Talking Pop Health
Episode 8: Jack Hill on integrating pop health in the workplace
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Eric Tower: Welcome to the podcast, Jack. Why don't you tell us a little bit about yourself and what you're doing here.

Jack Hill: Well, thank you for having me, Eric. I've been in the health care business for about 35 years. I actually started with Blue Cross of Indiana before it was Anthem, and through the years I've gotten involved in the HMO market place, the practice management area, the reinsurance area of health care, all around health care-related business. I've just seen all kinds of trends in the market place that surprised me, quite a bit and every acronym in the book you can imagine I've seen throughout my career working with employers, working with providers, working with brokers, working with provider networks, working with reinsurance companies and what have you, and going through health care reform like we have. We were very deeply involved with the number of health care reform initiatives including here in the Chicago area in Illinois with the co-ops and what have you, so it's been a real interesting ride up until now.

Eric Tower: Well I'm excited to have you on because frankly, I think our podcast has had a little bit of a focus on the providers and the issues providers face.

Jack Hill: Right.

Eric Tower: We've touched on the employer perspective but I really want to go a little deeper because I think it's important, even if someone is a provider, to understand how health care is selected by the employer and what the process is. So before we plunge right into some of the specifics, you know, can you give us your perspective if I'm running Eric's manufacturing company --

Jack Hill: Hm mm.

Eric Tower: How do I go about getting health care for my employees and, and what exactly am I thinking and what sort of data do I need and how do I go about all this?

Jack Hill: Well most employers work with an insurance broker, that's the typical distribution of insurance products, is through an insurance broker, an insurance agent, and typically, they'll either already have a

relationship with an agent or agents will call upon them indicating that they have access to certain products and services that that employer might, might want. Once they've selected the agent, the agent then takes that information that the employer has, typically the census, any claims information if it's even needed or required and that all depends on the size of the employer, and they'll go out and shop it in the market place. They'll shop it with Blue Cross Blue Shield, they'll shop it with Aetna, United, maybe a local regional HMO or possibly a third-party administrator. That typically takes the form of a proposal spreadsheet. They'll spreadsheet it out.

Typically, it's heavily driven by cost because that's how midsize employers and small employers make purchasing decisions based on cost. That's what the agent will do. Agents typically have a number of favored insurance carriers that they work with so sometimes that will be the basis for the recommendation that they'll make to an employer and that's basically how the industry works. And then the insurance industry that supports the brokerage distribution channels are constantly on conducting, you know, meetings and what would be with the agents in order for them to understand the products they offer – what differentiates them so that they can get the agent to promote and sell their products. Agents are heavily dependent on commissions and and bonuses, so a lot of times – and it's pretty standard in the industry that Blue Cross plans and United Net now, pay bonuses to brokers for certain levels of production and retention business. So that's basically, I mean that's been around as long as I've been in the business which is a little over 35 years.

Eric Tower: Would you say that there's a lot of transparency, you know, from the employer perspective about what are the drivers, or are they just getting – hey if you go with this plan, you know, we'll charge you this amount per month, how does that process work through the eyes of the employer?

Jack Hill: Employers essentially don't – I mean most employers that don't have access to claims or utilization data at all, they really don't know how to quantify the value of what it is that they pay for health care for their employees. Essentially, that's why the price is so price driven, it's so commoditized, the only basis I have for determining if the – if the benefits I'm offering are of value is two things, price and a lack of complaints coming from my employees and their members. So if I can get those two items and I have an agent or I have enough of information relative to what's available in my market place that is low cost, but give my employees decent access, that's the basis for their – for their decision making. They rarely know anything beyond just the price of – of the program and maybe any other ancillary benefits that may be beneficial to me or my members. It's price driven. And when you get into larger accounts, larger employers, they typically are a little bit more sophisticated relative to the plan and the type of information and claims information they may want from, from a carrier or a third party administrator. Typically those are employers that are

self-funded or self-insured and that's – represents a little bit more than 50% of employees are in a plan like that, nationally. So they – they typically are going to be reliant on having data but at the end of the day, their aggregate spend is a preeminent issue relative to them making a selection and that's based on a lot of factors.

