Special Webcast

How to Improve Claims Savings with End-to-End Transparency

September 28, 2021

THE CONFERENCE BOARD

DirectPay

Some of the critical questions and issues we will be answering today

- Learn how claims management and members are negatively impacted by traditional out-of-network claims repricing methods.
- Recognize important best practices for claims repricing and strengths and weaknesses of different industry programs
- Benefit plans and members deserve to have predictable and cost-effective out-of-network claims repricing and payment administration
- How end-to-end transparency in claims administration can produce improved benefit plan and member satisfaction

Earn Credits

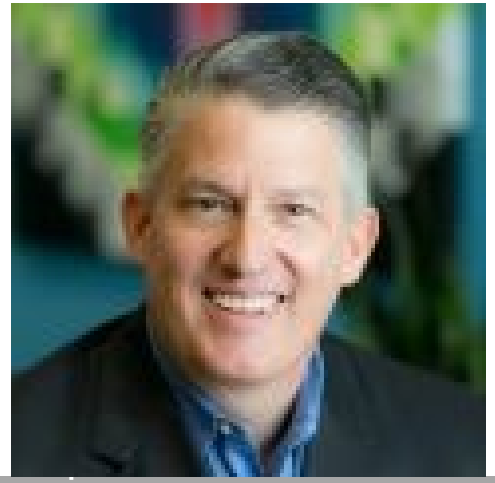
HRCI, SHRM, CPE (NASBA) Click the link in the **CEU Request Widget** to sign up for credit

- ✓ Stay online for the entire webcast
- ✓ Click ‘ok’ for 3 popups that occur during the program
- ✓ Credit available for participation in live webcast only

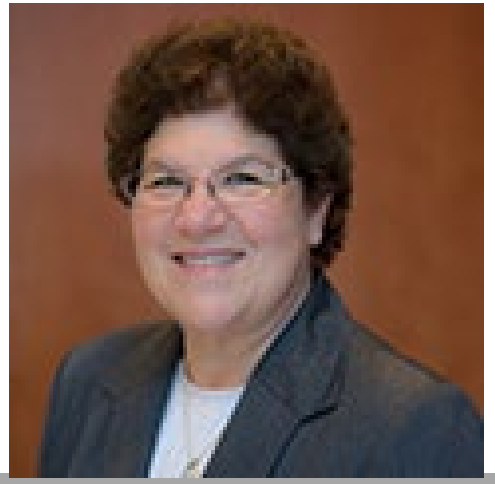
SIGN UP FOR AVAILABLE CEU CREDITS

Making the most of the webcast

Today's Speakers



Scott Smith
Chairman of the Board
TRPN DirectPay Inc.



Deb Cohen, PhD
(Moderator)
Consultant and
Distinguished Principal Research Fellow
The Conference Board

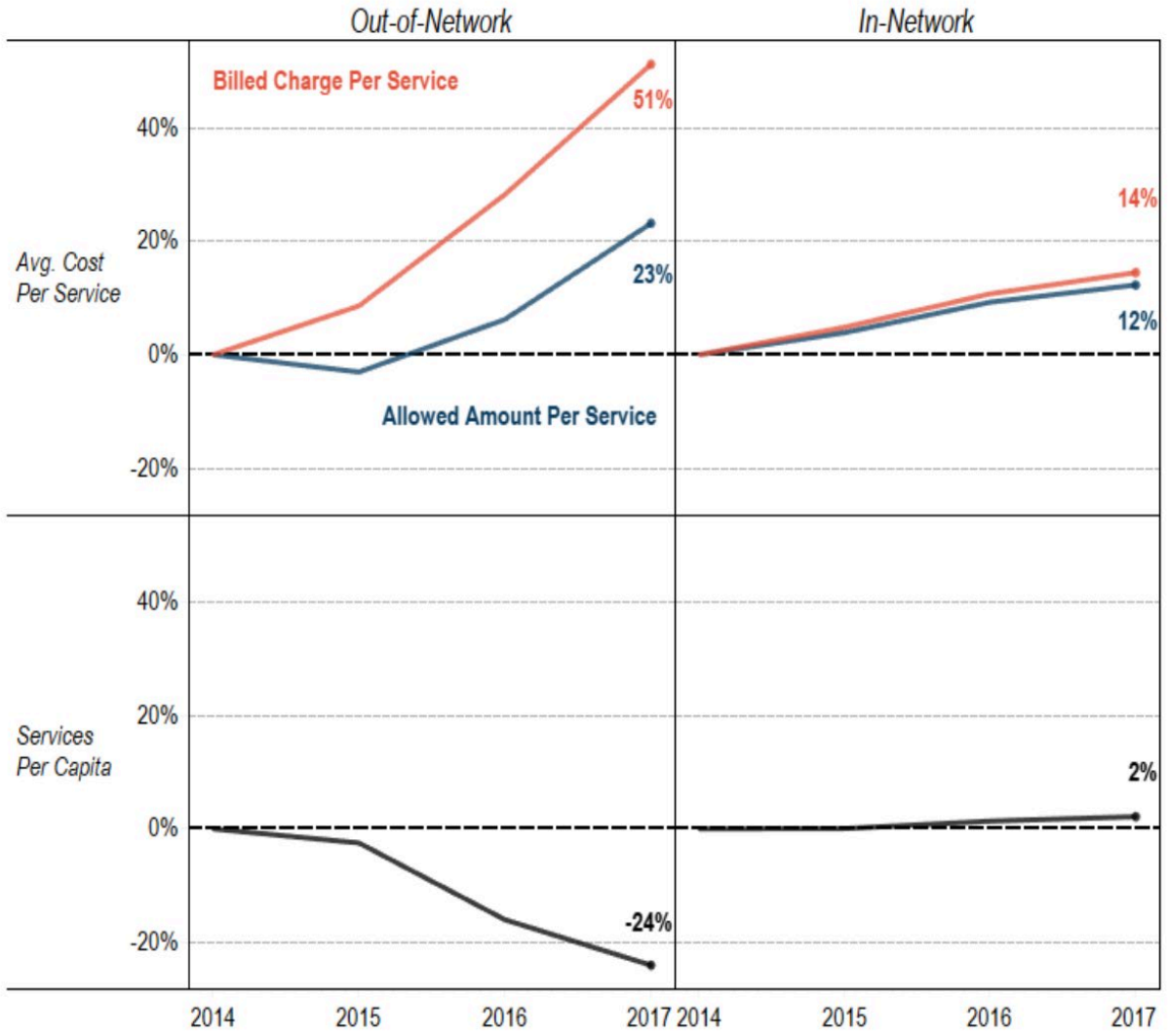
Out-of-Network Spending: Why Growing Attention

