

# Plan Design: Cost Containment Practices

## Gain Better Control of Claim Outcomes with a Well-Designed Plan Document

Since the implementation of the Affordable Care Act (ACA) and with the rising costs of health care across the nation, self-funded health plans have seen a spike in the frequency and severity of catastrophic claims. As a national leader and expert in Stop Loss insurance, HM Insurance Group (HM) often is asked if certain elements of plan design can help policyholders to better manage the cost of providing comprehensive health coverage, while continuing to offer access to quality care and promoting healthier populations.

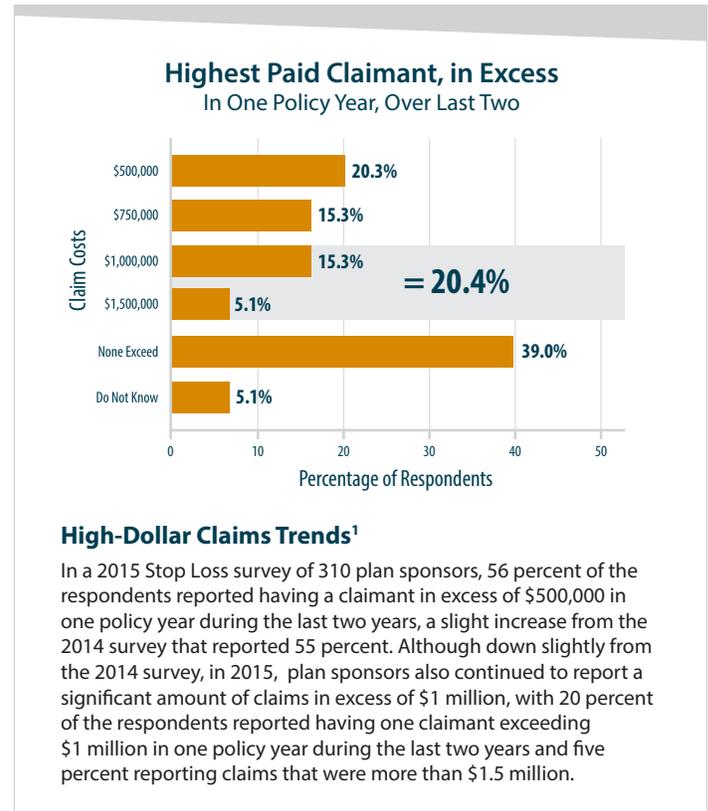
Based on our experience, we have identified key areas of plan design that you may want to consider for cost containment purposes. HM is sharing this information with our producers and policyholders to help them make well-informed decisions when designing benefits programs.

This information should be considered only as a guide. This does not replace more comprehensive, specialized plan design services. We recommend that as a best practice, our policyholders also consider having their plan designs reviewed by a qualified plan design professional.

## Areas to Address with Best Practices

The following are 18 areas addressed with best practices that we believe may help to build a stronger plan document for groups seeking high-quality care over high-cost care.

|    |   |
|----|---|
| 1. | Eligibility   |
| 2. | In-Network Incentives                                   |
| 3. | Out-of-Network Charges                                  |
| 4. | Mandatory Use of Case Management                        |
| 5. | Clinical Trials and Experimental Treatments             |
| 6. | Alternative Treatment Plans                             |
| 7. | Genetic Testing   |
| 8. | Transplants   |
| 9. | Centers of Excellence (COEs) for Other than Transplants |



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| 10. | Medical Implants                             |
| 11. | Dialysis                                     |
| 12. | Air Ambulance                                |
| 13. | Prescription Drugs                           |
| 14. | Medical Errors/Never Events/Substandard Care |
| 15. | Assault and/or Participating in a Felony     |
| 16. | Traveling Abroad                             |
| 17. | Coordination of Benefits (COB)               |
| 18. | Subrogation                                  |

## 1. Eligibility

Having a well-defined eligibility section in a plan document prevents a plan from being liable for claims when the eligibility of a member is unclear and saves the plan from drawn-out processes in making benefit determinations when eligibility is uncertain. To help to reduce some common questions regarding eligibility, the plan sponsor may want to consider the following areas of the plan's eligibility section:

