CHAPTER 13

INDEPENDENT CLAIMS ADMINISTRATORS VS. INSURANCE COMPANY CLAIMS ADMINISTRATORS –THE TRADE-OFFS

Adam V. Russo and Ron E. Peck

An increasing number of employers are looking to self-insure their employee health benefits for the first time. While this is a great first step toward better benefits and lower costs, it's important to realize that not all self-insuring is the same. It can vary enormously depending on whether you decide to work with an insurance carrier that provides the administrative services (ASO) or an independent third party administrator (TPA) that provides them.

First, let's nail down a few basic concepts. With fully-insured "traditional" insurance, your organization pays premiums to an insurance carrier and the carrier accepts the risk, meaning the carrier pays medical bills with its own funds. If the premiums exceed the medical expenses, the carrier "wins." If the medical expenses exceed the premiums, the carrier "loses." But for employers that can afford the risk—that have access to sufficient funds to pay the

occasional midsized to large dollar claim—self-insuring has been shown to be less costly overall.

When a company self-insures its health plan, it sets aside its own money plus employee premiums, using them to pay claims for medical services itself. But rarely does an organization have the resources necessary to process claims—to receive, interpret, and pay medical bills. Nor does it understand the intricacies involved in creating and managing a health plan while complying with applicable laws. Thus an ASO or TPA is required.

Second, while most self-insured plans have adequate resources to pay most everyday medical expenses, few have enough to cover the cost of catastrophic claims resulting from care of patients with cancer, hemophilia, premature birth, etc. To address this, a self-insured plan will purchase reinsurance or excess coverage from a stop-loss carrier. This is not health insurance in the traditional sense. The stop-loss carrier does not pay medical bills, or deal directly with providers of health care. Instead, the self-insured plan—that is you, the employer—pays the medical bills. But once you have paid a certain amount (referred to as the specific deductible, attachment point, or "spec"), you can seek reimbursement from the stop-loss carrier.

Note: at various times in this discussion, we will refer to the employer as the *plan sponsor* or the *client*, but we always mean *you* the CEO and/or your company. Employees are also called *plan members*.

ASO and TPA at a Glance

The traditional and simplest way to administer a self-insured plan calls for a large insurance carrier to shed its risk-bearing role but continue to serve as a claims processor for the employer—substituting the employer's money for its own.

ASOs prefer to pick and hire the stop-loss coverage company (sometimes called excess or reinsurance coverage) for clients themselves and provide a predetermined health plan that aligns with its own excess loss carrier and provider network

agreements. This bundling of the plan document, excess insurance, and network agreements severely limits plan customization. On the other hand, it eliminates potential gaps in coverage between these components.

The transition from a fully-insured health plan to a self-insured or partially self-insured plan is much easier with an ASO, because the insurer:

- Can continue to provide the same administration expertise it provided before, including the actuarial evaluation of how much money it will cost the employer to fund its own program
- Can provide other professional services such as accounting, legal advice, expert medical opinions, and regulatory compliance
- Is usually familiar with the medical providers known to the employees and their health risks, both important to handling claims

The downside is that the employer can't take as much of an active role in cost management or provider relations. Nor can it easily negotiate a direct contract with a hospital or "carve out" a particular type of claim. In return for one-stop shopping, you generally do what the ASO dictates, limiting flexibility to significantly reduce spending.

With a TPA, on the other hand, you call the shots and get more transparency and flexibility at what is generally a lower cost. The TPA does what you dictate.

As benefit plans have become more sophisticated and self-insuring more popular, we've seen a nationwide proliferation of increasingly professional TPAs. These independent administrators offer a broad range of services. At one end, is the simple administration of benefit payments. At the other, is a "turn-key" contract that includes a stop-loss provision like an ASO but is still more flexible and affordable.

Due to consolidation, there are fewer small "boutique" TPAs these days, but even the larger TPAs dominating the market still maintain more of a customized approach than an ASO. They are

more flexible, more likely to be local, and offer employers the opportunity to access claims data. They also let you pick and choose vendors and providers to meet your specific usage needs. Thanks to their highly specialized products and lower overhead, TPAs have developed pricing strategies that make them cost-effective. A TPA can afford medical expertise and achieve group purchasing discounts that are significantly more advantageous than those available to a single employer.

