YOU HAVE A RIGHT TO ACCESS YOUR DATA

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Do you have your full spectrum of data?

- Full spectrum data includes all transactional information associated with a self-funded plan's medical claims activity, including elements required on UB-04 and CMS-1500 submissions from providers, as well as derivative fields created by a carrier's adjudication processes.
- Full spectrum data is larger than the files recorded between the provider and payer, given it also includes all financial artifacts associated with a plan's expenses.
- You can and should own your full spectrum of data, as it is crucial to know and understand what you are paying for. It allows you to make prudent financial decisions for your employees and company.

Know the Federal Law

Under **ERISA** and the **Taft-Hartley Act**, carriers have a legal obligation to secure proper payment for self-insured employers. But, did you know that as an employer/sponsor of a health plan, you also have a legal obligation as a fiduciary? Pursuant to **ERISA**, you have a legal obligation to act in the sole and best interest of plan participants with the exclusive purpose of providing benefits. You have to carry out all your duties as a fiduciary prudently, follow your plan documents, and pay only reasonable plan expenses. Plan participants may sue plan fiduciaries that do not abide by **ERISA** and they can sue for unpaid benefits. Also, if found guilty for violation of **ERISA**'s reporting obligations, fiduciaries may be subject to fines and/or imprisonment for up to ten years.

Understand Your Carrier's Responsibilities

TPAs are paid to adjudicate and pay claims on behalf of a self-funded employer. While self-funded employers rely on TPA's to do so accurately, there is often little, if any, incentive to do so. In fact, because a TPA receives revenue both as a % of total claim dollars paid and also as a % of total claim dollars subsequently recovered as paid in error, the TPA is incented to pay first then chase later.

Hospital Transparency

A federal rule called the **Hospital Price Transparency Rule** took effect. It mandates that the nation's 6,000 or so hospitals must reveal the confidential prices they have been charging different insurers and employers for 300 different tests and procedures—like MRIs, blood tests and surgeries. The data revealed so far are shocking: Not only do prices for the same test or procedure sometimes vary between hospitals in the same city by 1,000 percent or more, but some health plans are charged four, five, or six times more for the same procedure at the same hospital.

That's right: Not only can an MRI at one hospital in Boston cost a quarter the price of an MRI at a hospital down the street, but a person getting that MRI at the same hospital might pay 75 percent less than someone else, depending on which health insurance plan they have. Two people, at the same hospital in New York City, getting the same surgery, from the same surgeon, can be charged $3,000 in one case and $15,000 in another.

How can that be? Why would health insurers paying the higher prices (sometimes ten times higher) tolerate such a thing? Don't they always negotiate the best rates for themselves, thereby keeping their costs lower and keeping our premiums under control?

Well, in a word, "no." See, bizarre market forces are built into the health insurance business. Among the most toxic is something called the 80/20 Rule, which can make insurers want to pay more, not less, for health care services and then pass the inflated cost along to consumers in the form of higher monthly premiums.

How can we help you with your data?

1. From Opaque to Clear
Previously siloed claims from every claim line are brought together by 4C into a single **harmonized view.**

2. See Cost Drivers from All Angles
Multiple analytics engines, both rules and behavioral-based, assess the converged claims data to identify patterns and correlations between members, **costs, and providers.**

3. Outside Data Comparison 4C shows you how your costs and outcomes compare to other employers.

4. New Opportunities are Revealed
Gain a true understanding of plan performance and be empowered with the insight to address plan weaknesses and/or optimize plan strengths.

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Here's how the rule works: Insurance companies must spend at least 80% of the revenue they generate from premiums on health care costs and quality improvement activities. The other 20% can be used for administrative, overhead and marketing costs—like, say, advertising campaigns to get more customers or salaries of executives. Insurance companies serving large businesses have to spend at least 85% of premiums on care and quality improvement, with the remaining 15 percent being theirs to spend as they wish.

That means there's only one way to make the 15-20 percent of discretionary money a bigger number for, say, those big salaries for executives. And that's to make sure more is spent on health care services, not less, because 20 percent of $1B is $200M, but 20 percent of $2B is $400M.

The fun money in the health insurance business can only grow if the prices paid for health services grow. And the higher costs are just covered by subscribers via higher premiums, anyhow. So, why would any health care insurance company aggressively negotiate the lowest possible prices for a blood test or an MRI or cardiac surgery? Talk about cutting off your nose to spite compensation.

The Obama Administration put the legal architecture in place that allowed the **Hospital Price Transparency Rule** (championed by the Trump Administration) to withstand cynical lawsuits from hospitals wanting to keep their prices secret. It's a rare and brilliant example of bipartisanship. Now, the Biden Administration could take the next step in healing the health care delivery system by surgically removing the 80/20 Rule.

Consolidated Appropriations Act of 2021

Part of the **Consolidated Appropriations Act of 2021** is a comprehensive fee disclosure requirement that companies must take seriously. Self-insured employers are exposed to substantial liability if they do not comply with the fee disclosure rule. This rule states that fees they are paying must be reasonable. If employers do not comply with this obligation, they can be reported to the Department of Labor.

There are ways to protect yourself from employee class action, representational harm, and violation of ERISA:

- Have a disclosure of all relevant information, service contracts, third-party fees and a year end reconciliation of those fees. If you fail to do so, you have a duty to notify the Department of Labor.
- Provide a detailed assessment of vendors and TPAs that you evaluated in the marketplace to prove you have done your due diligence.
- Ensure your fees are reasonable.