Current Situation:

Out-of-Network spending represents a small portion of total spending and has remained stable representing an average of 6.6 percent of total allowed spending per year from 2008 to 2016 among commercially insured.

The potential financial burden for those who received OON has increased. OON charges per service have grown rapidly, exposing patients to potentially larger balance bills.

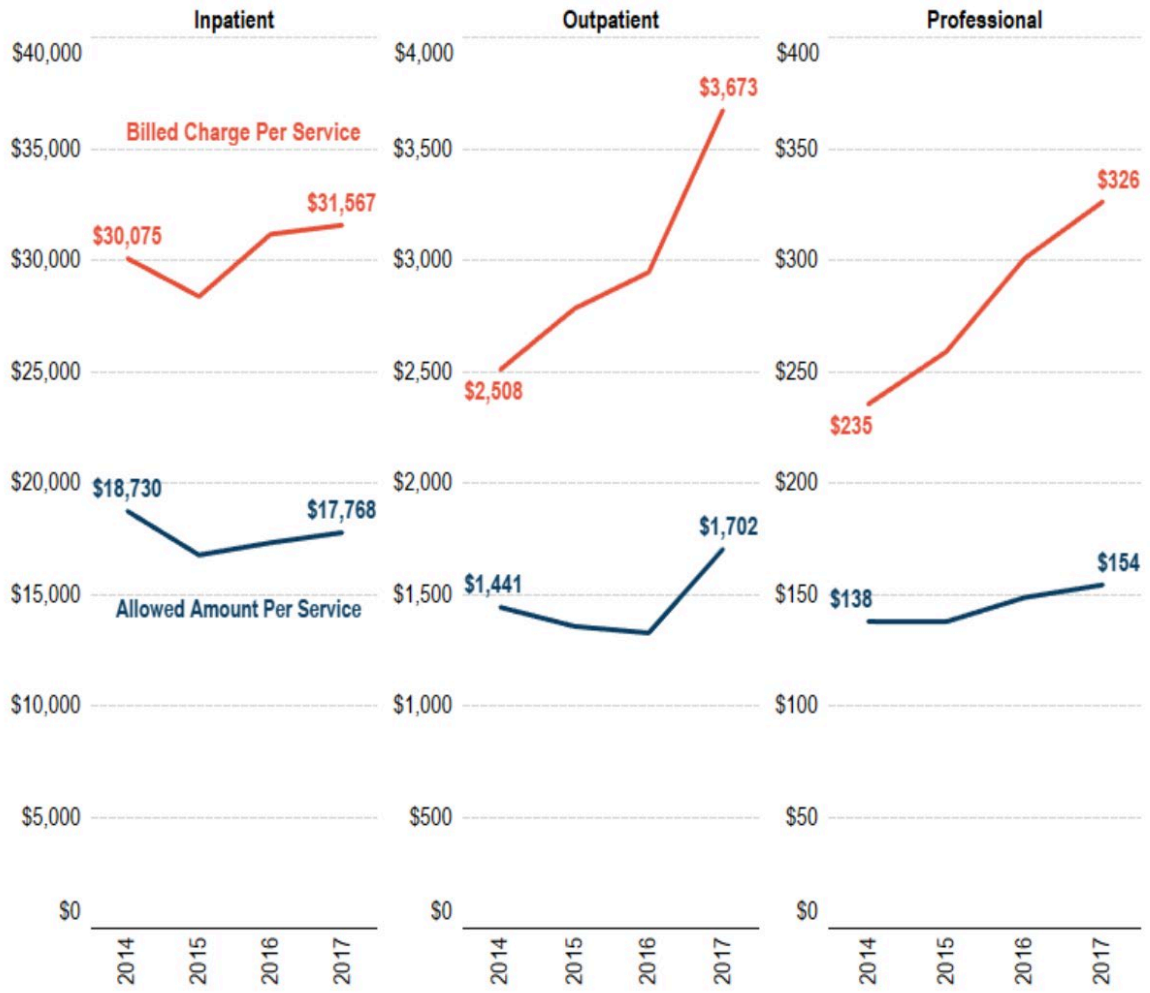
Change in billed charges vs. allowed amounts per service for in-network, out-of-network care 2014-2017



Source: Authors' analysis of Health Care Cost Institute commercial claims data, 2014-17.

