Have PPO Networks Perpetrated The Greatest Heist In American History?

Dave Chase Pharma & Healthcare *Speaker; Author; Exec Producer, The Big Heist*

Trillions Have Been Redistributed from the American Workforce to the Healthcare Industry Creating An Economic Depression for the Middle Class

The Washington Post and Vox have done excellent reporting that shows U.S. spends so much more than other countries for one simple reason -- price. The good news is that some have found the solution to severe pricing failure, however so few have that the Middle Class is in a 20-year long economic depression that is at least 95% due to healthcare. As we've delved into the issues putting together the story for The Big Heist film, it is clear that the explanation for the strangest presidential election in my lifetime has been badly misreported. At most, immigration and globalization account for 5% of wage stagnation (on the latter, a big reason for jobs moving overseas are healthcare costs). In other words, a minuscule portion of the wage stagnation is due to foreign countries.

We've gone to war for much less than what healthcare has done to America. In order to end the assault, one must look at the underlying drivers -- not the symptoms -- to understand how to restore the American Dream . There are a number of tricks the industry plays on healthcare purchasers but none is more pervasive, yet easy to fix, than PPO Networks. This has caused Americans to spend 30-50% (over $1 trillion per year) more than necessary resulting in nest eggs getting crushed and putting millennials on the path to be indentured servants to the healthcare industry.

To get a deeper perspective, I interviewed Mike Dendy over email. Dendy is the Vice Chairman and CEO of Advanced Medical Pricing Solutions, Inc., a healthcare cost management company. Few have a deeper industry background than Mike Dendy. Previously, he was the Chairman/CEO of HPS Paradigm Administrators a Third Party

Administrative services company managing group healthcare benefit plans for both the private and public sector. For four years, he ran the community health system business at Memorial Hospital in Savannah, GA. In addition, his father was on a hospital board for years so he has a deep perspective from both sides of the equation. Dendy has a Master of Business Administration and a Master of Healthcare Administration degree and has served employers as a healthcare consultant for the past 26 years.

The following is a summary of the points Dendy made in this extended interview:

- **The start of the economic depression for the middle class correlates with the rise of PPO networks**. The average of so-called PPO "discounts" nationwide is that employers pay roughly 2.6 times greater than what Medicare pays, however it varies widely between markets from some paying less than Medicare to most paying far greater. Dendy privately shared some client reports where it showed companies had PPO networks from the major carriers blindly paying scores of bills at over 10 times Medicare prices. PPO networks charge access fees, a fixed cost of a group health plan, of $12-$20 pe/pm for what is arguably the obligation to overpay providers for healthcare services.
    - **Virtually every company in America is failing in their fiduciary duty to their employees and face serious legal risk**. This breach hasn't gone un-noticed by lawyers -- both company and class action lawyers. An example of a recent settlement was a BUCA paying $40 million to a Global 200 company to make the lawsuit go away. It's hard to imagine how an employer can fulfill their fiduciary obligation unless they use an independent TPA such as Continental Benefits or EBMS that isn't conflicted.
- **The media has badly misreported the healthcare cost crisis**. This is aided by health plans designed deftly to make average people blind to the true costs of healthcare. People are left with the feeling that the only solution is to completely remove the private sector. As many employers have shown, they can dramatically out-perform public purchasers not only on price but also solving the second biggest problem in healthcare -- overtreatment. The role the government can play effectively (as it has with 401k/retirement plans) is to require that employers fulfill their fiduciary duty already in the law -- one small step can ensure that happens.
- **Hospitals have happily gone along with the PPO chicanery as they benefit when health plans blindly pay their outrageous bills**. As I've reported before, hospitals see the handwriting on the wall and virtually always go along with new, more reasonable payment models. However, they will feed at the trough as long as employers allow them. It's the biggest lie in the employee benefits arena to think that healthcare costs can't be controlled. Four graphs at the end of this piece clearly show that. Forward-looking organizations will embrace a new definition of transparency via a Fair Trade-like approach to gain market advantage over stuck-in-the-past competitors.
- **Too many HR leaders mistakenly believe that insurance companies are concerned about lowering healthcare costs**. Technically, I suppose that is true. They have a financial interest in NOT seeing healthcare costs go

down. It's Economics 101 to see they have every interest to ensure costs rise. They are operating perfectly rationally given their circumstance.

