90 DEGREE BENEFITS

A Turn For The Better

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Healthcare Guidebook

The Right Turn For Your Benefits

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A Turn For The Better

This book is your guide to everyday healthcare jargon. Use it and harness your full marketing potential with the knowledge of a complex system made simple.

It's not an easy industry. But we never shy away from a challenge.

Need to get up to speed

You're in the right place.

Need a quick reminder?

No problem. Everyone needs to refresh.

Need to visualize?

We've got you.

Let's start at the beginning.

The Healthcare Ecosystem

In the healthcare ecosystem, everyone operates within spaces of their own and with each other in different ways that lead back to the employer.

Employer

This is who purchases the insurance products and cost containment solutions. Can also be referred to as the client or group.

Employee

This is who receives the health insurance and cost containment solutions purchased by the employer. Can also be referred to as the member or member population.

Broker

This is the employer's trusted advisor who helps them make health benefit decisions and leads them to cost savings solutions.

Third-Party Administrator (TPA)

If an employer decides to self-fund their health insurance benefits, they hire a TPA to administer their plan and do things like process and file claims, track and provide claims reporting, manage cost containment solutions, the pharmacy benefit manager (PBM) and other vendors, provide plan guidance and perform other day to day tasks to run the plan.

Insurance Carrier

The entity that provides health insurance coverage to employers. They can provide Fully Insured coverage, Stop Loss coverage, voluntary product coverage, and other health-related insurance coverage.

Solution Vendor

Any company that provides services or solutions within the healthcare ecosystem. Examples include software processing systems, medical management companies, provider software contracting, and actuarial software companies.

Fully Insured, Self-Funded, and Level-Funded

Every employer must provide their employees with health insurance. This is a company's second most costly expense just after payroll. When in the market for employee insurance options, there are two major routes an employer can take.

Fully Insured

This option boils down to the equivalency of how you would pay for any other kind of insurance (car, home, pet) which means that based on the health data of the employee population and the amount of risk that the fully insured carrier will take on, the employer pays a set monthly premium for a standard "shelf" plan.

Self-Funded

This option is a bit more complex than the fully-insured option but gives the employer the flexibility to create more customized plans and have access to member data. Instead of a set monthly premium, the employer pays claims as they come in, so there is potential for savings if the plan runs well (healthy members = lower plan costs).

Level-Funding

Level-Funding is a type of Self-Funding and is what is referred to as the "stepping stone" between Fully Insured and Self-Funding. It's a way for employers to leave the security of a Fully Insured plan without having to dive into the unknown waters of Self-Funding all at once. Instead of paying claims as they come in from month to month, the employer pays a set amount each month.

At the end of the year, if the plan costs are below what they paid out through the year, they get back that surplus amount. If the plan spending is above what they paid out, then they are not on the hook for the extra amount.

Third-Party Administrators (TPAs)

If the company chooses to Self-Fund, they typically hire a Third-Party Administrator (TPA) to take on things like:

- Claim processing
- Claim filing
- Member (employee) customer service
- Plan guidance
- Reporting
- PBM management
- Wellness and cost containment solutions through vendor partners
- Stop loss renewal shopping (some)
- Other day-to-day tasks that go into running the health plan

How does a TPA make money?

TPAs rely on gaining new clients (employers) to build their business. There are several ways a TPA can generate revenue:

- Charging a PEPM (per employee per month) administration fee.
- Charging administrative fees on top of any additional services or vendor fees.
- Charging a percentage of savings on the networks they provide. (For example, if the TPA offers a nationwide network to clients, that means that all in-network claims will receive an in-network discount percentage. The TPA can charge the client a certain percentage of their total savings.)

How do TPAs sell their services to potential clients?

TPAs have a sales team who primarily work with brokers to bring in business. The way to the Employer is almost always through their broker. There are a few ways TPAs can target their sales pitch to win business. They can focus on:

- Key differentiators they offer in comparison to other TPAs
- Being a low-cost option
- Being a higher-end “boutique” option
- The network(s) they can offer
- High-quality services and client satisfaction

What are potential pain points for TPAs?

- Navigating the relationship between the broker and the mutual client (employer) can be a challenge.
- Clearly defining differentiators in the TPA market.
- Conveying to potential clients who have Fully Insured coverage that the potential long-term savings outweigh the upfront costs.