- OON services decline, cost of care increased greatly – average allowed spending per service grew 23%, in-network grew 12%
- Avg OON billed charge per service grew 51% and in-network grew 14%. A shift in more expensive services moved to OON
- Use of OON services decreased 24%

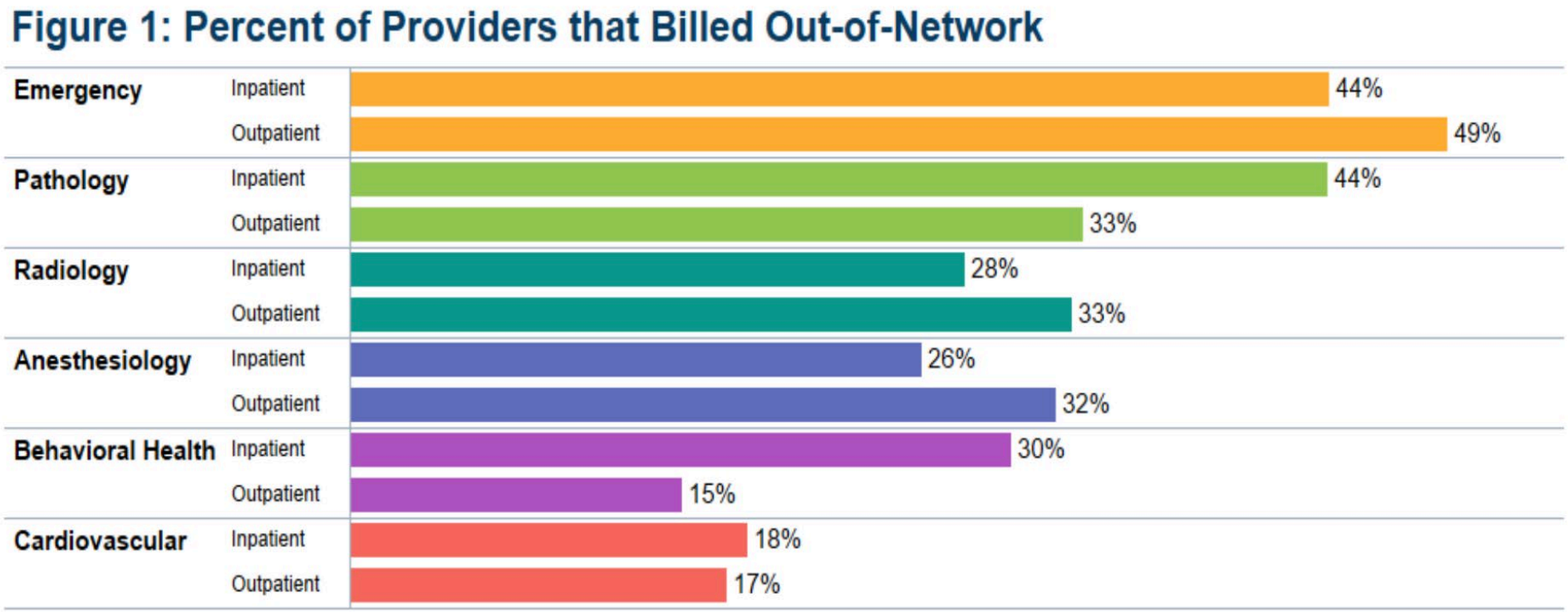
Rapid Increase in Out-of-Network Billed Charges Increased Potential Balance Bill



- OON billed charges per service grew more than 2x rate of allowed amounts (51% vs 23%).
- True across all 3 categories.
- Result: the gap between average billed charge and allowed amount equals potential balance bill. Risk grew 22%, outpatient services fastest relative growth 85%
- Conclusion: Potential balance bill faced by patients who received OON care has dramatically increased over time.

How often do providers bill out-of-network?

Less than half of specialist providers bill out-of-network



Health Care Cost Institute May 28, 2020

Provider Billing as Ratio to Medicare

Brookings Study all Physician types charge between **239% to 460%** of Medicare

Rand Study Hospitals and Health Systems charge between **198% to 420%** of Medicare