- **Dendy describes "healthcare's OPEC" laying out the roles and motivations of each party to continue to see this economic disaster continue as long as possible**. He details each party's motivation and paints an optimistic analogy of how the cartel can be thwarted.
- **Reference-based reimbursement is the most straightforward path that hundreds of companies have proven can be implemented rapidly to save the American Dream**. Since this is his business, Dendy goes into detail on how it works and how it is saving schools, businesses and municipalities millions every year -- money that can end the economic depression for the middle class if it isn't redistributed from the middle class to an administratively bloated industry paying executives fabulous salaries for average performance (from a health outcomes perspective).

What role have PPO Networks played in the healthcare cost crisis?

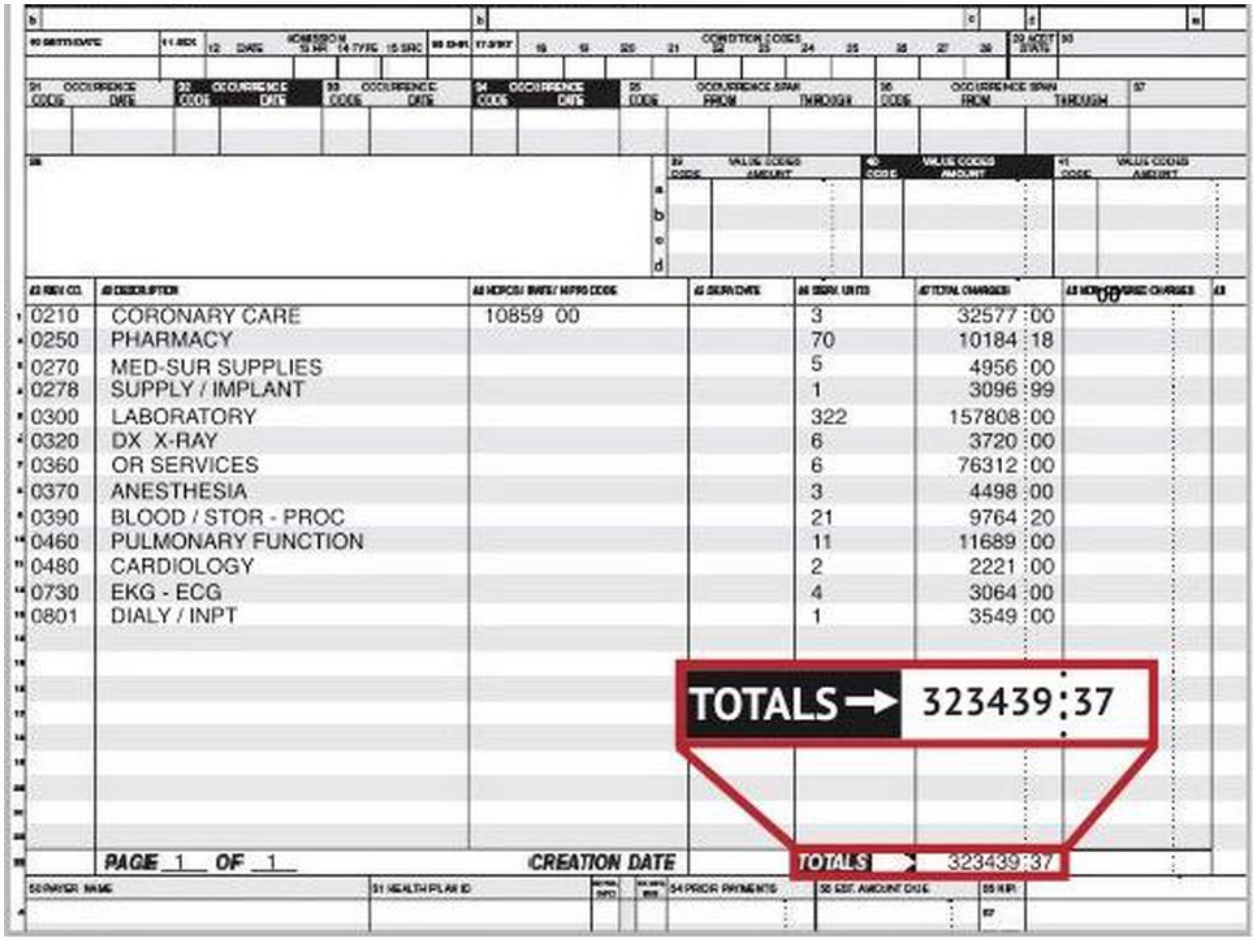
Mike Dendy: It is easy to trace the issues we have in healthcare financing back to the initiation of the PPOs. While hospitals appear to be the villains, and sometimes they are, they are taking advantage of the opportunity created by the quadopoly of the large BUCA-PPO plans *[BUCA stands for Blues such as Anthem, United Healthcare, Cigna and Aetna].* One could attribute it to not leaving money on the table as the seller of services. The discrepancy in hospital pricing is truly revolting. For example, in Savannah, GA the Savannah Business Group purchases hospital services for 85% of Medicare. It's about the same in Las Vegas where the Unions purchase in a similar range up to about 90% of Medicare. However, the same services are being veiled by the PPOs and paid for in other markets at prices well over 300% of Medicare.