Stop Loss

If the employer is self-funding the health claims, it comes with a much higher risk. To mitigate the risk of having to fund potentially catastrophic claims, employers purchase stop loss insurance. There are two main parts of stop loss insurance, the specific and the aggregate. Employers have the option to have only specific coverage, but if they elect aggregate coverage, they must also have specific coverage

Specific Coverage

This coverage is on an individual basis. For example, if an employer has a $50,000 Specific Deductible, it means that for each individual enrolled in the plan the employer pays $50,000 of their medical claims before the insurance kicks in to fund anything over that amount. Think about it like your insurance deductible but on a larger scale.

The amount that the employer pays each month for specific coverage is called their Specific Premium. It's like the monthly premiums you pay for your insurance coverage. The amount they pay is based on their monthly employee census information. They pay a certain rate per employee enrolled in single/individual coverage and a certain rate per employee enrolled in family coverage.

If an individual's claims cost goes over the specific deductible amount, then they are considered a "Specific Hit." Any claims over that deductible amount are sent to the carrier for reimbursement to the employer.

Aggregate Coverage

This coverage is for the member population as a whole. Based on the employer claims history, the stop loss carrier calculates an estimate for what the employer will spend on all claims for the entire plan year and then adds (typically) an additional 25% (it can range from 10%–50%). If the employer spends more than that amount, then anything over is eligible for reimbursement by the stop loss carrier.

The amount that the employer pays each month for aggregate coverage is called their Aggregate Premium. They are charged a set rate for each employee enrolled in coverage.

The suggested amount that the employer should contribute to the account that the TPA uses to pay claims is based on the Aggregate Funding Factors. These factors are calculated by taking a three-year lookback at monthly claims and averaging them for single/individual and family.

The Aggregate Attachment Point is calculated by taking the single and family aggregate factors and multiplying them by the current single and family enrollment counts and multiplying that number by 12 (months) and adding the 10%–50% corridor.

If the claims for the group as a whole go over the aggregate attachment point, then the group is considered an “Aggregate Hit.” Any claims over the attachment point amount are filed to the carrier after the policy period is over for reimbursement to the employer.

Contract Type

One of the key considerations when electing stop loss coverage is what type of contract type you want in place. Common contract types include:

12/12 **24/12** **12/15** **15/12**

The first number stands for the months that the claims are incurred within, and the second number stands for the months that the claims are paid within. For example, if you have a 24/12 contract that begins 1/1/2023, it means that your policy covers claims incurred from 1/1/2022–12/31/2023 and paid from 1/1/2023–12/31/2023.

Other Stop Loss Terms

Laser

When an insurance carrier assesses a group's data to provide pricing for their stop loss policy, they will sometimes assign a higher specific deductible to an individual that they think will likely exceed that limit based on a current diagnosis or plan of treatment.

For Example

If the group's specific deductible is $50,000 but stop loss reporting shows a member with a cancer diagnosis who is undergoing treatment projected at $100,000 for the policy year, they can assign a $100,000 deductible for that individual.

No New Laser/Rate Cap Feature

This is an extra protection that can be purchased (typically a 5%–15% increase to specific premium) that ensures no additional lasers (besides any already in place) and a maximum or capped rate increase (typically 50%) if you renew with the same insurance carrier.

Disclosure Statement

A legal document that carriers typically require the group to sign stating they have accurately disclosed all required medical reporting without omission.

Aggregating Specific

This is a coverage option in addition to the specific deductible that adds additional claims liability in exchange for premium reduction.

For Example

If the group's specific deductible is $50,000 with an aggregating specific of $30,000, then in addition to an individual meeting the specific deductible, a single or combination of individuals would also have to exceed $30,000 for reimbursement to kick in. Once the $30,000 is met once, it does not need to be met again during the policy year. In exchange for the group being liable for that additional $30,000, the annual specific premium is typically lowered by the same amount. In this case, $30,000.

Coverage Type

Groups usually elect to have both Medical and Rx claims covered under stop loss coverage. Occasionally a group will elect to only have medical claims covered, but as Rx claims have become more and more expensive, having Medical Only coverage is not as common. In addition to Medical and Rx, groups can also elect to include others like Dental, Vision, and Short-Term Disability (STD).

Insurance Carriers

These are the companies that provide insurance coverage, like Stop Loss. They can also provide other types of health insurance coverages and arrangements like Fully Insured, Captives, and Voluntary Benefit Coverages. The insurance carriers who usually come to mind are the BUCAs (Blue Cross Blue Shield, United, Cigna, Aetna).