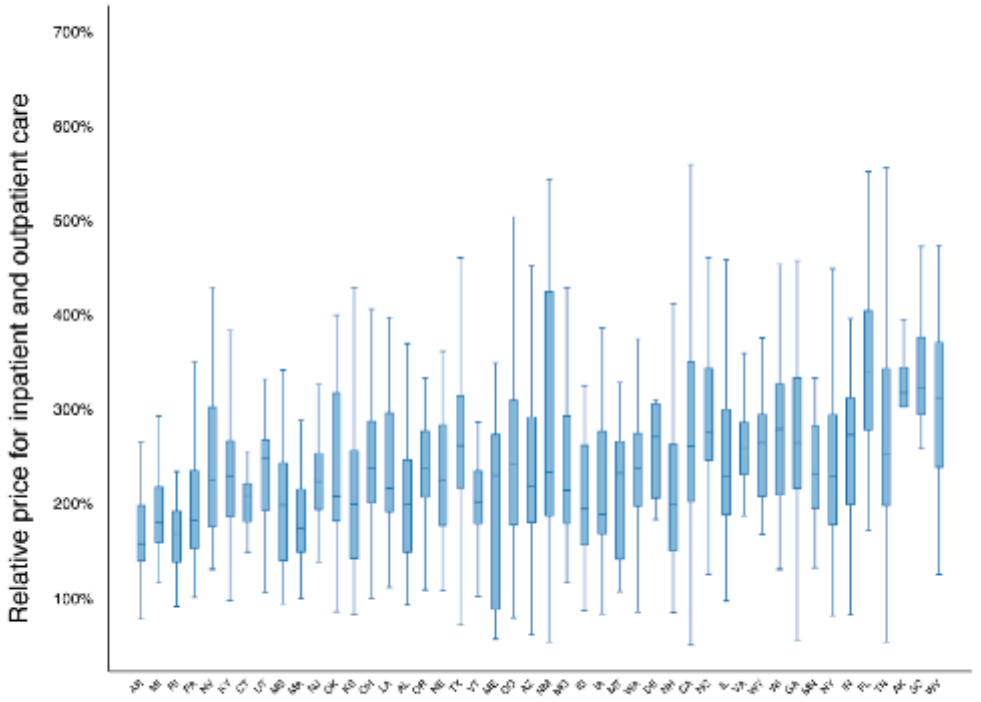
Table 1. Ratio of Charges to Medicare Rates by Physician Type, CY 2016

	Median	20th Percentile	80th Percentile
Emergency and Ancillary Physicians			
Anesthesiology	5.51	2.52	11.08
Emergency Medicine	4.65	2.79	7.50
Diagnostic Radiology	4.02	2.64	8.03
Pathology	3.43	2.25	5.10
Other Specialists			
Cardiology	2.59	1.73	4.57
Orthopedic Surgery	2.48	1.68	3.91
General Surgery	2.39	1.68	4.13
Primary Care			
Family Practice	2.03	1.38	3.82
Internal Medicine	2.03	1.39	3.45
Summary			
All Physicians	2.39	1.49	4.60
All Emergency and Ancillary Physicans	4.03	2.57	8.00
All Other Specialists (Not Emergency and Ancillary Physicians)	2.27	1.46	4.01
All Primary Care	2.03	1.39	3.54

Source: Authors' analysis of Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files, calendar year 2016. All Other Specialists includes all other specialist physicians included in the data, i.e., it is not restricted to only those examples listed under other specialists in the table.

USC Schaeffer BROOKINGS

Figure 4.3. Distribution of Relative Prices, by State, 2018



NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas. For each state, this figure denotes the 25th-percentile, median (50th-percentile), and 75th-percentile relative prices.

Problem – Out of Network Claims

Brookings Study all Physician types charge between **239% to 460%** of Medicare

Rand Study Hospitals and Health Systems charge between **198% to 420%** of Medicare

Out-of-Network Claims negatively impact both plan sponsor and members

- Unpredictable
- Create excessive cost

- 15-20% of visits result in Members being Balance Billed
- Member dissatisfaction, financial hardship, collection risk and abrasion
- Benefit Plans exposure to ERISA risk without having direct provider contracts securing discounts. Discount reversal further impact to benefit plan and member expense.
- Intermediaries erode 30-50% of savings generated.

Out-of-network claims represents one of the most significant pain points for the employer and employee

Out-Of-Network Realities

- The average out-of-network claim paid is 2x – 3x higher than what Medicare pays for the same service; often, claims are reimbursed at 10x or more than Medicare.
- Billed charges are typically 3-5x higher than what Medicare pays for the same service, having a significant impact on the cost sharing for employees (i.e., balance billing).
- Health plans (and their subcontracted cost containment firms) routinely retain 30% or more of provider discounts associated with out-of-network claims.
- Emergency services are a particular problem – employees are trapped as many hospitals use out-of-network physicians in their emergency room (e.g., 1 out of 7 ED visits in NJ). In 2016, the average surprise bill for an employee was $622.55.(1)
- Out-of-network business is more conducive to fraudulent billing practices.

Bottom Line: As out-of-network claims continue to skyrocket, the entire health industry is rewarded while employers and employees pay the price.

(1) Source: Z. Cooper, F. Scott, ,N. Shekita, Yale University (2017, July), Institution for Social Policy Studies, 'Surprise! Out-of-Network Billing for Emergency Care in the United States', (online) available at https://isps.yale.edu/sites/default/files/publication/2017/07/surpriseoutofnetwrokbilling_isps17-22.pdf

Key Takeaways – Why this Really Matters!

- Insurance companies are aggressively cutting new deals with their employer customers for out-of-network business. ***Out-of-network business is a <u>significant lever</u> used by insurance companies to drive profitability***.

- Little to no transparency exists when it comes to out-of-network claims. ***Employers and employees are <u>at the mercy of health insurers</u>, for out-of-network claims***.

- Currently, the mark-up that exists with OON is unsustainable. ***<u>Even when deals are struck</u> with individual out-of-network providers, the employer pays an inordinate administrative fee***.

<u>Bottom Line</u>: Benefit plans must establish direct control over out-of-network claims.

