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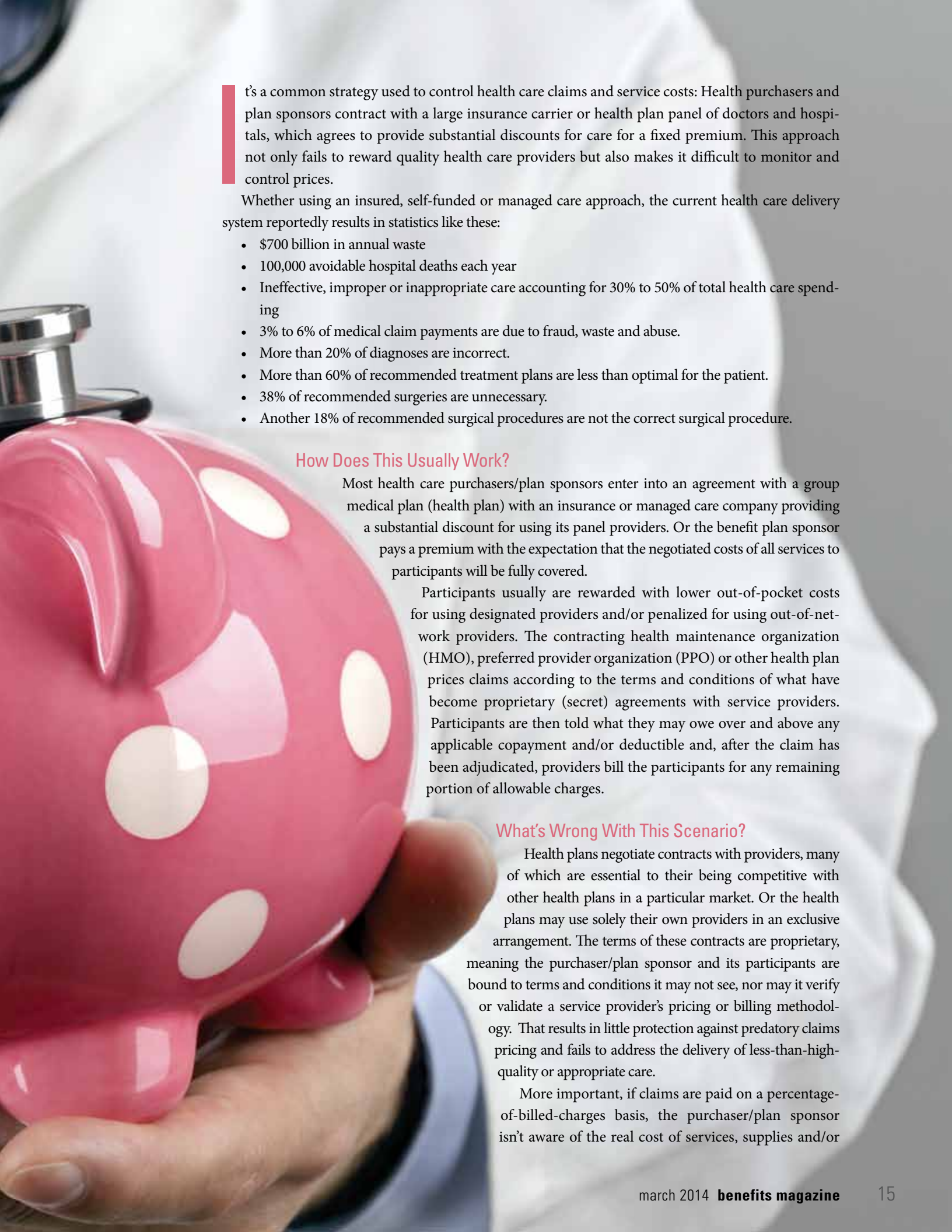
Quality and Appropriateness Can Help Contain Health Care Costs

by | **George McGregor and Ken Stuart**

Plan sponsors can work with their health plans to improve health provider networks to eliminate waste in the form of improper, ineffective and inappropriate care.



It's a common strategy used to control health care claims and service costs: Health purchasers and plan sponsors contract with a large insurance carrier or health plan panel of doctors and hospitals, which agrees to provide substantial discounts for care for a fixed premium. This approach not only fails to reward quality health care providers but also makes it difficult to monitor and control prices.

Whether using an insured, self-funded or managed care approach, the current health care delivery system reportedly results in statistics like these:

- $700 billion in annual waste
- 100,000 avoidable hospital deaths each year
- Ineffective, improper or inappropriate care accounting for 30% to 50% of total health care spending
- 3% to 6% of medical claim payments are due to fraud, waste and abuse.
- More than 20% of diagnoses are incorrect.
- More than 60% of recommended treatment plans are less than optimal for the patient.
- 38% of recommended surgeries are unnecessary.
- Another 18% of recommended surgical procedures are not the correct surgical procedure.

How Does This Usually Work?

Most health care purchasers/plan sponsors enter into an agreement with a group medical plan (health plan) with an insurance or managed care company providing a substantial discount for using its panel providers. Or the benefit plan sponsor pays a premium with the expectation that the negotiated costs of all services to participants will be fully covered.

Participants usually are rewarded with lower out-of-pocket costs for using designated providers and/or penalized for using out-of-network providers. The contracting health maintenance organization (HMO), preferred provider organization (PPO) or other health plan prices claims according to the terms and conditions of what have become proprietary (secret) agreements with service providers. Participants are then told what they may owe over and above any applicable copayment and/or deductible and, after the claim has been adjudicated, providers bill the participants for any remaining portion of allowable charges.

What's Wrong With This Scenario?