On average, we find hospitals around the country pricing services (gross billed charges) at about 550% of Medicare and the BUCA PPOs providing discounts of approximately 50% off of those prices. It is amazing how little employers know about what they pay. I recently visited with a Fortune 100 company that sports 110,000 US based employees. I asked their HR VP how much they thought they were paying for healthcare relative to a Medicare benchmark, they had no clue and were flabbergasted when I gave them the answer. The BUCAs hide that information, of course.

What is your take on the issue of companies failing in their ERISA fiduciary duty?

MD: You have written about some landmark cases in lack of fiduciary responsibility and the lawyers we have queried over the last 5 or so years confirm that basically every employer is in breach due to the fact that employers don't know what they are paying for services, with co-mingled money, and also the fact that their facility (hospital) claims are paid without any scrutiny whatsoever. Within ERISA, each group health plan has a single fiduciary who is responsible for protecting the co-mingled plan assets of the group plan. To see what will likely happen in the future relative to the poor decision making taking place now, just look at the scrutiny and penalties being imposed under the same ERISA law relative to pension and 401k plans.

Claims administrators (TPAs) from all of the BUCAs to the smallest TPA mom and pop shops all have the same operational process, they receive a useless Uniform Bill (UB) from a hospital as an invoice, they deduct the PPO discount from the billing and they pay with someone else's money. There is absolutely nothing on a UB that allows the payer to know what is being billed for nor the accuracy of those billings. I am attaching a UB for your review. Note on this one that 322 units of laboratory are billed out at $157,808. The payer of this bill could not have cared less that there is no such thing as a "unit of laboratory", they simply were prepared to write the check on someone else's bank account had AMPS not intervened. This one page UB represents the entire invoice submitted by the hospital on this $323k claim by the way. No one in their right mind, using their own money, would ever allow this to be the depth of their financial diligence so the only way this passes muster is the opacity of the US healthcare system perpetuated by the unholy alliance between PPOs and hospitals. The entire US corporate community have had the wool pulled over their eyes for the last 25 years.



0210	CORONARY CARE	10859 00		3	32577 00
0250	PHARMACY			70	10184 18
0270	MED-SUR SUPPLIES			5	4956 00
0278	SUPPLY / IMPLANT			1	3096 99
0300	LABORATORY			322	157808 00
0320	DX X-RAY			6	3720 00
0360	OR SERVICES			6	76312 00
0370	ANESTHESIA			3	4498 00
0390	BLOOD / STOR - PROC			21	9764 20
0460	PULMONARY FUNCTION			11	11689 00
0480	CARDIOLOGY			2	2221 00
0730	EKG - ECG			4	3064 00
0801	DIALY / INPT			1	3549 00

TOTALS → 323439 37

PAGE 1 OF 1 CREATION DATE TOTALS 323439 37

Uniform bill

To pour salt into the wound, the large BUCA payers charge $14-$20 pe/pm *[per employee/per month]* to allow access to health plan members to these most often ridiculous discounts. Yes, the $14 to $20 is just to have access to the PPO network providers. The assumption the big carriers continue to fool employers with is that one can't see a doctor or be admitted into a hospital without that access relationship. It is as insane as it sounds.

