Session 25 IF, Doctors without Networks: Alternative Arrangements for Medical Benefits

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Doctors Without Networks-Alternate Arrangements for Medical Benefits

Why Would a Doctor be Interested in a Transparent Pricing Model?

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- Our History
- The Journey
- My indoctrination with transparent pricing
  - Keith Smith, MD... Surgery Center of Oklahoma
Transparent Pricing... the parties involved

- The Patient-Physician Relationship
- The Patient
- The Physician
The Patient-Physician Relationship

• For centuries, healthcare has been based upon a personal relationship between a patient and their doctor
• Outside of a Third party based network, the patient and physician return to being the primary decision makers for the patient’s benefit
The Patient

• Returns the role of insurance to that of preparation for the unexpected
• Increases the quality of medicine practiced
• Improves access to medicine
• Reduces the cost of medicine
• Healthcare inflation is DEFLATED due to transparency... costs are known
• When doctors compete based on price, they also compete based on quality
The Physician

• Bureaucratic burden decreases
  — Benefit of keeping doctors in private practice
• Focus on providing medical treatment
  — Allow the doctor to do what they do best
• Levels the playing field with corporate medicine
• Restores physician control for honest pricing and charitable contribution of care
No network, not a problem

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ASO OR TPA:
LEARNING BY EXAMPLE

Presented by:
Adam V. Russo, Esq.
CEO, The Phia Group, LLC
ASO VS. TPA

Security

Carve-Outs
Direct Provider Agreements
Employee “Skin in the Game”
Auditing
Narrow Networks

Risk & Cost Containment
ASO:

“You agree to apply the terms of Our Summary Plan Description, regardless of any provision otherwise found within any other coverage document You offer.”
TPA:

“Claims will be adjudicated in accordance with the terms of the Plan Document including any ‘carve outs,’ usual and customary calculations, or other cost-saving measures, as applicable.”
ASO:

“Plan Sponsor may amend the Plan to change the Benefits provided to its Members at any time during the term of this Agreement, provided that Claims Administrator approves the amendment in writing.”
TPA:

“Plan Sponsor retains the ultimate responsibility for **drafting and approving the Plan Document**. TPA shall adjudicate claims incurred according to the terms of the Plan Document.”
With a TPA, you can do the following:

- Dialysis carve-outs
- Specialty drugs
- Reference-based pricing
- Employee incentives
- Medical tourism
- Claims auditing
- Free-market medicine
- Wellness programs
- On-site clinics
- Narrow networks
- Direct contracts
- “Telemedicine”
- Concierge doctors
- Data aggregation

...and more
THANK YOU!

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THE PROBLEM

Insurance PPO Networks have discounted prices which vary by 1,000% or more

They have very little transparency of quality, outcomes and pricing

PPO Networks virtually prohibit competition

The natural laws of supply and demand are replaced with the law of entitlement

Entitlement destroys transparency and competition

The Market creates transparency and competition
ENTITLEMENT

When I have health coverage, whether public or private, I pay for it

1. Whether it is part of my compensation
2. Whether I pay a portion or all of the premium
3. Whether it is paid out of taxes
4. Or whether I share in the cost at the point of service

If I pay for something, I feel entitled to use it
Mandated transparency, without the market forces of competition, is like a mirror without a comb. Just as legislated happiness would produce plastic smiles, legislated transparency produces a rear view mirror, with little effect on the road ahead...Ralph Weber 2014
CAN TRANSPARENCY BACKFIRE?

Yes

Employee earns $18,000
Pays $125/month premium
Has $6,500 deductible
Out $8,000 before he gets any value from the plan

Which provider will he pick?
## HOSPITAL PPO PRICING

<table>
<thead>
<tr>
<th>Hospital</th>
<th>MRI Price</th>
<th>Discount</th>
<th>Knee Replacement Price</th>
<th>Discount</th>
<th>weighted Discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$1,240</td>
<td>25%</td>
<td>$29,000</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$527</td>
<td>75%</td>
<td>$57,000</td>
<td>25%</td>
<td>50%</td>
</tr>
</tbody>
</table>

This is a simplified illustration weighted over thousands of procedures.
## WHAT'S THE RIGHT QUESTION?

