the FRONTPAGE

Clarity for an Evolving Industry

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NOTES from the PRESIDENT'S DESK

Greetings!

The days are growing shorter, the leaves are changing color, and summer is quickly becoming a distant memory. Still, I want to briefly look back to July, when our 25th annual Health & Business Symposium took place.

As always, Symposium was the perfect time to renew personal connections, enjoy the great outdoors, and share ideas. Three of our EBMS team members gave dynamic talks, each one presenting a different take on the industry trends that are being driven by new data analytics capabilities.

One trend focuses on improving the member experience by using data to personalize interactions and respond to requests with speed and accuracy. Another uses data to manage risk prospectively – in essence, preventing a fire rather than putting it out after the damage has been done. Data now provides unprecedented transparency about costs and quality. These are things we could only dream of not that long ago, when "data" meant numbers, without the context that lets us extract higher meaning today.

But dreaming of future possibilities is a good thing. This point was brought home by our Symposium's keynote speaker, Mike Rayburn. This Nashville-based singer and composer told us how he is now living his personal dream only because he asked the simple question "What if?" Mike explained how he took those two words and turned them into a mindset. This was such a powerful and inspirational success story that our leadership team at EBMS is now trying to do the same thing. We're working to incorporate the "What if?" mindset into our corporate culture by asking this questions of ourselves and each other at meetings, in planning documents, and in our internal dialogue.

What if we could improve the well-being of our entire member community? What if we could bend the curve on skyrocketing healthcare costs? What if employers were able to provide higher quality care while paying less? What if we could work together with brokers to create a more positive environment within the insurance industry?

Many weeks have gone by since Symposium. If you're like me, you went home feeling newly refreshed and inspired, full of plans and goals. Then, as the days passed, maybe those feelings faded slowly away as you became sidetracked by everyday life. That's why I wanted to use this opportunity to remind you how it feels to ask "What if?" or to set a new goal, believing anything is possible. In this crazy industry, we all need to seek inspiration every day, without waiting for Symposium or even the New Year to roll around and prompt a new round of goals and resolutions.

Then again, we can all use the professional boost that comes from networking and informational events like Symposium – so please save the date for next year, when Symposium will take place July 23-25, 2019.

Yours in health,
Kevin

Kevin Larson,
EBMS President

FACT OR FICTION

Do Reference-Based Pricing Strategies Result in More Balanced Billing?

THE MYTH

While reference-based pricing (RBP) is known to deliver impressive cost savings, it will also create heavy financial and emotional burdens for plan members, who are likely to receive high-balance bills and collection notices.

THE FACTS

With RBP, plan members benefit not only from lower out-of-pocket costs, but from open access to providers, in the absence of a narrow network. A strong member-advocacy program can help consumers navigate any billing issues that arise.

THE SUPPORTING EVIDENCE

Because RBP payments are a multiple of the Medicare rate (rather than a discount on the hospital chargemaster cost), RBP is a rational, fair, and transparent payment strategy. It can effectively manage costs for medical procedures with a wide price variance, such as diagnostic imaging and orthopedic surgeries.

There is always a chance that balance billing will occur with RBP. However, balance billing is a fairly common occurrence in all health plans, often occurring when a member makes an out-of-network claim in a traditional PPO. According to a 2015 survey by the Consumer Reports National Research Center, nearly one-third of privately insured citizens were surprised by an unexpected medical bill in the past two years, when their benefit plan paid less than expected. This issue is not limited to reference-based pricing. Nor is it insurmountable with the right member advocacy program in place.

THE EBMS POSITION

"When plan sponsors and brokers work with a TPA that is an experienced RBP partner, balance billing issues become less likely," explains Paige Corcoran, director of provider relations at EBMS. "There are two reasons for that. First, a good RBP solution will focus on fair payment to providers. But most importantly, the right RBP partner will have a strong member-advocacy program in place. At EBMS, we reach out to our members to explain how RBP benefits them, and we never abandon them to negotiate a balance bill on their own."

In fact, RBP can be quite consumer friendly. Well-managed programs can increase transparency, providing consumers with the information they need to compare providers not just on cost, but on quality benchmarks as well. RBP can also put pressure on the costliest providers to bring their prices more in line with fair market rates.

> "RBP will likely become more and more popular among self-insured benefit plans."

"We service many clients that rely on RBP, so we know firsthand how well it works," concludes Paige. "RBP will likely become more and more popular among self-insured benefit plans."

HR PERSPECTIVE

Personalized Benefits Can Boost Employee Satisfaction

Sixty-one percent of consumers view their health plan as "cookie cutter" and designed for the masses, rather than personalized or customized to their needs. Seventy-three percent say their plan does not reflect their current health needs very well.