Eric Tower: Well, if I'm the employer and I don't have all the data at my fingertips, how can I effectively negotiate for an insurance product, especially if I'm leaving or – or threatening to leave -- my existing insurer to get a lower rate somewhere else? I mean, aren't I kind of captive?

Jack Hill: To some degree. That's kind of an anomaly in the market that, that is controlled a lot by the insurance agent. In today's environment, it's been there again for the last 40 years, the kind of discussion that takes place is the insurance agent comes into the employer renewal and says I got good news and bad news. The bad news is that your rate went up 15%. The good news is it was going to be 30% but because of my interaction with the carrier, I was able to lower their rate of increase. So that – the employer depends heavily on the agent or other agents in the market place that bid on their business to get that price. They don't really directly negotiate anything with an insurance company unless they're a sizable employer in their community. Most employers will employ, you know, a broker or, or a consultant to do that transaction, to help with that transaction.

Eric Tower: Well, let's bring in your company, then.

Jack Hill: Hm mm.

Eric Tower: So you're out there, you've got 2.4 million lives --

Jack Hill: It's a little bit over 2.5 million lives under management right now.

Eric Tower: How do you, how do you fit into this milieu compared to some of the other actors that you mentioned?

Jack Hill: We're a health care risk management company. That's where we plant ourselves in the value chain as far as the options that employers have. And what I mean by that, is as an administrator for self-funded employers, we don't always go to the market place with the lowest prices. We don't always compete effectively with a Blue Cross plan or an Aetna or United if they are a predominant player in the market place, so several years ago, we made the decision that we needed to have our own population health program that we could deliver to employers because since we can't compete on unit price, we have to compete on use rates. We have to change the dynamic in the plan that manages the population.

About 20 years ago, we started an organization called the American Health Data Institute and we brought in two real key players into our organization to really establish our own population health data

analytics company. We've always been about data as an organization but we, we didn't have the type of analytical framework that we really wanted to take to the market place so we established American HDI we call it, American Health Data Institute, and over time, as we, as our medical director started to drill down into the data we, we were able to define an determine that there are 27 chronic conditions and co-morbidities that are manageable if the right type of regimens of care were established to help manage that population. So well over two million lives, we've been able to determine that 27 chronic conditions and co-morbidities represent around 90% of an employer's real spend. And, and of that spend, only around, you know, 15 to 20% of the eligible members in a group are really, you know, generating that spend.

So we drill down in the data, we stratify the risk on our data warehouse, we identify the sickest of the sick in a population based on their illness burden and, and, and their disease states and then we work with the employer to establish a benefit plan that doesn't – that, that increases the ability for people to get care at the right time. We structure the benefit plan to drive that kind of structure. Now secondarily, we have nurses who – where all the data, the, in our data warehouse which represents claims information, HRA data, nurse coaching information, pharmacy data, biometric information, all go into our data warehouse. And from that we profile a patient based on their perspective health index.

What we do is we encourage the employer to have all their members get access to our nurse coaches and then we reach out to those individuals on a proactive basis to get them to help self-manage their condition. And all of our nurses and our dieticians that are on our staff are taught in motivational adult coaching because it's really key to really getting across to the patient what they need to do to self-manage their condition. And those individuals are given incentives in many cases from the employer that if they get you their full regimen of care over a specified period of time, they may get a bonus, they may get a reduced employee contribution and what have you. So at the end of the day, we're measuring two key elements. One is service rates which are the total number of services that we have to provide for that population of that, for that employer and completion rates which are that these members that had one or more chronic conditions received 100% of their need of regimen of care over a specified period of time and if we can get completion rates for those regimens of care up above 50 to 60% we can show a reduction for an employer between 11 and 17% over a two to three year period. It's been consistently proven in our database, doing that.

Eric Tower: Couple questions. When you talk about the reductions, is that the total cost of health care or is that the total cost of health care and lost productivity?