OON Claims Alternatives

- **Reference Based Repricing – using reference pricing models.** Popular parameters used for reference-based pricing include Medicare pricing, the provider's reported costs, average wholesale price, third party databases, and more. Simply put, reference-based pricing is so-named because the plan's *pricing* is *based* on a *reference*.
- **Negotiations –** Establish a baseline for fair reimbursement with cost-based benchmarks and negotiate case by case.
- **Do nothing and member responsible**
- **Supplemental PPO Networks –** route via EDI to 1 or more supplemental PPO networks in search of a provider contracted discount.

Legislation

No Surprise Act

Interim final rule (the Interim Final Rule) implementing certain provisions of the No Surprises Act,[1] which aims to address balance bills on a national scale.

Effective for health insurance plan years beginning January 1, 2022, the legislation limits patient payment responsibility for certain unavoidable out-of-network services, prohibits providers and facilities from balance billing patients for those services, establishes price transparency disclosure requirements for providers and insurers, and mandates creation of dispute resolution processes for patients, providers, and insurers to address unanticipated medical bills.

Legislation

Transparency in Coverage

Hospital Price Transparency Final Rule went into effect at the start of 2021, requiring hospitals to publish their negotiated rates with insurers along with discounted cash prices for 300 common services. Like the new rules for health insurers, hospitals must provide online consumer transparency tools and machine-readable files for research and analysis purposes.

Health insurers to provide personalized information about consumers' out-of-pocket costs for covered services via an online, self-service tool. An initial set of 500 "shoppable services" are supposed to be available to consumers in 2023, with the rest to follow in 2024.

Insurers will also need to publish the underlying negotiated rates paid to healthcare providers, historical information on charges from and payments to out-of-network providers, and negotiated rates and historical prices for covered prescription drugs.

Who we are

National PPO Supplemental Network

Major Player

25+ years Operations

Experienced

2.6M contracted provider locations

BIG Network

Serve 180 payers, TPAs and Benefit Plans

Valued

100M members access TRPN DirectPay

Scale

Manage 1.7M+ claims per month

Consistent

Administer provider claims payments

Turnkey

Simplified OON Claim Payment Process

DirectPay is a claims payment process that integrates medical claims review and provider payment administration into a seamless application and payment process into current Employer ecosystem directing all OON claims to DirectPay

01 Adjudicate the claims as normal

Current ASO / Carrier

02 Determine appropriate payment to care provider

ASO Benefit Plan applies Max Benefit Allowable

03 Remit fully adjudicated claim and payment to DirectPay

EDI Claims and funds Fiduciary Bank account

04 DirectPay pays provider with final EOP

DirectPay reprices deeper discounts pays Provider 48 Hrs.

Core Elements

1

Uses a Proprietary Settlement Agreement

- PSAs have been used for 25+ years by every major group health, workers comp and auto carrier
- Final payment is contractually-based and tied to an Index Rate
- No required logo identification or steerage language

2

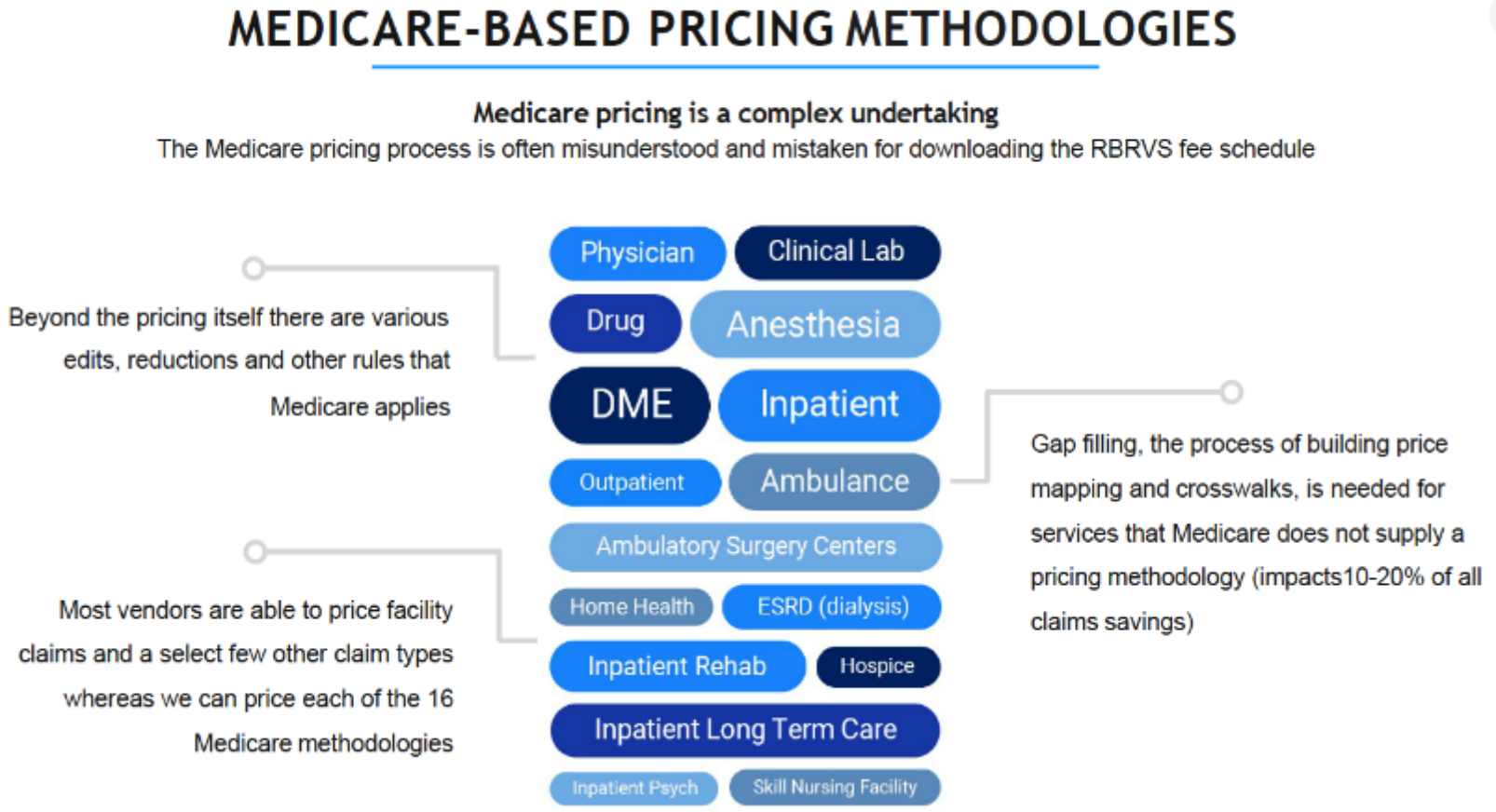
Guarantees no recourse by care provider to member