More employers are finding that it's worth risking potential gaps in coverage with a TPA, in exchange for being able to shop around and field offers from various stop-loss carriers. Also, ASOs are generally proprietary about claims data. If you as the employer want to know if your smoking cessation program has yielded an ROI, it can be hard to get data. If you want to examine your costs for diabetes treatment before deciding on a program for Type 2 diabetics, it can be hard to get data. With a TPA, you have complete access to the data, allowing you to design your plan accordingly. Increasingly, employers believe it's unconscionable to not have visibility into what is likely their organization's biggest expenditure after payroll.

Here's another difference. Many self-insured plans place great emphasis on their preferred provider organization (PPO). (See Chapter 6 for more on PPOs and how they are responsible for keeping health costs so high.) This is a prearranged network of providers that agree to treat plan members for a discounted rate and to accept that amount as payment in full. The biggest, most effective networks are owned and managed by large insurance carriers, but provide the best network access to their own insurance programs and ASO plans. While it is true that many TPAs "rent" networks from these carriers, the carriers do not provide their deepest discounts to anyone outside their organization.

That being said, some TPAs are forgoing the "national network" approach, instead focusing on direct contracting with individual providers for even better rates, and/or forming narrow networks of select providers for rates that rival or beat the best national PPOs. The downside, of course, is that if plan members go

outside the narrow network for treatment, they can be billed out of pocket for the balance after the plan pays the maximum amount allowable according to the contract—something that doesn't happen if the plan and provider are part of a national PPO.

With a TPA, there is a true unbundling of services. For some employers, the fact that a TPA requires the employer to see and select the moving parts is exciting. It allows a hands-on employer to more actively contain costs and pick what they feel is best for their employees. For others, it is frightening and overwhelming. For those employers, an ASO that makes the decisions for them is likely the way to go—if they're willing to pay the premium.

ASO Benefits

There are a lot of parts to administering a benefits plan and an ASO will take care of all of them.

- Accounting and recordkeeping
- Plan design
- Actuarial analysis
- Underwriting
- Securing stop-loss coverage
- Investment advice
- Enrollment
- Utilization review
- Medical record audits
- Plan booklet preparation
- COBRA administration
- Plan communication
- Reporting and disclosure
- Contribution determination
- Claims administration
- Statistical analysis
- Subrogation
- Claim appeals
- Record retention

The ASO will also decide whether, when, and how much to pay for claims.

Of late, insurance carriers, including their ASO arms, have improved their service capabilities, making them more transparent. In some cases, it is possible for a self-insured employer to log onto an ASO's technology platform and instantly receive claims status reports—for an extra cost, mind you.

As self-insuring has become more important in the market, some insurance carriers also have implemented programs to make their products easier to use. This revolution in customer service includes onsite processing personnel, 800 numbers, artificial intelligence systems, image processing, and other advanced technology designed to generate one-call responses to member inquiries.

Self-insuring with an ASO is truly a turn-key solution. You and your employees enjoy a seamless transition from fully-insured traditional insurance. There are no gaps between the plan's coverage and stop-loss coverage. Yet there is a cost for this all-in-one approach. In addition to administrative fees that admittedly range but almost always exceed the fees charged by TPAs (sometimes doubling them), your rights to examine data and customize your plan, as well as pick and choose stop-loss carriers and vendors, is limited, and stop-loss insurance premiums are usually greater. Together, these conveniences , along with bundled pharmacy services, significantly limit your ability to proactively and significantly reduce your total spending.

TPA Benefits

Different types of TPAs have different strengths. On large accounts, for example, the large nationwide TPAs can compete favorably with large insurers' ASO-driven products. Smaller, local TPAs can generally respond more quickly to plan changes than their larger counterparts.

Interacting and working with a TPA on a local level can bring a high degree of control to the administrative process. A TPA located in the same community as an employer has the advan-

tages of knowing the market, employees, providers, and general economic conditions. This familiarity can lead to administrative and benefits efficiencies. If the TPA is part of a local managed care organization, serving other employers, it has a stronger negotiating position.

A thorough knowledge and understanding of the labor market and the benefits available locally for various employee classifications will also help in planning benefits. This means they will be competitive and likely to achieve the goals of the employers' overall benefit strategy.