Jack Hill: Its total claims cost over a specified period of time. So we measure our results a couple of ways. One is we, we measure it based on the initial time that employer becomes a customer of ours, so we measure their historical cost and, and we then measure that against the completion rates for the chronically ill and, and we adjust for plan design and contribution changes and then over time we continue to measure completion rates to the health index of the population whether it's improving or not improving, to the net cost of that employer. And over time, we can show deltas of 11 to 17%, even greater, if an employer really pushes his plan and pushes those employees to get those regimens of care satisfied over a period of time. And that's why we can compete even in markets where we don't have the lowest price because we've been doing that and we do that, Eric, in instances where we're leasing networks or PPO arrangements whether it be a PPO that's isolated to a specific market but in all those instances the providers are not really integrated in the product, okay? They're passively participating like most providers do as a participating provider for a specified reimbursement rate.

Eric Tower: Interesting. And I just want to check real quick. You're scraping a lot of data but you're not getting the actual medical records, you're managing this through –

Jack Hill: Claims data, health risk assessment data, nurse coaching data. Not only nurse coaching with the individual participant but with their physician and biometric data that we have in the data warehouse and pharmacy data. We've been very effective at using those tools that are only available to us. The issue with medical records is typically medical records are isolated to a specified group of providers and in most instances, those providers don't do every single episode of care for a particular population so they have in some cases less information than we do. So we've utilized very effectively claims data to do episodes of care evaluation. We can use it to evaluate physician practice patterns. We can use it to evaluate whether gaps in care are being satisfied. We can use it to model the index of a population based on the information that we have in our data warehouse so we've been very effective at using claims data.

Eric Tower: So you've covered this notion of contracting with PTO's.

Jack Hill: Hm mm.

Eric Tower: How do you create your networks. I mean, if I'm an employer in a large metropolitan area –

Jack Hill: Right.

Eric Tower: There are going to be a number of different providers that are probably going to be necessary unless it's a highly consolidated market.

Jack Hill: Correct. Well, the normal way in which we've done business over the years, we do what we call a disruption analysis. We look at an employer, we look at the employer's zip code where their members reside and then we evaluate networks based on the composition of those networks in those various zip codes. Then we also evaluate the pricing of those networks based on impatient, outpatient and physician charges because we have that data.

Eric Tower: Would you think that one area of opportunity for you would be to unify with providers –

Jack Hill: Exactly.

Eric Tower: -- And come up with a shared upside, shared downside, an even cap?

Jack Hill: Absolutely, absolutely. And that's kind of what we are doing now in the market place and why we, we're putting a lot of our own strategic effort into assisting medical providers in certain markets to deploy their own proprietary health plan that they can deliver to the market place where in most cases it would be the first time that an employer and a provider are sitting across the table discussing budgets, the employer's health budget, how it's defined, the health index of the population, the illness burden of the population, because the medical provider is the clinical deliverer of care. The insurance community are financial transaction people that actually, that happen to control the distribution channel.

So I think it's revolutionary. If we can get providers to be able to sit across the table from an employer in a fully transparent way where we can deliver that data analytics to both the employer and the provider, they can start to talk about common issues around managing the population and thou the provider is incentivized an employer to change the way payments are made because in a fee for service environment – which is still predominant in the United States where the more I do, the more I get paid regardless of the outcome, that can't – that's not sustainable. So employers have to be educated that they need to think about the way in which they pay providers differently.

Eric Tower: Well how do you respond to the provider who says yeah, you know, things are tight. I'm getting squeezed but if I go down the road with Jack --

Jack Hill: Hm mm.

Eric Tower: I have all these bricks that I need to keep, you know, in the hospital, and I got to pay for all this and if I go this route and you know, my unit-based care, it's a lot of work. It's really painful and it really involves a complete change to how I deliver care.

Jack Hill: And that is a challenge, I admit. But here's, here's – here's the value proposition, is, in these arrangements, we're talking about working with a, you know, high quality, high performance narrow network. So if the provider really understands the moving parts and they're not – they don't have a 100% market share, then this is a great opportunity for them for a certain part of their commercial payor mix, to have a part of the business that they have in a controlled relationship with an employer. It's not controlled by Blue Cross, it's not controlled by Aetna, it's not controlled by United.

This is one part of the business where I have control of the employer relationship, I have an opportunity to impact plan design, how the plan's designed, I can impact on the definitions of the plan itself, I have impact on the delivery system, the protocols of care and now I have the ability to generate incremental revenue that I can't do in the current market place because it's controlled by somebody else. I can control the manner under which I determine how patients are attributed to my delivery system.