Further, the BUCA administrators often charge $30 to $60 pe/pm to pay bills using the no scrutiny method. A good gig if you can sell it since the BUCA payers typically auto-adjudicate 95% or more of the claims they touch. Representing another Fortune 100 company we recently assisted the head of HR-Finance with a hospital bill well over $2mm. He was shocked to learn that the BUCA-administrator did not ask for anything beyond the one page UB yet were about to pay the hospital invoice before we intervened.

The consulting industry is catching on, most quality brokers are now working off of a very transparent fee basis and don't have their incomes tied to an employers' overall spend. However, I recently visited with an employer in Texas that has about 300 employees and a broker that is paid over $300,000 annually on their account. I hear of such egregious over compensation occasionally and wonder if the employer does not know what their broker is being paid or does not care. I would suggest that it is a breach of an employer's fiduciary responsibility to their plan members to make gross overpayments to brokers (or anyone else for that matter) as healthcare funding is typically co-mingled funding from both the employer administrative cost and employee/members health spend.

What role does the media and employers themselves play in this?

MD: I hear the talking heads on business TV (like CNBC) talk about stagnation of incomes for the middle class. Wrong. The additional money is there every year, it's just going into a pool to pay for healthcare instead of into the pockets of the employees in the form of salary increases.

Americans overpay for healthcare by at least 30% and likely 50% in aggregate. For all intents and purposes, every employer in America gives every covered member on their healthcare plan a blank check every year and says….consume all the healthcare you want, anywhere you want, anytime you want, and never be concerned with or ask the price because it's all paid for. Deductibles and co-pays are irrelevant, especially to hospitals, because pricing is so high it becomes somewhat immaterial.

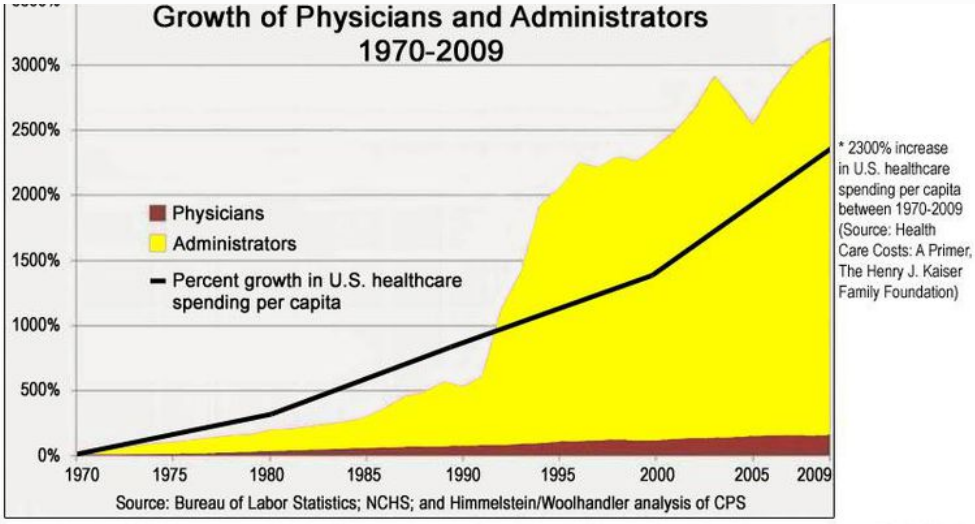
Imagine a group as large as the State of Texas (677,000 employees), they use United Health, paying ~$12 pe/pm to access providers in their own State. One of the big problems is most HR managers are less than 50 years old so none were in the industry before PPOs were initiated (like I was). The other big mistake of employers is that their directive to the HR team is to "keep everyone happy" instead of finding ways to stretch their healthcare dollar to lower costs for the employer and employee alike (healthplans use co-mingled money….typically about 70% paid by the employer with/30% paid by the employees).

While there are some markets where the average commercial payment is below the 260% of Medicare number, there are many more where that number is significantly greater, going as high as 1,000% of Medicare at times. It is stunning to think that an area of cost for many companies that represents as much as 15-20% of the total cost of a business is spent in such a clouded and non-transparent way. Providers and the large health insurance companies have hidden this incredibly crucial data from employers for the last 25 years and continue to do so. An employer not having transparency into this information is beyond preposterous.