- Employee – Specify hours worked requirement and waiting periods for full-time, part-time and seasonal employees and for non-resident employees, including any continuation of coverage and termination provisions as noted below.
- Retirees 65 and Older – Specifying that Medicare is the primary provider of coverage in the plan document can help to clarify the order of responsibility and can make the plan secondary. The plan sponsor also may want to encourage retirees to enroll in Medicare Part A and B.
- Retirees Not Eligible for Medicare – Clearly specify what conditions apply to retirees who are not eligible for Medicare.
- Dependents – Clearly define who is considered a dependent, including dependents of retirees and whether children of dependents are covered under the plan.
- Covered Individuals Other than Employees – Specify when coverage begins and ends, including whether the individual must fulfill a minimum number of hours worked or a waiting period before coverage is effective for eligibility classes such as:
  - Elected Officials
  - Board Members/Outside Directors
  - Contractors
- Continuation of Coverage and Termination Provisions – Clearly specify when a member is and is not eligible for coverage, defining the dates when coverage begins and ends, and indicating who is responsible for paying health premiums for the following circumstances:
  - Actively at Work
  - Leave of Absence (LOA)
  - Consolidated Omnibus Budget Reconciliation Act (COBRA) Participation
  - Family Medical Leave Act (FMLA)
  - Short Term Disability (STD) and Long Term Disability (LTD)
- Late Entrant Provisions – Clearly define when and under what circumstances a late entrant will be admitted into the plan to provide nondiscriminatory practices and help reduce exposure to the plan from individuals who elected not to participate prior to a health concern. To protect against anti-selection, a plan may want to specify that late entrants, other than those with a life event such as marriage, divorce, birth, etc., are not eligible for coverage until the next open enrollment period.

## 2. In-Network Incentives

A well-designed plan may provide an incentive for members to choose an in-network option when the network is effective.

- In- and Out-of-Network Differential – To help incent members to choose high-quality providers with good cost points, the plan sponsor may want to consider how much of a differential in co-insurance and deductibles would be needed to encourage in-network selections and design each tier of the plan accordingly.
- Accessibility – To help provide access to high-quality care, the plan sponsor also may want to consider whether the network includes providers in the majority of specialties in geographic locations convenient to the majority of its members.

## 3. Out-of-Network Charges

Regardless of incentives, there are situations where members will seek out-of-network care unknowingly, by choice or in an emergency situation. Defining how out-of-network reimbursements will be determined in the plan document can help reduce a plan's exposure to excessive charges. The plan may want to consider specifying that it will only reimburse out-of-network charges up to the maximum allowable charge, whereby the allowable charge is the lesser of:

- The provider's billed charges,
- Reasonable and customary charges, or
- A certain percentage (e.g., 175%) of the Medicare allowable reimbursement or other price reference, such as the Centers for Medicare and Medicaid Services (CMS) cost-to-charge ratio or other industry benchmark; or
- An amount negotiated by the claim administrator or a third-party vendor that has been agreed to by the non-participating provider.

Defining how reasonable and customary is determined in the plan document establishes a basis for the reimbursement. The plan may want to specify that it will reimburse an amount equivalent to a certain percentile (e.g., 80th) of payments made for the same or similar treatment, service or supply provided in the same geographic area by providers of like services. The reimbursements may be based on a commercially available database or other such reference, with consideration to the complexity of the individual's required treatment.

Applying the practices fairly and consistently across the plan will help substantiate the reasonableness further. The language also may specify that the plan has authority to determine what's considered reasonable and customary.

It is important that out-of-network language in the plan document clearly defines what the plan will pay so members also are aware that they may have additional financial responsibilities, some of which may not count toward maximum out-of-pocket expenses as defined by the plan and as limited by the ACA.

## 4. Mandatory Use of Case Management

When case management services are not required, the member may forego participation in these valuable services that may reduce the overall cost of care by helping to ensure an appropriate course of treatment. To increase participation, the plan sponsor may want to include a financial incentive, such as lower co-insurance, in the plan document when case management is used.