Eric Tower: Sure, yeah. How do you go about stratifying the patient population, then? Let's assume you've come up with one of these networks, I mean.

Jack Hill: Hm mm, yes.

Eric Tower: You know, you've got software that stratifies you said 26 conditions, right?

Jack Hill: Twenty-seven.

Eric Tower: How do you integrate in with them under these circumstances?

Jack Hill: Well, the thing that we have that's of value to the provider is we've been managing employer-based, employer-sponsored health plans for forty years. And our programs are based on working with an employer-sponsored plan and we do have the ability to stratify working with the data that we have. When we take over a plan, we really drive the employer to really encourage health risk assessments to begin with because a lot of time we don't have historical claims on an employers.

We get really basic information from the insurance carrier because they don't really have their reporting in such a format that you can really take actionable steps about a population. So we'll typically encourage the employer to have their employees do an HRA so that way we know it runs right in line with the 27 chronic conditions that we manage. So from that information, we can reach out to the patient and validate that information they provided is accurate and we use that as one basis for initially determining the illness burden of an individual and a population.

Eric Tower: Do you find some providers that say thanks, but I'm not having some software program tell me how I need to handle these conditions?

Jack Hill: We haven't had that, to be quite honest with you. Most providers when they drill down below the surface of our data, they agree with the way in which we've been managing the chronically ill because most medical providers by specialty haven't really been trained in population health. They haven't been trained in preventative care or wellness. They've been trained in really providing a specified medical service for a particular diagnosis.

Eric Tower: How do you typically interact with the providers now? It sounds like one thing you've done – you've taken away – you're certainly not a high deductible health plan.

Jack Hill: No.

Eric Tower: So, and there are a lot of incentives and interactions there for the employee to come and get the care.

Jack Hill: Hm mm.

Eric Tower: How do you handle this vis-à-vis the providers and making sure that they feel engaged and part of this process?

Jack Hill: That is – that's probably one of the biggest difficulties that, that we or anyone else face when they're working with a provider. Typically, we're working with either a house system, a large multi-specialty physician group, a PHO, any number of – I mean it depends on the market that we're in and, and who the provider is that we've been introduced to as to how we interact with them. So to be honest with you, if you've seen one provider, you've seen one. So they're all organized differently, they're all – have different political situations, they all have different ways in which the delivery system is set up, so we work with them at where they're at, at that point in time.

Eric Tower: You said something interesting there. Let's talk about a large, multi-specialty medical group.

Jack Hill: Hm mm.

Eric Tower: Let's call it Eric's multi-specialty group.

Jack Hill: Hm mm.

Eric Tower: Hey I want to work with you. I want to contract direct to employers. Do I really need a complete health system as part of that or can I go through you and then we purchase everything on a pre-unit basis through your PPO, or how does that work?

Jack Hill: That's real interesting because this comes up every time. Not every provider group has every medical service delivery item necessary to deliver a full to an employers and we know that. So part of our job in working with the provider is to uncover what medical services that provider doesn't provide. As long as they provide the core services, primary care, specialty care, some ancillary, maybe even some facility services, we can generally work with them to wrap those other services through arrangements we already have in place. To give you an idea, we work 83 different passive PPO networks around the United states and any number of those networks may suit that provider well to fill in the gap of service delivery they don't have.

Eric Tower: So if you're in a market like, alright we'll throw out, Chicago because we're sitting here -- it's a pretty big market, so, depending on how you define it, that's an eight county region. Could you contract with Eric's multi-specialty group even if we're just in Cook County, or would we have to come up with a way to work with some other providers and wrap further out?

Jack Hill: I lived 27 years here and I can, and I've worked in the city, I've worked on the north side, I've worked on the south side, and I, at different times – and most employers are the same way with their members, you know. So you're going to have to have enough dispersion of providers so that you can really provide cover for that employer. So it wouldn't really be viable if all you were doing was providing medical services just in Cook County or just in Chicago because there's so many employees that live like in DuPage County or Will or McHenry or Lake, and so there you might end up as a provider having a partner. That's one particular opportunity.