These startling numbers come from a 2017 HealthMine survey of consumers with employer-sponsored health insurance. A study by the LIMRA Secure Retirement Foundation got similar results, concluding that nearly three-quarters of American workers would like the ability to customize their benefits package.

It's no secret that aligning benefits with employee needs is a crucial part of your retention efforts – and a way to maximize workforce engagement and productivity. But with four distinct generations in the workforce and skyrocketing health costs, structuring a health plan to include personalized services can take some creative effort.

"The key to offering personalized health benefits is to understand the relevant qualities of your employee population," says EBMS Executive Vice President of Human Resources Melissa Lyon. "Which health services are they using? How can we improve their care experience at the individual level, so they feel their plan was tailor-made for them?"

A strategy for personalization often starts with workplace wellness programs that can help individuals address current health concerns or meet health goals, such as reaching an appropriate weight or giving up tobacco. But for true personalization, nothing beats clinical support programs, often known as concierge or navigation services.

Consumers generally lack the skills and specialized knowledge needed to navigate today's complex healthcare system on their own. A high-touch advocacy and support program can go a long way toward keeping employees engaged. (It can also keep you competitive and reduce wasteful healthcare spending!)

Increasingly, companies are recognizing the value of such services. According to the Large Employers' 2018 Health Care Strategy and Plan Design Survey, 36 percent of survey participants offer concierge and navigation services this year, up from 28 percent in 2017.

Concierge and navigation services go far beyond typical customer service issues, such as replacing a lost ID card or explaining what counts toward a deductible. Navigators are usually highly trained professionals (nurse, social worker, certified patient navigator) who can provide compassionate, personal attention. They can help a plan member understand treatment options, manage side effects, find a high-value provider, or coordinate transportation to care appointments. They can distill complex information from many sources into comprehensible guidance and an action plan. A health plan can offer concierge/navigation services only to members with complicated or chronic conditions, to those in need of inpatient care, or to everyone covered by the plan.

Personalizing health benefits helps an organization to build a positive relationship with employees over time. It is an effective strategy for building a healthy, loyal, and engaged workforce.

TRENDS

Advanced Data Analytics is Quickly Gaining Favor as a Strategic Tool

In a 2017 report, the consulting firm Capgemini outlined 10 emerging trends in the insurance industry. One of these highlighted trends was "the use of analytics for improved profitability and customer experience." About the same time, a Deloitte survey of health plan executives found that two-thirds of respondents agreed that "leveraging health data analytics is a top priority."

THE FACTORS BEHIND THE TREND

One of the key drivers for this trend is the newer reimbursement models, including pay-for-performance and value-based purchasing. The need to keep patients healthier while simultaneously containing costs has given new importance to care management and disease-management programs. Data analytics and predictive modeling can help identify the patient populations that would benefit from these interventions, before a health complication or high-dollar claim occurs. When it comes to patients with chronic conditions, data can facilitate a focus on managing utilization patterns and seeing that care benchmarks are being met – which not only reduces spending but also improves the patient experience by closing care gaps.

"The rewards of data analysis can be huge," EBMS Chief Information Officer James Vertino says. "Healthier, more satisfied plan members; higher value care; more insight into how well a plan is performing; and more informed decision-making. All of these things are priceless to a self-funded plan sponsor."

THE CHALLENGES BROUGHT FORWARD BY THE TREND

The Deloitte survey also highlighted some of the challenges inherent to collecting and using data strategically. One of these is finding or training staff analysts who can compile reports and extract meaning from the numbers. This expertise is needed to turn raw data into business intelligence and to apply new insights in ways that can mitigate troubling trends – whether it's unnecessary ER use, a lack of adherence to a prescription regimen, or high spending on orthopedic surgeries.

"It can be difficult to know how a plan is performing in specific areas," points out Laura Rookhuizen, an EBMS healthcare informatics analyst. "We all know that healthcare costs in general are on the rise. But do you know how fast your costs are rising as compared to the national average? Do you have on-staff capabilities to determine the clinical drivers of spending, by really drilling into data from claims, prescriptions, lab, and biometric evaluations?"

Another challenge is data quality. It was listed as a top concern by a whopping 60 percent of those surveyed in the Deloitte study. In this context, quality can refer to data accuracy, completeness, relevance, accessibility, and real-time status.

> Is there any doubt that advanced data capabilities are a business necessity today and that a health plan that lags behind in analytics will quickly lose its competitive edge?