## 5. Clinical Trials and Experimental Treatments

The use of clinical trials and experimental treatments can raise many questions, particularly when considering whether or not a plan will pay for medical services for a person involved in a clinical trial. State and federal guidelines for ethical standards and regulations help protect individuals and govern clinical trials and experimental treatments, but the plan sponsor may want to limit coverage and/or require preauthorization when services are not mandated.

If the plan does not specifically exclude those that the plan sponsor does not want to cover, the presumption is that they are covered. Specifying in the plan document under what circumstances and to what degree the plan covers such services can help avoid costly treatments when there is no evidence as to the efficacy. It also establishes unbiased rules and sets expectations before the plan is faced with making point-in-time decisions that also can set precedence for future situations. Another way to limit exposure is to include a general exclusion that states that charges for services not specified are excluded.

## 6. Alternative Treatment Plans

Plans often limit the use of home treatments, skilled nursing and rehab facilities. While these limits may help to avoid overuse in some instances, the plan sponsor may want to consider including an alternate treatment option in the plan for when these types of facilities can be used instead of more expensive inpatient options.

- Medically Appropriate and Cost-Effective Options – To help avoid improper use, the plan sponsor may want to include certain requirements in the plan document that help demonstrate that the alternate treatment option selected is both cost-effective and medically appropriate.
- Non-Covered Services – The plan sponsor also may want to ensure that the plan language is specific so it does not permit otherwise “non-covered” services.

## 7. Genetic Testing

Similar to clinical trials and experimental treatments, specifying in the plan whether genetic testing is covered and under what circumstances may help protect the plan from paying for costly services that may provide little value to the member. This is especially true when there is a potential for an entire test package to be ordered when only one test is

deemed necessary. Unnecessary testing may be avoided if the plan requires medical reasons for tests (based on established guidelines, including peer-reviewed medical compendia) and further specifies that the only tests covered are those expected to determine a covered course of treatment or the prevention thereof.

## 8. Transplants

The use of Centers of Excellence (COE) for transplants can help to provide quality care and lower the overall cost of a transplant. Better outcomes can mean fewer complications post-surgery. To help encourage the use of COEs and the added benefit of having a case manager helping to direct care, the plan sponsor may want to consider putting the following requirements into the plan document for transplant-related services:

- Prior Authorization – When a request for authorization is received, it provides an opportunity to help direct care, negotiate prices and ensure accepted protocols are met.
- Participation in Case Management – When participation in case management is not enforced, members may choose to decline these valuable services that are focused on positively impacting claim costs and the overall quality of care.
- Use of an Approved COE Facility – When members are not incented to choose an approved facility, they may elect to use a facility that may not be as appropriate for care.
- A Second Opinion – The transplant may be found to be unnecessary by another professional, and another treatment option may be more effective.

The plan sponsor also may want to consider achieving compliance with these requirements through the use of a financial incentive, such as waiving certain costs or applying a penalty like a higher co-insurance amount.

## 9. Centers of Excellence (COEs) for Other than Transplants

Providing coverage for services through COEs rendered outside of a person’s local geographic region along with travel benefits can be beneficial to the patient and the plan. Cancer treatment centers with contracted rates may provide the best overall outcome. The plan also may want to provide certain services, such as bariatric surgical services, only when certain facilities are used or require that knee, hip and/or back surgery is done at certain facilities where rates have been pre-negotiated.

Defining in the plan document what is covered and what is not, including how follow-up treatment will be handled, is essential. Requiring prior authorization to approved facilities or through approved vendors also may help ensure successful outcomes. To help encourage patients to use less convenient locations when it is beneficial for their treatment as well as cost-efficient, the plan may want to consider waiving deductibles or other out-of-pocket expenses in those scenarios.

## 10. Medical Implants

The mark-up by distributors and facilities for medical hardware, such as cardiac, spinal and orthopedic implant devices, can increase the cost of claims. To help to control costs, the plan sponsor may want to consider specifying the following in the plan document:

- The Right to a Retrospective Review – The right to review the cost of medical implants and the right to re-price them based on a defined mark-up; and
- That an Invoice Is Required – An invoice from the supplier or a line item bill from the facility is required; or that
- Cost Reference Pricing Will Be Used – A cost reference, such as Medicare plus a pre-determined percent or other industry benchmark, will be used to limit payment for medical implants.