You might want to develop other relationships with providers in those other communities that have – are like minded with you, relative to what it is you want to deliver to the mark place. We're – there could be also an opportunity where we attach you to a network that we already have in place where the core group of providers in Cook County provide the plurality of care for a particular employer but where those members need access to other providers we give them access. But I would say legitimately, you really want to have as much cover around the City of Chicago and the collar counties so that you could at least deliver basic primary care services, I would say. And then we could probably wrap everything else into other contractual arrangements we have.

Eric Tower: Let's turn briefly to a topic that's near and dear to my heart: networks and antitrust. Most health systems or – or providers even, I…I don't think we could say that this product is limited to health systems. They have challenges in so far as they either don't have geographic coverage or they don't provide care up and down the entire continuum. How do you approach that as far as developing the networks?

Jack Hill: We look at where the provider is in terms of the medical service delivery that they currently do. And then we evaluate where they have, as you stated, gaps in medical service delivery and, and then we look at the potential of filling in those gaps with already existing contractual arrangements that we might have and we currently have 85 different provider networks or PPOs that we contract with. And, we do that for a number of reasons.

One is, most providers that are sponsoring a program like this, because, there not always fully financially or clinically integrated with every provider in – in their geographic area. So, there has to be some means of closing those gaps so that that sponsoring provider will not run awry of potential antitrust or price-fixing or anything of that nature. So, what we've done is we've been able to create the custom proprietary network for that sponsoring organization.

Eric Tower: So, if I've got St. Elsewhere Health System and I've got, you know, a couple of hospitals, a physician group, probably don't have home health, certainly don't have anything in the way of rehab or long-term care, are you saying you can bolt that on and I can have the St. Elsewhere branded product offered out to the public direct to employers?

Jack Hill: That's exactly correct. You can basically have a full service delivery system with these other, contractual arrangements that are, as you stated, bolted on with…and, and over time you build more critical mass with your program, you can start to reach out to some of those providers that may be under more of a PPO contract arrangement and talking to them about working through the PPO arrangement for a better contractual rate because now you can support a better contractual rate with, with, with a volume or they could make those other providers over time part of their clinically integrated network if they have one.

Eric Tower: And how about geographic coverage? If I've got a three systems, with maybe an overlap in geography, have you done this to, to give the geographic coverage to make the plan attractive to employers?

Jack Hill: Yes. And the way we've done that is we with the wrap networks we can. We can also provide coverage regardless of where the members reside, because what invariably happens is a local sponsoring provider who's branding this program as their own, um, when – when the program is sold in the marketplace it doesn't – most employers have employees that reside in other geographic locations. And that provider in order to deliver a full solution to that employer is going to have to have access to providers in other locations.

Another way we do that is if the employer has concentrates of employees in different locations, but the primary majority of their employees reside within the geographic locations of the sponsoring providers. We can do what we call disruption analysis. We can look

at, okay here's this employer in Chicago but they have employees in St. Louis, they have employees in Detroit – we'll look at those other markets for purposes of pricing and network access.

Eric Tower: How have employers responded to this new experience? Are they welcoming with open arms or are they, you know, you have to do some talking or where, where do things sit?

Jack Hill: Well, the key is the message that you're delivering and the value proposition that you're delivering to that employer. And as I said earlier what we're trying to do is marry the local provider with the employer and enable that a dialog to happen around the care and quality of health care that's being delivered to that employer. But it's being done with a clinical provider of care sitting across the table from that employer. And a lot of employers have been looking for this type of transaction for years because most of the large commercial carriers and, and, and TPAs for that matter and networks are the intermediary between the employer and the network provider.

And, and many times they don't even know that they have the ability to take this and deliver this solution to a provider. So the message and the value proposition is key. The second to that is, we have to demonstrate that the pricing is there. So, a provider that's delivering their own proprietary network to an employer has to price their product to where they – to where that employer is going to find it to be attractive enough to relegate their employees to a narrower, but higher performing, network. And employers heretofore are moving more and more towards these arrangements than ever before because of the price and tolerance in the marketplace.

Eric Tower: Well if St. Elsewhere is starting off cold here and we've never done this before, how do we get our arms around how we price and accomplish the plan design and all this other great stuff you're talking about?

Jack Hill: Well, we always feel that the first place that a health system, especially that's sponsoring one of these direct employer arrangements needs to seriously consider doing it on their own population to begin with because it's a natural controlled laboratory where they control the plan design, it's their own delivery system, the care management of – of services for their own employees.