3

Simplifies payment resolution

Bill Review Repricing

DirectPay leverages a supplemental gap fill method to price Professional, DME, and Clinical Lab procedure codes that are not covered by Medicare and are therefore not included in Medicare fee schedules. This method uses procedure code level data compiled by the Veterans Administration Chief Business Office as instructed in the Federal Register.



Index Savings

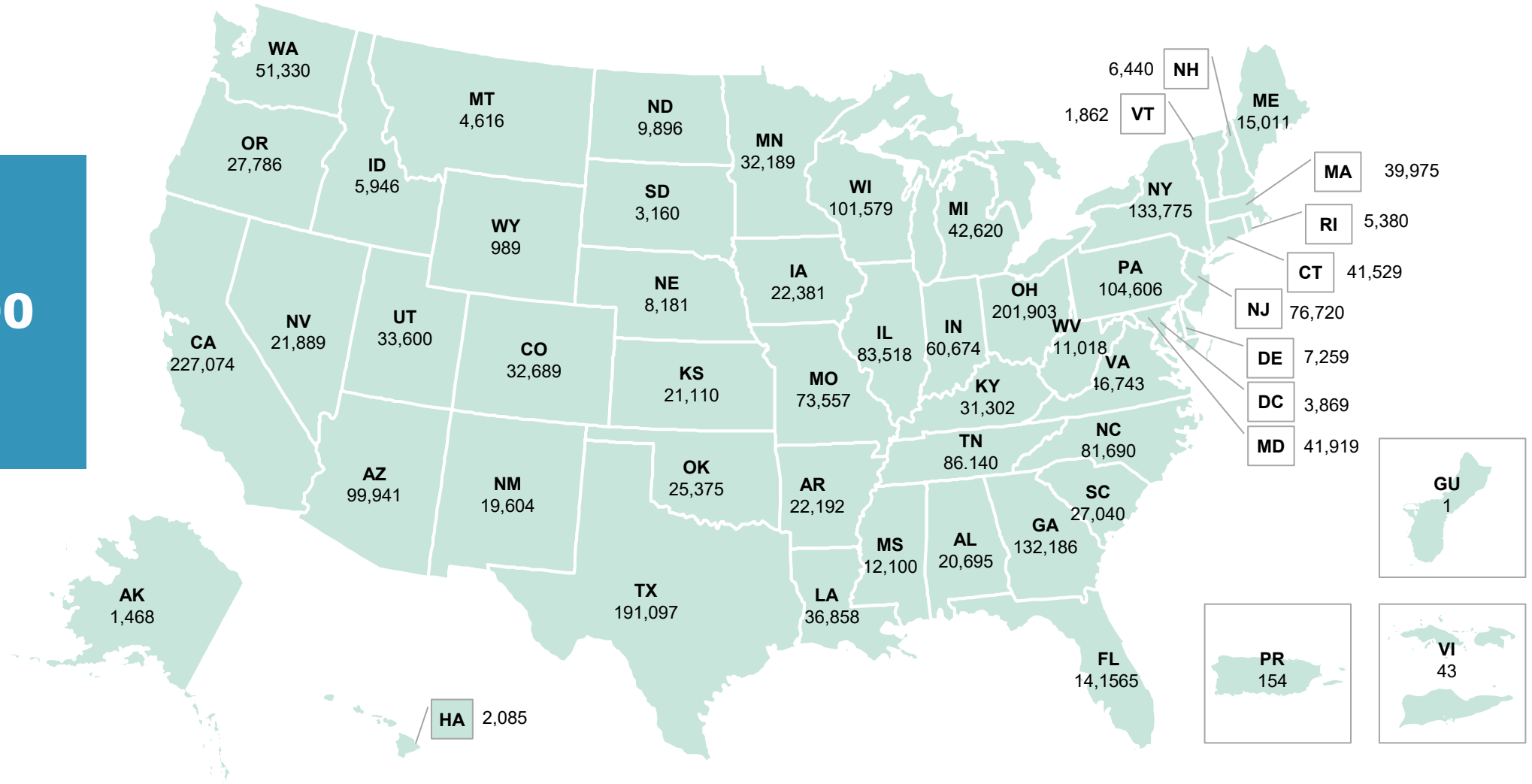
State	UB Discount	HCFA Discount	Total Discount
AK	67%	72%	72%
AL	89%	74%	74%
AR	77%	67%	57%
AZ	85%	67%	69%
CA	90%	72%	74%
CO	67%	62%	60%
CT	72%	65%	65%
DC	77%	69%	69%
DE	70%	69%	69%
FL	85%	82%	83%
GA	91%	66%	68%
HI	73%	61%	62%
IA	81%	53%	57%
ID	78%	63%	64%
IL	83%	70%	71%
IN	74%	70%	70%
KS	77%	58%	58%
KY	79%	66%	72%