"To use data in meaningful ways, we must become comfortable with the concept of data governance," Vertino says. "Governance reflects overall management of data assets, including privacy and security. Every organization will need to define its practices and processes for making sure data is available, accessible, accurate, and secure. So it's somewhat of a rocky path to meaningful data analytics, but it's a rewarding one."

REGULATORY REVIEW

The DOL's Final Rule on Association Health Plans May Expand Your Options

By Matt Johnson, EBMS corporate counsel

When the U.S. Department of Labor issued its final rule on association health plans (AHPs) in June, it suddenly became easier for groups of small employers to join together to buy health benefits in the large group market. Here's what you should know about this new regulatory environment.

The purpose of the DOL's final rule is to make health insurance more affordable for small companies and their employees. Essentially, it does this by conditionally relaxing mandates under the Affordable Care Act (ACA), including its requirement that all small group plans include certain "essential health benefits" that are not required of large group plans. (Generally an employer with fewer than 50 employees is legally considered a small group and would be required to include coverage for benefits such as emergency care, hospitalization, maternity care, prescription drugs, mental health care, and pediatric dental care).

After the DOL's reform, small groups may now more easily join other small groups to pool their employees for the purpose of being classified as a large group employer. The incentive for doing so is to enjoy a wider choice of health coverage and lower costs, given that large groups are not required to comply with some of the ACA's expensive coverage mandates. In order to make use of such choices and potential cost savings, small group employers must collectively qualify as a *bona fide* association. (Non-*bona fide* associations are treated as individual employers and do not receive the same advantage).

The test of a *bona fide* association association is still a "commonality of interests," which prior DOL guidance had defined very narrowly. However, the new rule expands the definition to declare that an association can demonstrate a commonality of interest among its members based on either geography or industry. Specifically, association members must be either (1) in the same trade, industry, or profession throughout the U.S., or (2) in the same principal place of business within the same state or a common metropolitan area, even (in limited circumstances) where the metro area extends across state lines. An association may still not exist solely for the purpose of offering benefits – it must have at least one other substantial business purpose, such as lobbying or educating members.

The final rule does not eliminate or supersede state laws that govern multiple employer welfare arrangements MEWAs), so it's important to consult with experts on applicable state laws and regulations. If your company is already in an AHP that was formed under the stricter commonality-of-interest test, you should know that the rule is not intended to force existing AHPs to become *bona fide* associations as defined by the new rule. However, there may be significant advantages for you to do so. As part of a *bona fide* association, you can:

- take advantage of economies of scale in ways that are typically enjoyed only by large employers
- mitigate risk by increasing the size of the insured population
- strengthen your bargaining position to negotiate more competitive provider contracts
- reduce administrative overhead

Note that you can do all this while offering your employees a wider array of benefit options!

If you are still uncertain as to whether the DOL's final rule on AHPs could work to your benefit, please reach out to your account manager. EBMS is happy to discuss your options with you.

DATA DISPATCHES

What Is a MARA Risk Score?

"Across all [reimbursement] models, the identification, stratification, and management of high-risk patients is central to improving quality and cost outcomes."

–The Association of American Medical colleges (AAMC), in High-Risk-Patient Identification: Strategies for Success

The Milliman Advanced Risk Adjusters (MARA) tool uses each member's medical and prescription drug claim history to predict the individual's relative healthcare cost risk, as compared to an average population risk.

In recent years, traditional medical underwriting has been replaced by the risk-adjustment process. Payers now try to identify high-risk patient populations so they can mitigate the associated costs through various care-management programs. This has created a need for new risk-assessment and risk-scoring tools. EBMS has chosen MARA to complement its data-driven approach to benefit plan evaluation and management

EBMS has chosen MARA as a risk assessment tool, to complement our data-driven approach to evaluating benefit plans.

"MARA can provide us with category risk scores for different health services – like inpatient, outpatient, ER, and prescription," explains Laura Rookhuizen, a healthcare informatics analyst with EBMS. "This level of detail means we can help our clients make more strategic decisions."

Laura also points out that risk stratification for care-management purposes can be quite complex. For example, it's well known that each year, only a small percentage of plan members incur high spending. In fact, the top 5 percent of spenders can account for up to half of all healthcare dollars. However, a 2018 issue brief from the Health Care Cost Institute points out that there is high turnover among these top spenders – it found that, during each year studied, more than three of five top spenders were not top spenders during the previous year.

"That's why it's important to use a prospective model of risk scoring," Laura explains. "We want to focus on predicting which individuals may incur high costs in the near future, because they may benefit from care interventions in the present time."