In other words, they really need to think strongly about doing that. And there's also some self-serving elements that are built into those. One is to optimize domestic steerage so they can save their plan even more money and, and that's dependent on what their occupancy rates are and how many staff beds and how high of an occupancy rate they have because the higher occupancy they have the less they maybe tend to want to drive domestic steerage. So, there's considerations around that, but they need to experiment on their own population, work through the bugs of – of how they're going to handle referrals

and attribute attribution of patients, and then it's a strategic issue for them also because when they decide to go to the marketplace, they want the product to be well-oiled and, and working effectively.

They can do that with their own plan. And there's another strategic element that's tied to this, is that when they go to the marketplace with a proprietary program direct to employer, invariably the marketplace is going to ask, well what are you doing with your own plan? They need to be able to say, we're buying our own plan which is why we're taking this to the marketplace.

Eric Tower: I guess and maybe this is obvious, but it strikes me that one of the key benefits you have…I guess I shouldn't use the word key, right? Key benefit administrator.

Jack Hill: Right.

Eric Tower: You don't have to put up these enormous insurance reserves and get an insurance license, which could be a real impediment and you already have existing brokerage relationships. Do you want to comment on that at all or?

Jack Hill: The one thing that many health systems that we've talked to over the last few years are, are concerned about is: are we an insurance company? Do we have to assume risk? Are we going to have to put up a lot of capital and surplus to support a license? None of that is required under the model that – that we've been deploying for the last few years. These are essential for the providers that's sponsoring the plan, fee for service, arrangements with an upside gain share, okay?

They're primarily sold and promoted to self-insured, self-funded employers in their marketplace. And in many parts of the country we have programs that could go down to two employee lives on a level-funded basis, which looks and smells just like a fully-insured contract but it is partially self-funded. And, so they don't have to worry about filings or, or insurance bureau issues or contractual arrangements or compliance. It's all pretty much there. It's already in place, but it's got to be customized and modified to fit that provider's current situation the network providers and their own internal protocols.

Eric Tower: Jack, one area where there's been a lot of commentary on is the issue of costs around pharmaceuticals. Everyone says they're escalating, at an unsustainable rate, and certainly a lot of even health care providers say their costs are out of control and they're passing those on as well. What are – what are you doing around this issue?

Jack Hill: Well we recently, made a decision as an organization not to play that game any longer ourselves. We've been a very large user of a number of commercial pharmacy benefit management companies and there are a lot of games that are being played rebates and average wholesale price and what have you and we know it. We know that

those games have been played. So we made a conscious decision that, for two reasons, that we – we need to make that whole process transparent. We believe that the employers are really funding a large part of this and it's impacting the cost of their plan, pharmacy is becoming a much larger percentage of the overall health spend of an employer, some cases in excess of 20% with some employers that we know. And so, and a lot of that is due to things that happen below the line that really nobody knows about which is why some of the big PBMs aren't doing so well financially. So we made the conscious decision that we want to eliminate a large part of all those – we want to eliminate all of the financial arrangements that happen in PBMs that don't directly benefit the employer. So rebates are passed on 100% to all the employers that we work with and all the wholesale prices that are directly negotiated with manufacturers are all 100% passed on to the employers.

The only thing that we do, is we have a pharmacy admin fee to do the transaction. The other reason that we feel it's, it's absolutely critical, important is that we integrate pharmacy into our data warehouse and, and it's important that we know that – what the compliance rate is for pharmacy in order to properly manage patient populations. A lot of commercial pharmacy benefit managers don't really integrate their data with claims information. So we – there's two reasons, we feel like, like we have an obligation as a, as a planned fiduciary for certain employers to provide them with complete transparency of every transaction that happens relative to pharmacy spend and to help that that employer manage that spend with our, with our clinical staff.

Eric Tower: So if you're not getting rebates, I think we could both agree that rebates have some effect on tiering within formularies. How are you – how are you conducting the tiering? I mean is this strictly, this drug is cheaper or, you know, do you have analytics to support the efficacy?

Jack Hill: We do have analytics to support certain formularies that employers can get access to. The larger the employer, as we said earlier, the more sophisticated they might be. They may have a particular formulary we want to duplicate initially, and we'll do all that. We're flexible with respect to that.