State	UB Discount	HCFA Discount	Total Discount
LA	77%	82%	82%
MA	76%	58%	58%
MD	90%	68%	75%
ME	44%	66%	66%
MI	74%	63%	63%
MN	81%	67%	69%
MO	88%	63%	64%
MS	87%	67%	68%
MT	68%	53%	54%
NC	93%	66%	68%
ND	64%	51%	52%
NE	87%	58%	58%
NH	79%	56%	57%
NJ	87%	84%	84%
NM	74%	53%	60%
NV	85%	73%	78%
NY	88%	86%	87%
OH	71%	74%	73%

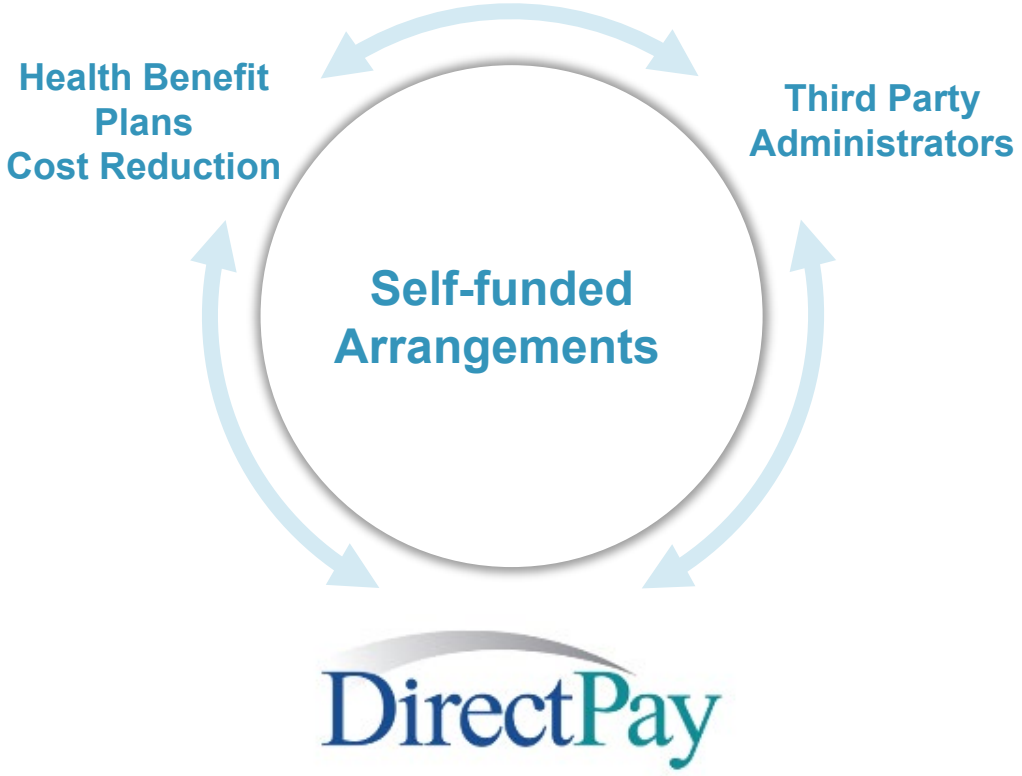
State	UB Discount	HCFA Discount	Total Discount
OK	80%	78%	78%
OR	83%	76%	76%
PA	87%	63%	64%
PR	64%	67%	65%
RI	57%	54%	55%
SC	73%	70%	70%
SD	77%	72%	72%
TN	81%	80%	80%
TX	86%	86%	86%
UT	83%	75%	76%
VA	83%	65%	65%
VT	74%	55%	60%
WA	92%	63%	64%
WI	77%	75%	75%
WV	71%	61%	61%
WY	58%	68%	67%
National Avg	**78%**	**67%**	**68%**

Provider Locations

2,536,329.00
TOTAL PROVIDERS



DirectPay Program



Plugs into Existing Ecosystem

Results in:

- Lower Plan Total Costs
- Annual Savings Range $7M - $65M
- Provider Contracts – Hold Harmless and No Member Balance Billing
- Faster Payment for Providers
- Reduced Member Abrasion
- Employer Greater Realization of Savings
- Guaranteed Discounts
- ERISA Protection with Direct Provider Contracts

Pricing

- **Free Claims Savings Analysis – 12 Months Out of Network Claims**
- **No Implementation or Set Up Fees**
- **Monthly Administration Fee**
  - Based on Program Metrics
  - Either Fixed Cap Rate or Access Fee % of Savings
- **Shared Savings**
  - No Shared Savings up to Maximum Benefit Plan Allowable
  - 50 / 50 Shared Savings Below Maximum Benefit Plan Allowable

Recap Summary

Problem: Benefit Plan and Member costs for out of network claims are unpredictable and excessive up to 500% of Medicare with members many times getting surprise bills and or being balance billed.