Two other advantages that TPAs have over ASOs are negotiating "in network" claims and changing terms in the summary plan description (SPD). Because many ASOs are affiliated with the PPO network they use (often sharing a parent company or other affiliation), they are typically expected to process all in-network claims quickly—without examining them. While quick and painless claims payments certainly limit conflicts with providers and insured individuals, they also make it more likely that excessive charges, duplicate and fraudulent claims, and other billing errors will be missed.

Recently, a TPA processing claims for its self-insured plan client performed an audit on in-network claims (something an ASO might not be allowed to do) and discovered a $3.6 million claim *after* the network discount. The claim featured many coding and other mistakes, but once these were addressed, the final payment was a much more manageable $1.6 million!

Whether because the claims processing system is keyed to work with a particular benefit plan template, or because applicable network and stop-loss policies are written in concert with the plan document, many ASO-managed plans are stuck with a predetermined SPD document. For many self-insured employers, this is a great comfort. For others, the lack of discretionary authority is troublesome. In one case, an employer working with an ASO was strongly opposed to paying for claims arising from any and all illegal acts. The plan document excluded only claims arising from felonies. When the employer asked to expand the

scope to all illegal acts, he was told that such a change would disrupt coordination with the claims system, stop-loss, and network contracts.

As cost containment and managed care become increasingly important, the balance is tipping toward the TPA alternative.

Another Consideration:
Are You Hiring an Independent Advocate?

Whether ASO or TPA, some claims processors are partly owned by large insurance carriers, health systems, network administrators, and other entities. This means that when you want to dispute something with one of those entities, their claims processor may need to bow out due to a conflict of interest. In one instance, a small employer's plan members were being asked by a local hospital to pay a portion of their bill *up front* because the plan didn't use a recognized provider network. The hospital was not hassling members of other, much larger area employer plans administered by the same TPA and likewise not using a network. The TPA confronted the hospital on the plan's behalf, leveraging the weight of all of its clients, to force the hospital to explain the issues and devise a better solution. Had the TPA been beholden to the hospital, this wouldn't have happened.

In another instance, the employer sponsoring a self-insured plan was questioning a hospital's billing practices. When it refused to pay the full billed charges, the hospital returned the plan's partial payment, threatening to "balance bill" the individual directly for 100 percent of the billed charges. Had the plan been working with a TPA or ASO that was affiliated with the hospital, it almost certainly would have pushed the employer to reissue payment in accordance with the network terms.

Because the TPA was entirely independent, it agreed to issue the plan's maximum allowable payment directly to the indi-

vidual. In addition, it hired an advocate to represent the individual in negotiating with the hospital. By taking these steps, the individual, employer, and TPA were able to get the provider to abandon a 2 percent discount in favor of a 35 percent discount, saving almost $30,000.

A Closer Look at Fiduciary Responsibility

One benefit inherent in an ASO approach relates to fiduciary duties. A self-insured employer, unlike an employer purchasing a fully-insured health plan, is deemed to be a fiduciary of the plan members. This means he or she is legally bound to act prudently and only in their interest. Actions that are deemed to be in error, arbitrary, or capricious can expose employers to treble damages, that is, penalties are sometimes equal to three times the damage caused. For many employers, who have never taken on a fiduciary role, this is intimidating and not welcome. More often than not, an ASO is willing to take on that role with you.

With TPAs, things are less straightforward. A TPA is a contract service provider, not a plan administrator. The administrator role is reserved for the employer or trustee-appointed fiduciary. However, TPAs increasingly are taking on plan administrator functions—and with them, apparently, increased liability.

For example, TPAs are promoting programs such as Multiple Employer Welfare Arrangements or "MEWAs," which are statutorily regulated plans comprised of multiple smaller employers banding together to form a plan, moving into marketing, stop-loss procurement, and consulting services. In response, TPAs are coming under scrutiny for their handling of plan funds and invested assets. Courts already have found some traditional claims administration functions to be of a fiduciary nature—particularly in regard to handling and management of plan assets—and have held TPAs accountable under the higher standards of conduct as functional fiduciaries.

Some states have attempted to regulate TPA services as a form of insurance business. However, a number of courts have held that state regulation of TPAs—and of self-insured plans—is preempted by ERISA (the Employee Retirement Income Security Act of 1974).