TECHNOLOGY & INNOVATION

Automation Makes Open Enrollment a Breeze

EBMS customers will find that enrollment tasks have become much faster and more efficient. As part of our investment in technology upgrades this year, we've implemented an innovative, fully automated online enrollment system, which plan sponsors and members can access through the miBenefits portal. The new systems simplifies both the seasonal open enrollment period and ongoing enrollment due to qualifying life changes.

Today, with full automation, most functions can be processed in less than 60 seconds–because the system uses a rules engine to present employees with only the choices they qualify for. When members add a dependent or have a life change like a divorce or adoption, the system steps them through the entire process of managing dependents, adjusting the coverage tier, and modifying contributions to health savings accounts.

Other advantages include:

Greater visibility and transparency. From the member's point of view, the online experience includes more explanation and detail. The enrollee is stepped through the enrollment process, screen by screen. And if there is a choice between different plans, members can compare them side by side. "It's becoming more common for employers to offer more than one plan," points out Julie Vaskey, EBMS director of configuration. "Many companies are adding a high-deductible option, along with the traditional PPO, because they're so popular with younger employees." This greater visibility translates into fewer members going to the HR office with questions.

Streamlined processes. We can now administer open enrollment for solutions from other vendors, including dental, vision, life, disability, and the various financial accounts. Members can sign up for everything through the miBenefits portal and can view all benefit options in one place. The system communicates electronically with other insurance carriers to seamlessly complete enrollment.

Increased efficiency. Those who manage benefits enrollment can now track the entire process. Through the miBenefits portal, they can monitor how many employees have completed enrollment and can send out automated email reminders to those who have not. This time-savings can free up HR people to work on other projects.

Member satisfaction. With streamlined processes and greater visibility of plan details, members can more fully understand their options and make more informed choices. The experience feels more personalized, and the messaging is more consistent. This improved level of service builds employee loyalty and satisfaction.

Reduced costs. With fully automated open enrollment capabilities, you get all the advantages of paperless transactions. You can virtually eliminate paper forms, thick packets, and time spent on data entry. Automation helps ensure accuracy, so you eliminate costs associated with correcting errors.

If you have any questions or concerns about the open enrollment process, please get in touch with your account manager. We want your open enrollment period to be a smashing success this year!

NEWS & NOTES

EBMS Adds Medical Director, VP-Legal, and CFO to Team

Dr. Murray has Strong Record as Leader

Experience in medicine and business makes Dr. Andrew Murray, an exceptional addition to the EBMS team as Chief Medical Officer and President of the company's miCare and miRx healthcare solutions.

Dr. Murray comes to EBMS from CareAllies, a Cigna-owned Population Health Management startup, where he served as Vice President of Population Health Management and Clinical Services. At CareAllies, Dr. Murray worked with healthcare providers to ensure their success in value-based arrangements. He has also focused on payer-provider partnerships with hospitals, physician groups and other value-chain partners.

Before joining Cigna, Dr. Murray served in senior leadership with Discovery Health, a leading multinational insurance company, as Chief Operating Officer for Ping An Health, and as Deputy General Manager for DiscoveryCare, a managed care organization serving over 3 million members from more than 12 health plan clients.

CFO Schott Brings Financial Expertise

Alex Schott has been named Chief Financial Officer and will lead EBMS' financial strategy teams as a member of the company's Executive Team. In his recent position at BioScrip, Inc., he served as Senior Vice President of Strategic Operations and interim Chief Accounting Officer. The Denver-based company provides infusion and home-care management solutions from nearly 80 locations in the U.S.

"Alex's accomplishments demonstrate a commitment to excellence in strategic leadership and technical acumen," said Kevin Larson, President. "His expertise in building, growing and scaling financial and accounting functions in healthcare organizations will be an asset to EBMS as we continue to expand our products and services to contain costs, improve care and simplify the benefit journey."

Schott holds a BS in Accounting from Metropolitan State University of Denver and is a Certified Public Accountant.

Johnson Adds Legal Experience

EBMS' new Corporate Counsel and Vice President of Legal is Matt Johnson, who had been serving as Lead Counsel at Aetna as the Primary Counsel to American Health Holdings and Co-Counsel to Meritain Health.

He obtained his law degree in 2008 from Nashville School of Law while he was working at Concentra Health Care as a legislative and regulatory affairs analyst. He has extensive experience in healthcare law, compliance and government relations.

"Matt will be a great addition to the legal and leadership team in partnership with our clients, brokers and vendors as we work together to change the way healthcare is purchased and delivered," said Melissa Lyon, Executive Vice President.

EBMS, a national leader in innovative healthcare solutions, was founded in Billings in 1980 as Montana's first third-party administrator. The company now serves more than 275 organizations and nearly 150,000 employees and family members across the U.S.

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