Break Through: DirectPay is a national PPO supplemental network having all its providers under direct contracts of Medicare 120-200. DirectPay pays adjudicated claims to its network providers and guarantees discounts. No impact on member or member requirements.

Impact: DirectPay employer savings range $11.3M to $65M per year. Employers realize full value of program savings directly from DirectPay. Members guaranteed no balance billing.

Traction: DirectPay is fully operational with its PPO network for over 25+ years and now is direct contracting with employers. DirectPay has a number of carrier and self-insured benefit plan clients utilizing network services. Implementation at any time in ~ 90 days without any member impact.

Pricing: Monthly administration fee based on program requirements
Shared savings on savings below plan maximum benefit allowable.

Discussion

Thank You

Upcoming Webcast Programming from The Conference Board

- How to Strategically Measure Program Impact Through Data Trends **(September 29, 2021)**
- Inclusive Leadership for Building Equitable Organizations **(October 7, 2021)**
- The Employee Experience: Definition, Measurement, and Its Role in Promoting Positive People and Organizational Outcomes **(October 12, 2021)**

View all our upcoming webcast programs at
https://www.conference-board.org/webcasts/upcoming/

NEW Podcast Series: C-Suite Perspectives - Insights for What's Ahead™

Hosted by our CEO, **Steve Odland**, this bi-monthly series features in-depth interviews with thought leaders from The Conference Board to provide senior and C-suite executives with data-driven insights to prepare them for what's ahead.

Available on our website at https://www.conference-board.org/podcasts/c-suite-perspectives-podcast or on most popular podcasting platforms, including:

Listen on Apple Podcasts

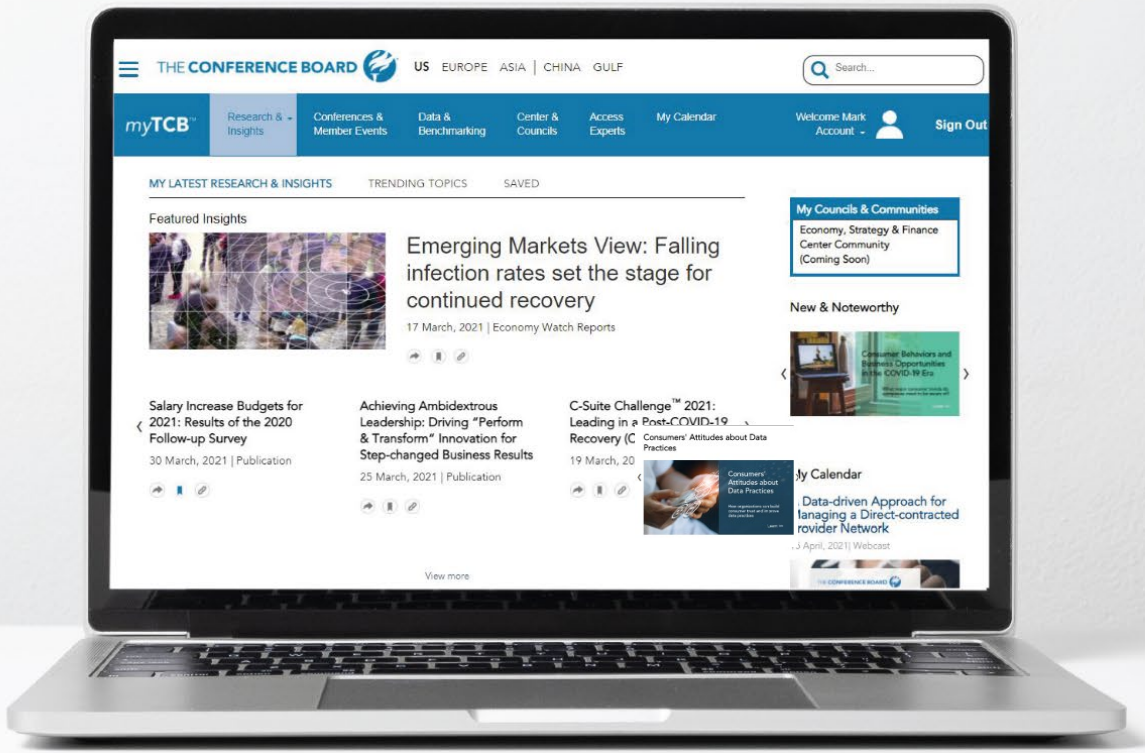
Listen on Google Podcasts

LISTEN ON Spotify

myTCB™

Sign in to enjoy customized, convenient access to the full range of Member benefits – the latest research, benchmarking & data tools, peer networks, and events delivering Trusted Insights for What's Ahead.

Watch this short video to get started.



2021 ANNUAL

EMPLOYEE HEALTH CARE CONFERENCE

TRANSFORM: SOLVING FOR THE NEW BUSINESS AND EMPLOYEE IMPERATIVES

OCT. 28 – 29 , 2021
NEW YORK, NY

Register now at
www.conferenceboard.org/employeehealthcare