What is your assessment of hospitals role in this situation?

MD: Let's start with hospitals. A well run hospital can make money from Medicare payment schedules. The problem is that most hospitals are not financially well managed and have no reason to be when they can pretty much charge for services at will. Through commercial payer sources (the PPOs), hospitals around the country are collecting on average about 260% of what Medicare would pay for the same procedures. Look at that number closely. A hospital can make a profit on Medicare yet they are collecting 2.6 times , or more, that amount from commercial (employer) payers.

So, where does the excess money go within a hospital when many claim to be financially insolvent at some level? According to a study first reported in Health Affairs September 2014 edition, U.S. hospitals have administrative costs that are significantly greater than their counterparts in other countries. Administrative costs account for 25% of total US Hospital expenses according to the study. The US has the highest administrative expense of all countries studied and US hospital expenses are twice those of Canada and Scotland.



"It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication, somehow think that we can afford to pay for doctors, hospitals, medication, and a government bureaucracy to administer it." –Thomas Sowell

Data shows how most of healthcare's inflation has resulted from increased administrative spending

Hospitals are out of control, Sutter Hospital has ~32 executives that make over $1mm per year in administrative roles….they don't even get anyone well. The CEO of UPMC admitted on 60 Minutes that his salary is $8mm per year without ever discussing the value of his bonus, executive benefits etc. There is no incentive whatsoever for hospitals to care about controlling healthcare expenses for employers.

People think insurance carriers are concerned about the cost of healthcare. What's your assessment?

MD: Health insurance and administrative services are mostly a commodity and thus must be price sensitive. The large insurers seek to maintain a steady margin of somewhere between 4% and 8% but of course, as the cost of insurance goes up their revenues go up even with a fixed margin. So, as the cost of medical service payments to providers goes up, the insurance company's profits go up in lockstep. We have already reviewed the fact

that the PPOs' negotiated rates often pay 2x to 4x what Medicare would pay. So for an insurer/PPO to push providers for more reasonable reimbursements of a smaller margin over Medicare would mean they would be negotiating their own revenues downward as well. In another note of irony, employers entrust their health-plans and share fiduciary responsibility with large health insurers that, as we have shown, have the absolute opposite financial objective as the employer. How can an administrative service only (ASO) provider that owns a PPO, which intentionally overpays to perpetuate their own existence, operate to protect an employer's plan assets? Remember that these same ASO-PPO organizations hide the data necessary for an employer to understand and then act upon this illusion of partnership and cost management.

You've called this healthcare's OPEC. What do you mean by that?

First, you need to understand the players in the cartel analogy and how they are part of the problem.

- Hospitals: Make Own Pricing, operating like unregulated utilities
- Physicians: Greater Utilization = More Income
- Insurance Concerns: Higher the Cost, Greater the Profit (Even w/Fixed Margins)
- Brokers: Often, Higher The Cost Greater Their Income
- Pharmacy: Unabated Greed, No governors On Price Or Profits (think EpiPen)
- Ancillary Services : Greater The Turmoil, The Greater The Need
- Employee/Members: Have little to no financial interest in their purchase decisions

Who Loses?: Employers, employees and the general public.

In the aggregate, these healthcare players are healthcare's OPEC. Like the oil producing cartels that for many years controlled the cost of the world's energy in unencumbered fashion, there is absolutely no catalyst for healthcare providers to reduce their fees or for an employers' covered members to be concerned whatsoever with their spending. I know of no CEO or company that is willing to raise their hand and ask that fees or salary paid to them be reduced so that they can provide their crucial services at a more affordable level. OPEC laughed at the US and the rest of the world when we complained that $120 per barrel oil was choking the life out of business and the public in general around the world. Rather, they built ski mountains in their deserts out of the rest of the world's money and threatened to drive oil prices even higher. *Until it ended.* OPEC's stranglehold on the world ended when other countries, led by the U.S. and Canada, started finding alternative ways to produce oil themselves (fracking) and started to initiate aggressive efforts in alternative energy. Note if you will that just a few months ago, the OPEC countries were willingly and aggressively pumping oil and selling all that they could for less than $30 per barrel. Since it only costs the OPEC countries about $10 per barrel to extract oil, there is still a significant margin in the pricing of oil at $30 per barrel. A similar metamorphosis is available for healthcare costs but such will require an external catalyst in the form of employer righteous indignation with a bit of help from the government.