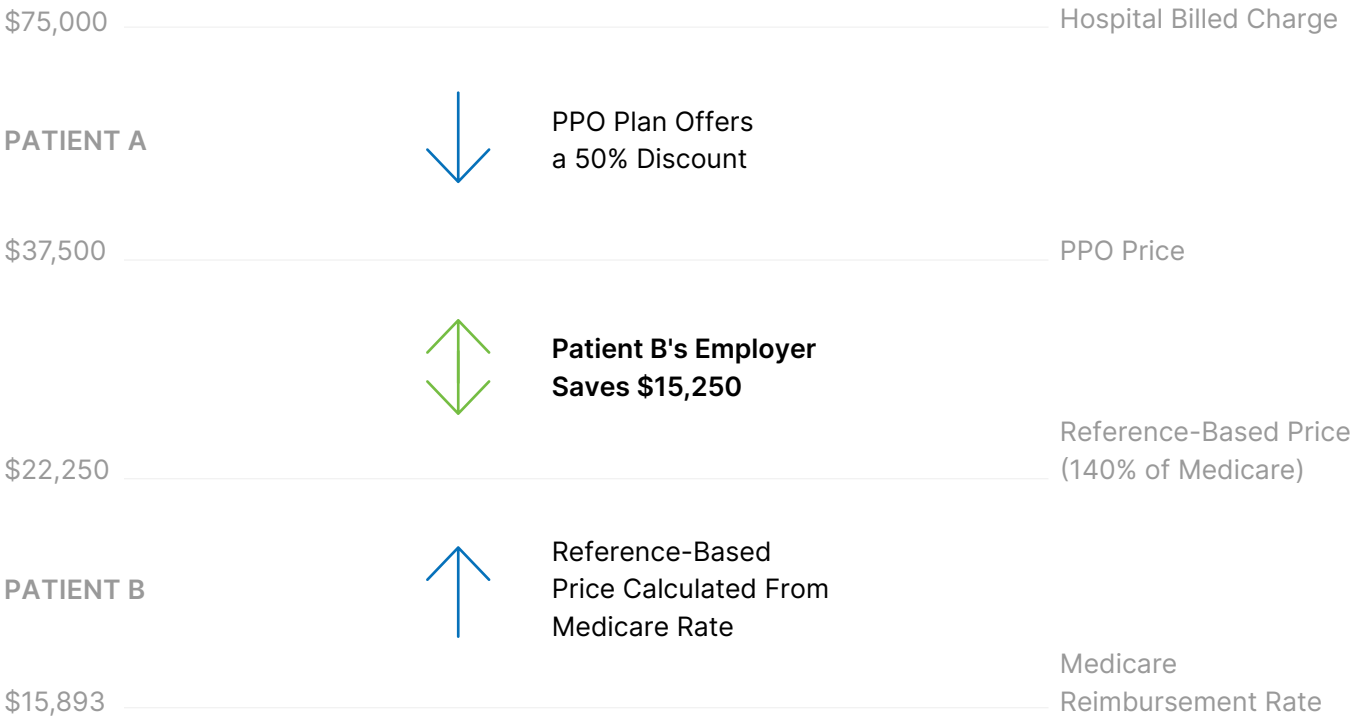
Insurance carriers use actuarial software to input group data and output rates and premiums based on risk. The people who price, or underwrite, a group are called Underwriters. Carriers operate in much the same way as any other type of insurance like what you purchase for your car or home. They charge the employer monthly premiums in exchange for protection against high claims costs.

The target audience for insurance carriers is brokers, TPAs, and employers. You will see carriers focus more on selling to brokers and TPAs since they are the avenue to get to the employer.

Reference Based Pricing

Reference Based Pricing (RBP) is a pricing method used in place of a traditional PPO network that uses a reference, typically Medicare pricing, as a base and then prices up from there depending on the percentage used to calculate the final price. Here is an example showing how PPO prices down based on a discount percentage, and RBP prices up from a lower base price (Medicare).

EXAMPLE: Knee Replacement Procedure



	Patient A Top-Down Pricing	Patient B Bottom-Up Pricing
Hospital Billed	$75,000	$75,000
Reimbursement	$37,500	$22,250

Patient B's health plan reimbursed $15,250, which is **40% less** than the reimbursement from Patient A's health plan.

You can see from the example that even with a 50% network discount on the hospital billed charge, the employer still sees significant savings when you begin with the Medicare price for the same procedure and then add 40% on top of that price.

Although savings can be significant, it may not be the right choice for all employer groups. There are a few concerns to keep in mind when speaking to an employer/broker audience about RBP.

