *pharmacy benefits manager*, or PBM. With the increase of new drugs, coupled with the significant cost of specialty prescriptions (sometimes six figures or more annually), the importance of

working with a knowledgeable PBM consultant can't be overstated. (In fact, the PBM sometimes flies so far under the radar that I didn't even bring it up in the first edition of this book. Never fear! After some thought and reflection, I have returned with this brand-new chapter. One catch: To take advantage of the consulting and expertise of a PBM you typically must have over a hundred employees *and* be covered under a self-insured platform. If this describes your organization, with proper due diligence you can look forward to saving nearly twenty percent on your pharmacy spend.

A pharmacy benefits manager is a third-party administrator of prescription drug coverage for insurers and employers**.** If your broker isn't constantly paying attention to these below components on an annual basis, someone is NOT doing their job and it can cost you $$$ hundreds of thousands of dollars. These PBM concepts include, but are not limited to:

- **Brand/generic algorithms**
- **Pharmacogenomics**
- **Step edits**
- **Prescription adherence/medication therapy management**
- **Therapeutic equivalence evaluations**
- **Rebates and discounts**
- **Patient-assistance programs**

Let's take a look at each part and see what it all means . . .

Brand/Generic Algorithms

When medical cases become complex so do the corresponding drug therapies. Traditionally, physicians and pharmacists relied upon published tables to determine effective (and safe) patient treatments. Now, thanks to ever-advancing technologies, treatment trends are analyzed and adjusted in real time, and inputting symptoms and diagnoses into an automated algorithm produces recommended treatment options based

upon recent medical history. Pharmacy benefit managers have access to the same technologies, allowing them to analyze prescriptions and choose the best money-saving options—often generic substitutions for name-brand pharmaceuticals—without fear of error or misprescription. Just be aware and understand that brand/generic algorithms is where a PBM can manipulate their drug usage to achieve the discount percentages they have in their contracts. It's the first tool in the toolbox that helps the PBM increase efficiency and save money.

Pharmacogenomics

Even more on the cutting edge is the field of *pharmacogenomics* which, if your DNA information is available, allows the prescription of precise dosages and exactingly specific medications based upon your unique, personal genetic makeup. While still relatively unusual in 2022, pharmacogenomics are increasingly utilized across the

spectrum of American medicine and will one day mean the end of one-size-fits-all treatments and prescription dosages. It's another tool in the toolbox, and if you have the good fortune to work with people who have access to it consider yourself lucky. If you don't, be patient. It's coming.

Step Edits

Step edits, COMMONLY KNOWN AS STEP EDITS THERAPY, is a mechanism that health insurers use to control drug costs. In general, it means that patients are expected to use lower-cost medications (like generics) and move to higher-cost medications, in tiers, only if necessary to achieve the desired results. This method places more control in the hands of the insurers, hopefully without jeopardizing the health of consumers. It also gives PBMs a way to negotiate prices with providers (if a provider wants its product to sell in higher volume they may have to lower its retail price). Combine this tool with

algorithms and pharmacogenomics and you can see how this is all starting to come together.

Prescription Adherence and Medication Therapy Management

It's become an open secret that many of us—especially seniors—don't take medications as prescribed. Doses are skipped and dosages are cut, all in an attempt to stretch a prescription and save money. The rising cost of healthcare can be a real issue for those on fixed incomes, but here's the catch: not adhering to prescription recommendations *increases the cost of healthcare* because the medications don't work as intended when patients don't take them as prescribed. In the old days, when a patient received a prescription, little thought was given to what the patient would do with it, but as recent studies have highlighted the prevalence of the problem, this lack of attention has changed. Some insurers have initiated *medication therapy management*, an

initiative that provides more robust guidance to **patients,** helping to ensure they use their medications properly, and helping to keep healthcare costs down for everyone, an obvious area of concern for PBMs.

Therapeutic Equivalence Evaluations

You can't just say that a drug is a generic equivalent; you have to *prove* it. A *therapeutic equivalence evaluation* is how the FDA certifies that a given generic alternative is, in fact, a generic equivalent of a brand-name pharmaceutical. In making this determination, the FDA examines four principal factors for equivalency:

- Active ingredient(s)
- Strength/concentration
- Dosage form (a pill, a liquid, etc.)
- Route of administration (how is the drug taken?)

All four of these factors must be judged equivalent to the name-brand drug before a new one can be certified as generic. This keeps us safe, prevents lawsuits, and keeps costs down for everyone.

Rebates and Discounts

Because a PBM presumably works with multiple clients at any given time, they are able to pool buying power and negotiate rebates and discounts from drug manufacturers which they are then able to pass along to providers and plan members, once again lowering prescription costs. Just keep in mind that when choosing a PBM, some portions of the rebate may fluctuate depending on when the contract is terminated.

Corporate Social Responsibility (CSR) vs. Patient Assistance Programs (PAP)

The general public sometimes takes a dim view of the pharmaceuticals business. Tales of

rampant greed and profiteering at the expense of the poor and infirm seem to fill the news. Patient assistance programs provide an opportunity for pharmaceuticals companies to demonstrate social responsibility by making prescription drugs available to low-income groups and low-income employees at affordable prices which also increases the customer base—a win-win—because customers perceive those companies as socially responsible and prefer the medicine they produce. CSR also helps companies attract and retain a talented workforce that wants to be a part of an organization that thinks beyond profit—a key motivator for millennials.