## 11. Dialysis

Dialysis services can be very costly, especially when they are provided for an extended period of time by a facility with high rates. To help manage the quality of care and costs, the plan sponsor may want to consider including the following in the plan document for dialysis services:

- Prior-Authorization Requirement – Prior authorization provides the opportunity for cost containment actions, such as negotiating costs prior to services being rendered or directing care to a preferred facility.
- Required Use of an Approved Treatment Facility – High-quality, lower-cost treatment facilities can greatly reduce the cost of care when dialysis is required.
- Coordination with Medicare – If the member is diagnosed with End-Stage Renal Disease (ESRD) and is eligible for Medicare Part A and enrolls in Medicare Part B, the member can get the full benefits available under Medicare to cover certain dialysis services.
- Dialysis Specific Reimbursement Language – To avoid excessive charges, a plan sponsor may want to consider putting non-discriminatory, specific reimbursement language into the plan document for dialysis services so that the cost is limited to an industry standard or reference price.

The plan sponsor also may want to increase the likelihood of compliance with the above requirements in the plan document through the use of a financial penalty, such as higher co-insurance, if they are not met.

## 12. Air Ambulance

Transportation by an air ambulance is costly and may be used more for convenience than medical necessity if the plan does not specify under which circumstances the service will be covered. Appropriate plan language can stipulate that air ambulance services will be covered only when it is used to transport a patient with an urgent medical need or when another mode of transportation would cause or is likely to

cause the patient harm, and then air transport is approved only to the nearest in-network (if applicable) facility with the appropriate specialty, unless approved otherwise in advance. The plan also may further specify that pre-approval is required for non-urgent air flight. Setting these parameters can prevent the plan from paying for such services unnecessarily and can provide the plan a better level of control.

## 13. Prescription Drugs

- Step Pharmacy Approach – To help control the use of high-cost, brand name prescription drugs, the plan sponsor may want to include provisions in the plan that require use of a less expensive generic alternative when available.
- Compound Drugs and Off-Label Drug Use – Requiring prior authorization for compound drugs or off-label drug usage exceeding a certain dollar amount can provide the opportunity for case management interventions when more expensive solutions are being employed and equally effective lower cost options are available. Some compound and off-label drug use will fall within clinical trials or experimental treatment guidelines; however, drug compounders and/or manufacturers may promote other uses.
- Specialty Pharmacy Drugs – The usage and costs of specialty pharmacy drugs continue to grow. To help control the use and administration of these costly treatments, the plan sponsor may want to consider one or more of the following options:
  - Require Prior Authorization – Prior authorization for drugs exceeding a certain dollar amount can provide the opportunity for the plan to direct the member to a specialty pharmacy vendor that has competitive pricing.
  - Using a Specialty Pharmacy Vendor – Carving out the pharmacy benefit from the plan and using the right specialty pharmacy vendor with a focus on cost management may provide valuable services and help to control costs. If the pharmacy benefit is carved out, the plan sponsor may want to consider how the data on medical expenses is combined with pharmaceutical costs. Having a more complete understanding of the cost of a member's care on an ongoing basis may help to identify potentially large claims early enough in the course of treatment to be able to use successful cost containment services.
  - Making Specialty Pharmaceuticals a Major Medical Expense – When these drugs are covered under the major medical plan instead of the prescription drug plan, the plan may see the cumulative cost of a member's care earlier in a plan year to be able to use cost containment services.

## 14. Medical Errors/Never Events/ Substandard Care

While there are really no guarantees for medical services, and a multitude of factors can affect successful outcomes, there may be circumstances where the plan should not be financially responsible for an individual's care, such as when the service is to correct substandard provider care or for an event that never should have happened, such as surgery on the wrong body part.

To help protect a plan from the liability related to substandard or erroneous care, the plan document may add a limitation or exclusion that specifies provider reimbursements will not be made or will be reduced when services are medically necessary due to a serious illness or injury acquired in a hospital or other patient care setting that for the most part should have been prevented.