What is going on with Reference-based reimbursement and what does that mean for employees?

MD: Reference based Reimbursement is about to break-out and will someday eliminate the burden of PPOs altogether. PPOs are a contract for opacity, deceit, and to overpay and once employers and their members have the facts the decision will be easy. It is utterly ridiculous to think that providers will only service patients with a PPO emblem on an ID card. Providers want paying patients and hospitals, in particular, want patients who via their employer will pay a larger percentage of their bills than they do through the high deductible/ high out of pocket plans the big health insurers promote now. Healthcare delivery needs to be, and can be, fair and just for all involved and costs will tumble 30% to 40% in doing so.

Assume for example that 70% of hospitals in the country would agree to provide the services of a standard baby delivery for $16,000 (the same service is delivered in Europe for about $3,000 by the way), why would we allow payment to a hospital of $20k, $30k, or even $50k, just because a member chose, without any consideration for cost, to have their baby at one of the more expensive hospitals. If that same employee were traveling on behalf of the employer a budget would be provided as to what would be reimbursed relative to airline, hotel, and food/ beverage charges during the sponsored trip. Few employers would be accepting of that employee flying first class, staying at The Ritz Carlton, or eating caviar and lobster constantly during the trip. Rather, a reasonable budget would be provided taking into account that while hotels are more expensive in New York than in Omaha there are plenty to choose from and at multiple levels of expense. Controlling travel expenses are a critical cost management item for most companies yet those same companies take no interest whatsoever in trying to control their healthcare expenditures in a similar way even though the bottom line effect would be significantly greater for doing so.

There is more than ample data available to allow an employer to provide a well vetted defined contribution healthcare plan for their members. Hundreds of employers are now providing such an option for their group healthcare plans through Reference Based Reimbursement or Cost Plus programs and those employers are being rewarded with cost reductions to their overall healthcare spend of 20% to 40% annually. Those savings accrue to both the employer and their employee/members alike, of course, ultimately increasing take home pay and the profitability and sustainability of the organization. The defined contribution options are also superior to the newly manufactured narrow network program concoctions of the large insurance companies in that they allow members to utilize any provider of their choice rather than have a very limited provider, HMO, type of option.

An employer can spend all the time they want utilizing peripheral options for controlling healthcare spending but, until they address how they allow their members to purchase healthcare, nothing is going to change the cost curve for the better. The solution for employers is incredibly simple, just budget what a health plan will pay for a service and push the consumer to make financially reasonable choices. This is not as ridiculous as it sounds. CALPERS did exactly that with a handful of services for their California based employees. They announced what they were willing to pay for commonplace events like knee or hip replacements and asked providers to raise their hands if such were not sufficient. The handful of hospitals who initially would not accept the CALPERS

payment levels quickly changed their minds and acquiesced when they saw the volume of business they were losing. Eliminating the “healthcare payment fairy” from the purchase equation would force the buyers of services and the sellers of services to meet on neutral ground and find common value.

Understanding the cost of health care is directly related to what we agree to pay, more and more employers are questioning managed care contracts upon which their health care costs are based. Many are discovering the truth for the first time. Secretive contracts between health care givers and third party intermediaries contain provisions that guarantee continuous and systematic cost increases. Shared savings side agreements and other schemes found in the health industry economic chain help fuel raging health insurance costs.

Bill Rusteberg produced a report on Reference-based Reimbursement that said the following:

In 2007 – 2008 we approached several of our clients to suggest something different to control costs. The concept was simple. Eschew managed care contracts in lieu of claim benchmarking off multiple data points such as Medicare reimbursement rates. Removing managed care contracts, i.e, PPO, and paying providers quickly, fairly and directly had an immediate impact on claim costs.

After 15 months we performed a study by running 100% of claims back through the prior PPO network reimbursement rates. This exercise proved a net savings of 43% above and beyond the PPO discounts we would have otherwise experienced. Instead of doing the same thing year after year, our clients did something different and it worked.

It has been seven years since our first client exited the managed care world. Subsequently more clients have embarked on the same journey, most with equally good results. None have returned to the world of managed care.