Eric Tower: Wow, that's pretty impressive. Well, how do you, how do you respond to some of these recent initiatives that you hear about with some of these brokers go up to employers and they say, hey I have this great plan and we're going to use Medicare as our base rate and we're going to pay a little more than that and, you know, we'll come up with something and that will be the health plan you offer to your employees and they don't go ahead and negotiate that openly with the providers. It's a little bit of a shell game. What are your thoughts around that because obviously that might be very attractive to an employer in lieu of what you're doing?

Jack Hill: We refer those – to those types of arrangements as non-network reference-based pricing arrangements, and as we kind of talked about earlier, these employers in this country are at a level of price intolerance that they'll almost buy whatever they think is going to work to reduce their costs. So there are a lot of operators in the market place now that are really proponents of these types of arrangements. We think there's a lot of problems with them. We even to the extent that they may not even be qualified health plans under the law because they don't address the maximum out of pocket price. When brokers are selling these types of arrangements, they're really selling the employer a non-network plan. The providers that the – the members go to under these reference-based plans don't have any contractual obligation for a reimbursement rate so when a member goes to get medical services, the plan that the employer has adopted asserts exactly how much they're going to pay for that service. It could be a multiple of Medicare, but it's always lower than market rates in a particular area.

So an example might be this, and this – this plan document will say that the most that they'll pay for an institutional stay is 120% of Medicare, when the actual lowest commercial rate in the market is 150%. So the member goes into the hospital, they – they get the care and the hospital bills the plan charges, whatever their charges are, which could be three or four hundred percent of Medicare. So the member ends up getting balance billed and then the plan asserts its rights to the medical provider that you've accepted the payment we made and that's all the plan – we're an ERISA plan so we're not subject to state insurance department regulations so that's all we're going to pay you and if the patient gets balance billed for that particular service, then these operators will provide patient advocacy. You know, they'll work with the provider to settle that claim, at the point where the provider is balance billing the patient. But these arrangements are in my wake, somewhat insidious because the member is the one that's left holding the bag because the provider is going after the patient then for the balance bill.

Eric Tower: Right. And the member thinks they have full insurance coverage --

Jack Hill: Correct.

Eric Tower: When in reality they could be on the hook for huge bills.

Jack Hill: Absolutely. And, and two people really lose in that transaction. Well the employer loses because the member's typically not satisfied, okay. But the member obviously loses because they could be subject to balance billing for years, long after these plans may be terminated and they move back toward a traditional network arrangement. But the provider is hurt too because the provider has just been relegated to nothing more than a commodity. All your worth is 120% of Medicare and providers that allow these types of arrangements to

continue to persistent in their community are adding to that same level of commoditization of medical providers.

Eric Tower: Oh with all due respect, I think it's worse than commoditizing -- You're becoming the enemy if you're the provider. I mean you're, you know, you're legally entitled to your full charges in some instances you're required to make collection efforts on those and, you know, the poor patient who thinks that they were covered ends up, you know, holding the bag. The employer, from, from your description, probably doesn't even realize exactly just how insidious this is. So, you know, the bad actor in all this is the one putting together the plan, right?

Jack Hill: That's true but, but it happened even before that because before the employer makes the decision to move into this area, they've already been told that the provider is the enemy. They've already been told that the provider is charging well in excess of what their costs are and so that process of vilifying the provider has already taken place long before the employer adopts the plan and that's the problem. If the provider doesn't have a connection to the community where they can start to define the value that they deliver in the community and talking directly with employers, somebody's going to fill that void because the employers already are price intolerant and on top of that they're being told that the medical provider is part of my problem. So they're very vulnerable to these types of pitches from different brokers and TPA – different people in the market place that are pitching reference-based pricing and they believe it. They believe that yeah, this is the answer. And the problem with that is that it may only be an answer, financially, for two or three years. Because as I said earlier on, the one thing that this does is that it addresses the unit price of health care. It doesn't address use rates.

Eric Tower: You're obviously a strong advocate for what I might call provider-led health plans, then. What do you see the process being going forward? You know, I mean we're at a point where costs of health care are spiraling out of control. You're, you're offering an option. If I've got St. Elsewhere in Nowhereville, you know, how do I start with this whole process?