<table>
<thead>
<tr>
<th>HOW MUCH DO I SAVE</th>
<th>HOW MUCH DO I PAY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed Charge</td>
<td>Billed Charge</td>
</tr>
<tr>
<td>$10,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Discount 55%</td>
<td>Discount 40%</td>
</tr>
<tr>
<td>$5,500 savings</td>
<td>$2,000 savings</td>
</tr>
<tr>
<td>$4,500 Paid</td>
<td>$3,000 Paid</td>
</tr>
</tbody>
</table>
## NATIONAL COSTS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>National PPO Allowable</th>
<th>Medicare Rates</th>
<th>MediBid Actual Bids</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
<td>100%</td>
</tr>
<tr>
<td>Knee MRI WO</td>
<td>$500</td>
<td>$2,866</td>
<td>$281</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>$24,890</td>
<td>$73,947</td>
<td>$14,604</td>
</tr>
<tr>
<td>Knee Arthroscopy</td>
<td>$2,803</td>
<td>$14,637</td>
<td>$1,942</td>
</tr>
<tr>
<td>Hernia Repair</td>
<td>$3,449</td>
<td>$10,778</td>
<td>$2,187</td>
</tr>
<tr>
<td>Total Hip Replacement</td>
<td>$20,059</td>
<td>$70,934</td>
<td>$14,486</td>
</tr>
<tr>
<td>Anterior Discectomy</td>
<td>$11,442</td>
<td>$35,755</td>
<td>$8,270</td>
</tr>
</tbody>
</table>
CASE STUDY IN REFERENCE BASED ALLOWABLES

An employer switched to a reference based allowable plan on 2/1 from an ASO plan with a carrier.

An employee was scheduled for a laparoscopic procedure.

The billed charges would be $72,000. After a likely discount the allowable would have been $40,000.

Employee would have paid $6,000-$7,000 on old plan.

The previous plan would have paid $34,000-$66,000.

Under the new plan, the facility would not offer a discount, so the new plan would pay $14,000 and the employee would pay $58,000.

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THE POWER OF CONSUMERISM

The Employee made an online request and a facility 2 miles away came in with a global bid of $21,000

Employee would pay $7,000, the plan would pay $14,000

He also got bids from nearby states

A facility in Phoenix (with a better surgeon) bid $11,650, so the employer agreed on a $1,000 travel allowance

The employee had no out of pocket costs, and has a reasonable travel allowance

The plan will pay $12,650
THE TALE OF TWO HIPS

A patient needed a hip replacement in 2013.

It was scheduled in Dallas, but then 5 days before the surgery, the hospital called the Patient and said the carrier would not pay, but that they would offer a 30% cash pay discount. After discount, the cost would be $70,000, and the procedure had a 6 month recovery.

He got bids on the procedure ranging from $7,000 to $21,000. The one for $21,000 was the most expensive bid, but the surgeon practiced a minimally invasive technique.

The surgeon was right there in San Antonio.

Two months ago, he had the other hip done. Same hospital, same surgeon, but the insurance company paid $30,000 plus he paid $6,500 OOP.
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Direct Primary Care

- Physicians are paid directly rather than through insurance, usually via a monthly fee
- No copays, deductibles or coinsurance
- All primary care services are covered, including preventive care, basic tests, care coordination, and care management at no additional cost
- May include labs, images and medications at wholesale cost
- Same day appointments of 30-60 minutes, 24/7 access to the physician via text, email or phone
- Affordable monthly fees
- DPC + “wrap around” or high deductible insurance is acceptable coverage under Section 1301(a)(3) of ACA
- DPC is a rapidly growing practice model. There are currently nearly 5000 practicing DPC physicians in the US, up from 146 in 2005 and 756 in 2010
DPC – Advantages to the Physician

• More of this:
  – More time providing care
  – More stable revenue
  – Better patient outcomes
  – Doctor – patient relationship

• Less of this:
  – Less time spent on paperwork and administrative tasks like filling out insurance forms, negotiating payment rates and prior approvals, navigating complex coding requirements
DPC – Advantages to the Patient

• Better access to the physician and to needed primary care
• Costs for primary care are more transparent and predictable
• Care is more comprehensive and coordinated, leading to significantly improved outcomes. A study of one large DPC practice found
  – 35% fewer hospitalizations
  – 65% fewer emergency department visits
  – 66% fewer specialist visits
  – 82% fewer surgeries
• Savings can be considerable. In one study, the decrease in preventable hospital use saved $2,551 per patient, which is more than the cost of the DPC membership fee
• Another study concluded that unlimited primary care makes health care 20% less expensive yet leaves patients feeling more satisfied with their care
DPC – Advantages for the System

• Improved doctor-patient relationship
• Higher satisfaction for doctors and patients
• Better care, better access to care, and improved outcomes for patients
• Savings for patients and 3rd party payers, leading to lower spending and lower premiums. DPC seems to have potential for bending the health care cost curve
• Moving toward true insurance. With DPC plus wraparound insurance, we are no longer trying to force events that are not insurable (routine, predictable primary care expenses) into the insurance mechanism
• DPC can be effective for self-funded employers, Medicaid, Medicare Advantage, and public exchanges
• Direct care models can also be effective for some specialties, such as pediatrics, cardiology and psychiatry
Additional Information