Even if you hand over fiduciary duties to a TPA or ASO, ERISA says you may remain liable for its breach of its duties *if*, say, there are no procedures in the plan to delegate those duties. But if there are procedures and you follow them, you will be held responsible for the TPA's misconduct *only if you failed to exercise prudence in selecting the TPA or monitoring their performance.*

Naturally, you will want to consult an attorney in this matter.

Ready to Get Started?
A Checklist for Decision Makers

Here are some reasons you might decide to self-insure.

1. **Plan control.** You choose what to cover and exclude. With a TPA, you are able to directly control costs by designing and implementing care strategies that are informed by your culture, employee behaviors, and local health and provider resources.
2. **Interest and cash flow.** Funds are in your hands until they're needed.
3. **Federal preemption and lower taxes.** ERISA states that a private, self-insured health plan isn't subject to conflicting state health insurance regulations.
4. **Data access.** You can, if you have a TPA, examine claims data, study trends, allocate resources, and form partnerships to address your company's unique needs.
5. **Risk reduction.** Reducing risk and costs directly impacts you and your employees, plus you're unaffected by other populations.

On the other hand, you and your employees are used to a fully-insured traditional insurance policy, with all that implies:

"in-network" access to providers, often nationwide; knowing those providers will accept whatever the plan dictates in terms of charges; predetermined decisions about what is covered and what is not, and how a complicated claim should be handled.

How important are these things to you?

Take some time to consider the following before making your decision to self-insure pick either a TPA or an ASO.

- Do you want to make the effort to compare your plan document, which you helped draft, to a stop-loss carrier's policy to be sure you won't be stuck paying certain types of claims the carrier doesn't cover? Or, would you rather someone else handle drafting the plan and picking stop-loss?
- Do you care whether you have a nationwide network or do you prefer local narrow networks and direct contracts, which might save you more money, but expose your employees to the possibility of balance billing?
- Do you care who services your plan—who's watching the claims and who's making sure your plan is being reimbursed when someone else is supposed to pay?
- Do you care whether you're paying for services and programs your employees don't actually need or use? Are you concerned your population has needs not being adequately addressed?
- Do you want to implement the most innovative, evidence-based practices to improve employee health and reduce waste and costs?

If you place more importance on a large network, steep discounts (albeit off of inflated prices you've never seen and over which there are no controls), and avoiding decision making (and liability for those decisions), then you are an ideal candidate to self-insure with an ASO.

If you are willing to risk potential gaps in coverage between your plan and your stop-loss and assume liability for decision making as a fiduciary, in exchange for controlling which provid-

ers your employees have access to, what your plan covers, and which programs, vendors, and carriers you work with, then you are a prime candidate for self-insuring with a TPA.

Ron E. Peck, Esq. is senior vice president and general counsel and Adam V. Russo, Esq. is the cofounder and chief executive officer of The Phia Group, an organization dedicated to empowering health plans' ability to maximize benefits while minimizing costs.

What to look for in a TPA

Is the TPA able to drive you value? This can be in the following forms.

- Value-based contracting
- Integration with local primary care practices
- Chronic care management and reporting
- Cost and quality transparency
- Seamless integration and promotion of third-party solutions like telehealth or second opinions
- Flexibility in customer communication (phone only between 8am and 5pm? Or text, email, chat anytime?)

Will the TPA be able to smoothly accommodate you as a new client? One clue is the size of your company relative to the TPA's other clients.

What is the TPA's performance track record on things like turn-around time for claims processing (seven to 10 business days is average) and accuracy (look for a percentage in the upper 90s)? Reputation in the stop-loss market is a good indicator.

What do their turnover rate, past performance evaluations, reference checks, feedback from dissatisfied clients, and pending litigation tell you about the performance of individual staff who will administer your program?

Is the TPA's technology sophisticated enough to account for and appropriately allocate the cost of benefits, provide a superior customer experience, evaluate the cost of the various benefits being offered, and the efficiencies of providers? (In many cases, the answer is no.)

Does the TPA have a strong relationship with a stop-loss carrier that might help sway excess coverage reimbursements in your favor?

Is the TPA able to meet the competing demands of federal privacy rules and Department of Labor claims procedures rules that accelerate the decision-making process? Can it meet HIPAA's standardization requirements for electronic codes and formats?

Is the TPA prepared in terms of technological capabilities and capital resources to operate in the ever-more demanding compliance environment?