The top pharmaceutical companies have each adopted some form of CSR. Some have banded together with non-governmental organizations (NGOs) to distribute medications or build medical infrastructure in remote areas. These domestic CSR programs, in partnership with the government, work on various programs such as

improving healthcare access in underserved rural areas.

There are always government and NGO programs working to develop services, but when the private sector gets involved the effectiveness of any campaign is enhanced. Right off the top of my head I can name three pharma companies that are stepping up to the plate to improve the affordability of prescription drugs.

COVID-19 Drives Demand for PAP Support

As funds provided by the government through the paycheck protection program and the supplemental unemployment benefits disbursed during the COVID-19 pandemic dwindle, we could see a surge in patients needing financial assistance to cover their medications. As a result, PAPs offered by drug manufacturers are becoming more flexible and are embracing technology to ensure access, helping patients navigate

through the complexities and challenges posed due to COVID-19 and its aftermath, simplifying the path to better patient outcomes.

There are many such programs available, but to the layperson they can seem confusing and inaccessible. A PBM can act as a coordinator and guide, matching people to the best option for coverage.

The Bottom Line

A pharmacy benefits manager can save you and your company significant money *if* you have over a hundred employees *and* use a self-insured platform. If this describes your situation, please make the effort to work with a knowledgeable PBM consultant and reap the many benefits they can provide. I can introduce you to one of the nation's premier PBM consultants. Get in touch with me. I'm always happy to help, and it can mean adding thousands, hundreds of thousands, or even millions of dollars to your ROI.

You wouldn't hire a psychiatrist to perform brain surgery. Both are doctors, but they perform profoundly different functions. Don't just rely on your broker to understand all the components of the pharmaceutical maze. Get help and guidance. PBM consulting is like a minefield. Be careful where you step!

CONCLUSION: AN IDEA WHOSE TIME HAS COME

Over the years I've seen far too many business owners and CEOs stress over their annual health-plan renewal when they should be focused on making a profit, or worried about how they'll pay for next year's coverage instead of figuring out how to beat last year's earnings. Reference-based pricing can be the answer, a solution that most people don't even know exists. Fortunately, there are a few passionate souls out there spreading the word, trying to hand the power back to the people

and create a more equitable, more affordable, more bottom-up approach to group health plans for the American workforce.

But as we have seen, it isn't something that should be undertaken without expertise and guidance. As with anything else involving insurance and health care, it can be complex, and rife with legal implications and choices that can impact you, your company, and your employees. The best place to start is with someone who has the expertise, the qualifications, and the appropriate certifications to help you take the first step on a liberating journey to a simpler, less expensive, and more self-directed future. Contact me for a consultation and evaluation. We'll assess your current situation and look at a new plan that could be in place as soon as your current one expires. Or you could continue to suffer under the outrageous premiums and lack of control that traditional plans offer.

Make the *right* choice. Contact me, Rick Solofsky, at Rick@SolofskyFG.com, or at 215-432-7425 and together we'll create a bold new plan for the future.

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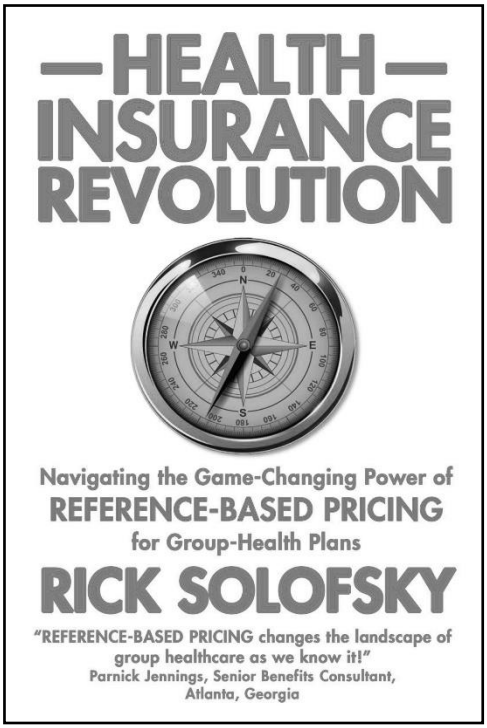

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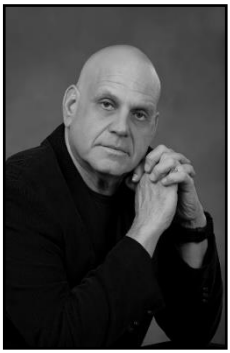

Rick Solofsky, a 1979 graduate of West Chester State University, has over thirty years of experience as a health-care broker and high-level consultant with a specialty in Medicare and the interpretation of "Medicare Secondary Payer Law" and how it applies to the group insurance culture. Today, Solofsky Financial Group administers over 150 group health-care accounts in Pennsylvania and New Jersey, in addition to over 300 individuals, and Medicare-supplement policies for more than 400 individuals. Rick frequently educates other brokers, CPAs, and attorneys about changes in the Medicare/health-insurance landscape. A regular contributor to many financial talk shows, Rick credits his dual major—Health/Physical Education *and* Psychology—with helping him better understand the "Big Picture" of the role of health insurance in American life.

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