Jack Hill: Well, definitions are key and when you say provider-led health plans, that reminds me of what happened back in the late 80's and 90's when a lot of medical providers started getting into the HMO industry and there was a lot of capital and surplus required to get a certificate of authority. There was a lot of cost to build infrastructure and, and they felt that that was the right thing to do at the time and I'm not talking about that at all. I'm talking about providers developing a plan and constructing a network strategy around supplying services to self-funded employers. And in our model, it doesn't require that they come up with any capital and surplus to support risk. These arrangements are essentially discounted fee for service arrangements with an upside gang share but with an eye on – also working with some employers, on the total cost of care, because the one thing that

we do know how to do is help establish a basis for what an employer budget would be.

Eric Tower: Let's assume I want to start today. I pick up the phone, I say Jack, I want to get going. How long does it take to stand this plan up? I mean already, you know, I realize that 2020 just started. I would assume most employers are, if they haven't already made decisions about benefits for 2021, that would probably start happening fairly soon, right? Are we looking at 2022?

Jack Hill: No.

Eric Tower: No?

Jack Hill: Not at all. We can actually establish and put together a full plan with all the component parts to allow a provider to deliver a turnkey solution to the market place in less than eight months. And that includes the delivery system. That includes the actuarial pricing of the network, that includes the reinsurance, that includes the plan design, that includes the managed care protocols. We've done it enough times to where we've got it down to a point where we can deliver a full turnkey product in between six and eight months.

Eric Tower: And how does that work with respect to the employer relationships, because even though St. Elsewhere is in a community, they might not have a direct line of sight into those HR departments.

Jack Hill: That's true. We still believe that it's important that we work in a community with the stakeholders that are there. And that would include the insurance agents and brokers that – that are actively selling and promoting health insurance products in the market place. We work with the same type of agency distribution system. We think it's important that this gives the health care system an opportunity to communicate directly to the employers in their community to give them an opportunity to explain exactly what they're doing to help those employers with their costs.

Eric Tower: If I were to look at the continuum I might characterize that as health care providers have talked a lot out clinical integration. I coordinate my physicians with my hospitals with my home health, and you're talking about taking that from the other end of the chain, coordinating the employer down through sort of the managed care product, we'll call it, the care product and then into the provider. So you're talking about – you're not going to interlace the hospital and the physician necessarily but you are talking about coordinating sort of the total cost and the total approach to health care through – with the employer through the health system.

Jack Hill: The health system is, is the, the primary stakeholder that's developing the program. So that's not necessarily the case. What we're trying to do is marry our 40 years of experience working with employers with

the health care provider that's delivering the clinical care and enabling those two people to sit down at the table and work on the health of the population. And that hasn't happened in any great way in our country. So if – clinical integration is, is the ultimate goal for most of these medical provider groups. They want to be fully clinically integrated and I think that is an ultimate goal. And we're all for that but that doesn't have to be the current state of the provider that wants to sponsor one of these arrangements. They don't have to be fully clinically integrated. They don't have to be an accountable care organization under the law, but there should be components of that initial provider's structure that would allow them to deliver this type of medical delivery system to an employer.

Eric Tower: Well my crystal ball broke but let me ask you about yours. Let's say for the next five years, you know, where do you see things, where do you see them going?

Jack Hill: If the political situation is sustained in the next election, I don't see there being a lot of regulatory impact on the market place like there was in the past, so. I think there will be a lot of opportunity for innovators to do some really good things but the status quo is going to continue. There's no doubt about it. You're still going to see employers grapple with the cost of health care and you're going to still see health insurers vie for market share but I, my hope is that more and more, medical providers and more and more employers will start to see the value of trying to work together to solve part of the problem because it's not going to change. Health care costs are going to continue to go up in my way of thinking, UMM but that would be my hope, is that we would see more providers, really, want to take the lead and be something to somebody in their community.

Eric Tower: That's all I got.

Jack Hill: Me too.

Eric Tower: You too. Alright. I'll just do a quick closing. Jack, thanks for joining us. It was a pleasure having you chat here on Talking Pop Health.

Jack Hill: Thank you, Eric, I appreciate it.