1. Member balance billing

In some instances, members can be billed the balance between the RBP reimbursement amount and the hospital billed amount. Most employers/TPAs/carriers are aware of this and have programs in place that enter into negotiations with the facility so that the member does not have too many additional out-of-pocket payments.

2. Access to hospitals and facilities that accept RBP

Before an employer group makes the decision to switch from a PPO to an RBP plan, they will run a disruption report that looks at information like member zip codes and claims information showing which doctors and facilities they use in order to determine what kind of disruption in service members could expect to experience since not all facilities accept RBP arrangement. Some areas are better for RBP than others.

3. Member education on RBP

Since RBP is significantly different from a traditional PPO plan, which most members are familiar with, making sure that members receive the right education and understanding of how their new plan functions are essential. This can be a concern for HR since, in many cases, the burden of educating members on health benefits falls to them.

Captives

Captive Insurance provides an easier way for smaller employers to self-fund by taking away some of the risks. This is made possible by banding together with other similar companies into a single buying group. Combining with other companies increases the member population of the group, allowing for:

- Increased negotiating power (lower insurance rates).
- Lower impact of shock claims (what would significantly impact an employer with 50 employees, has less of an impact on a group of employers totaling 5,000) .
- Higher savings potential since there are thresholds of entry such as having cost containment requirements (if you're in it together you want to know that everyone is doing their best to keep members healthy).

Medicare and Medicaid

There are a few different government programs that fall into the healthcare space. The two primary ones are Medicare and Medicaid.

Medicare

Federal health insurance for those over the age of 65, and some under the age of 65 who have certain disabilities or conditions that qualify them for coverage. There are a few different types of Medicare.

Medicare Part A

This is for hospital coverages that include, inpatient care, skilled nursing facility care, hospice, and home health care

Medicare Part B

This is for medical coverage including, physician, outpatient care, home health, durable medical equipment, preventative services

Medicare Part C

These are Medicare Advantage plans that bundle together various Medicare parts into a complete plan.

Medicare Part D

Available for prescription drug coverage.

Medicaid

Federal health insurance for those under a certain income level, qualifying individuals who are pregnant, have certain disabilities, or families who have a child with certain disabilities or conditions. Qualification varies by state. There are also additional programs that fall under the Medicaid umbrella like CHIPS and ABD.

CHIP

Children's Health Insurance Program

ABD

Aged, Blind, or Disabled

Healthcare Solution Vendors

Software Processing Systems
This can be something like a claims processing platform or something that TPAs or insurance carriers use internally to help them with day-to-day tasks.

Medical Management Companies
These companies generate savings by catching high-cost claimants early and connecting with them to help them live healthier lifestyles, encourage regular doctor's appointments, enroll them in programs, and monitor their condition(s) to minimize claims cost.

Actuarial Software Companies
Software like what is utilized by underwriters to produce quotes and analyze claims data.

Provider Contracting Software
Provide tools that can connect employers and TPAs to networks and Direct Primary Care.

Cost Containment Vendors
These companies provide tools or programs that help guide members through different initiatives to help lower costs.

Carve Out Vendors
Provide insurance or protective coverage and cost containment for specific high-cost areas.

Healthcare Acronym Guide

ABD
Aged Blind or Disabled

ACA
Affordable Care Act

BUCA
BlueCross, United, Cigna, Aetna

CGT
Cell and Gene Therapy

CHIP
Children's Health Insurance Program

CM
Case Management

COB
Coordination of Benefits

COBRA
Consolidated Omnibus Budget Reconciliation Act of 1986

COE
Centers of Excellence

DPC
Direct Primary Care

EOB
Explanation of Benefits

ERISA
Employee Retirement Income Security Act

FDA
Food and Drug Administration

FI
Fully Insured

HIPAA
Health Insurance Portability and Accountability Act

HMO
Health Maintenance Organization

LB
Limited Benefits

LF
Level-Funded

MEC
Minimum Essential Coverage

NSA
No Surprises Act

OOP
Out-of-Pocket

PBM
Pharmacy Benefit Manager

PCP
Primary Care Provider

PHI
Protected Health Information

POS
Point of Service

PPACA
Patient Protection and Affordability Care Act

PPO
Preferred Provider Organization

RBP
Reference-Based Pricing

RFP
Request for Proposal

SF
Self-Funded

TPA
Third-Party Administrator

TiC
Transparency in Coverage Rule

UR
Utilization Review