The National Quality Forum (NQF) defines such events as Serious Reportable Events (SREs) commonly known as "never events." Some states have adopted the NQF SREs, while others have either modified or created their own or have not enacted reporting systems. These guidelines can help define what is considered substandard care. And while substantiating a denial may be difficult, having the language in the plan document provides a basis for disputing charges.

## 15. Assault and/or Participating in a Felony

Plan sponsors looking to limit coverage for members involved in unlawful acts may want to avoid specifying that coverage is excluded when the individual is convicted of an assault or felony. While the intention may be to exclude coverage for care when the member is acting in an unlawful manner, including a requisite that the individual needs to be convicted opens the plan up to paying for services that otherwise may be excluded.

The plan may instead exclude coverage for individuals who incur any costs as a result of the individual committing or attempting to commit a crime. Many offenses do not end with a conviction due to plea bargaining or other legal agreements, so using conviction as a requisite leaves the plan open to paying for the care. And, if the individual is convicted, it may take several years, leaving the plan liable for an extended period of time and open to recovery.

## 16. Traveling Abroad

The plan sponsor may want to consider specifying in the plan that when traveling abroad, the member will be covered only in emergency situations for a defined period of time. This may help the plan avoid high-dollar claims where the plan has little control.

## 17. Coordination of Benefits (COB)

Specifying the COB right of recovery clearly in a plan document can provide the plan an advantage in recovering claims costs where another party is responsible. The plan sponsor may want to consider including the following provisions in the plan document:

- Right of Recovery – Specify that the right of recovery is on a COB basis instead of subrogation to allow the plan to recover claim costs in certain states where subrogation is not allowed.
- Order of Benefit – Specify that other plans that do not have coordination provisions will pay first.
- Order of Recovery – Define the order of recovery as: the last to pay is the first to recover.

## 18. Subrogation

Many plans have subrogation clauses that provide the plan sponsor the right to subrogate when a third party is liable for a loss suffered by a plan participant and the participant has recovered the loss from a third party. Difficulty may arise when a plan participant does not pursue recovery from the other party and the plan does not have the right to pursue that party. To help ensure the plan sponsor's rights, the subrogation clause in the plan document could include the right to take action.

# How It Can Work

## Examples of How Plan Design Elements Can Help to Control Costs

### Pre-Certification for Dialysis Services

When pre-certification is not required for dialysis services, a person could be receiving services without the TPA or Stop Loss carrier's knowledge until a bill is received. In that case, any price negotiation takes place after the treatment has begun. If the provider refuses to negotiate on services already rendered, no savings can be achieved. When pre-certification is required, the TPA knows up-front that dialysis is needed and can pro-actively contact the provider to negotiate costs prior to service.

**Example:**<sup>2</sup>

| Cost of Dialysis Services | Negotiated Discount | Savings from Requiring Pre-Certification |
|---------------------------|---------------------|--|
| \$30,000 per month        | 30%                 | \$9,000 per month                        |

### Language to Limit Costs of Implants

Some surgeries require implants like rods, pins and screws. They can be quite costly. If plan language does not require a supplier invoice or limit payments to cost plus a reasonable mark-up, it is difficult to limit the total charge for such devices. However, when plan language requires a supplier invoice and/or limits payment to the cost of the items plus a reasonable mark up, costs can be reduced.

**Example:**<sup>2</sup>

| Billed Cost of Implant | Actual Supplier Invoice for Implant | Mark-up Defined by Plan | Approximate Plan Payment with Defined Mark-up | Savings from Reduction |
|------------------------|-------------------------------------|-------------------------|---|------------------------|
| \$652,000              | \$150,000                           | 40%                     | \$210,000                                     | \$442,000              |

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<sup>1</sup> Source: Aegis Risk Medical Stop-Loss Premium Survey, 2014 and 2015. The Survey is sponsored jointly by Aegis Risk and the International Society of Certified Employee Benefit Specialists (ISCEBS).

<sup>2</sup> Examples are for illustrative purposes and do not necessarily represent actual savings that may be achieved.

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