Health plans negotiate contracts with providers, many of which are essential to their being competitive with other health plans in a particular market. Or the health plans may use solely their own providers in an exclusive arrangement. The terms of these contracts are proprietary, meaning the purchaser/plan sponsor and its participants are bound to terms and conditions it may not see, nor may it verify or validate a service provider's pricing or billing methodology. That results in little protection against predatory claims pricing and fails to address the delivery of less-than-high-quality or appropriate care.

More important, if claims are paid on a percentage-of-billed-charges basis, the purchaser/plan sponsor isn't aware of the real cost of services, supplies and/or

medications or how much they are being marked up. In addition, the billing service provider expects the contracting health plan to guarantee payment in accordance with the terms of its contract. The health plan will either pay the claim as billed or, if claims are paid by a third party, will demand that its contract be honored.

Because of contractual restrictions or "hospital-friendly" internal policy, health plans might not apply nationally standardized code edits to claims. These codes were established to protect against improperly constructed claims and/or excessive charges being billed. It must then be asked, how does this protect their purchaser/plan sponsor clients?

Even where hospitals are required to post charges publicly, purchasers/plan sponsors usually have no assurance that their health plans effectively monitor year-over-year increases or billing methodologies emanating from these posted charges. With no valid oversight as to what hospitals charge overall year over year, in particular with respect to specific charge codes, even a hospital that agrees not to change its overall discount percentage can generate substantial increased revenue by simply increasing the underlying cost for a service or supply item. The service or item is then extensively marked up to determine a billed charge of which a specified portion is to be allowed. For example, a hospital that is allowed to mark up the cost of a chemotherapy drug by 1300% receives a payment of 780% of the drug's cost even after a healthy 40% discount.

Using a health plan-created panel of providers provides little or no assurance that participants are being treated correctly and/or appropriately. Add to this the cost of improperly composed or adjudicated claims, and it is easy to understand why the cost to provide good group health care benefits continues to escalate at alarming rates.

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John C. Garner, CEBS. Aspen/Wolters Kluwer, 2014.
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Why Must Purchasers/Plan Sponsors Try to Control Their Own Destiny?

When a health plan negotiates contracts with medical service providers, the health plan decides how much its purchaser/plan sponsor/consumer customers will pay for billed services. In comparing allowable charges for the same procedure codes, there appears to be a tendency for health plans to agree to higher allowable charges for larger health systems (hospitals and medical groups) than for independent providers in the immediate area. For example, an oncologist with a medical group affiliated with a large hospital system in San Diego, which understandably uses the hospital to procure chemotherapy medication, billed $61,442, of which $34,715 was allowed by the health plan. The allowable charge for the same medication from an independent oncologist right down the street would be its actual cost, $4,163, plus a nominal markup that brought the cost to $5,412.

Why is this? To keep large health systems in their network, insurance companies may be willing to accept higher allowable charges. Allowing and paying higher billed claims affects the underlying claims experience that drives up renewal premiums for insured plans. Because health plans receive a percentage of the gross billed premium, there may be no real incentive to control the costs that drive premium charges.

Purchasers/plan sponsors should recognize that health plans do not adequately protect their financial interests. Plan sponsors may need to demand that their insurance plans closely monitor the ways in which service providers increase their charges and/or prepare their billings, apply all available code edits to billings or diligently apply usual, reasonable and customary pricing standards when processing claims. Even more important is that health plans work to eliminate waste in the form of improper, ineffective and inappropriate care. They can do so by identifying and featuring in preferred networks only those service providers that demonstrate they deliver high-quality and appropriate medical care that is expected to result in optimal medical outcomes for participants.

Containing cost is particularly important in the construction industry as every 1¢ per hour added to the health and welfare contribution rate not only reduces a working employee's direct wages but can impair a signatory contractor's ability to win bids on no-prevailing-wage jobs. The sponsoring parties to

those collective bargaining agreements have even more incentive to hold their contracting health plan's feet to the fire to ardently pursue identifying high-quality and medically appropriate providers.

What Is Quality and Appropriate Medical Care?

The Institute of Medicine defines *health care quality* as the extent to which health services provided to individuals and patient populations improve desired health outcomes. The care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making. *Total quality* is an attitude—an orientation that permeates an entire organization and the way in which it performs its internal and external business. People who work in organizations dedicated to the concept of total quality constantly strive for excellence and continuous quality improvement.

Appropriateness presents an expectation that all services will be delivered on a quality basis and will conform to established guidelines and protocols established by the American Medical Association and/or any organization responsible for establishing such guidelines and protocols to be followed by all physicians.

How Can Plan Sponsors Identify Quality Providers?

Plan design is the major way health care plan sponsors can influence which service providers their plan participants may use. Plan sponsors can incorporate programs into their plan design and/or claims adjudication processes that focus on identifying poor-quality and inappropriate medical care as well as preventing claim payments to service providers whose billing practices are inappropriate.

Coalitions or cooperatives of local purchasers/plan sponsors can be an effective way to accomplish this goal. Coalitions can aggregate claims data along with available public data to identify where inappropriate care is being provided. This data also can be used to identify physicians and hospitals delivering appropriate care and can be combined with additional information to find the highest quality providers. Those providers can then be aligned in a preferred network with incentives built into plan design to induce participants to use these providers.

The coalitions or cooperatives also can notify the health plans serving their geographic area(s) that the member purchasers/plan sponsors want a voice in negotiations with local service providers.

Two California-Based Coalitions Making Strides

The California Health Care Coalition is working with three large insurance carriers on a two-phase project. The first phase consists of studies to identify inappropriate procedures being delivered statewide. The second phase will identify which service providers are delivering inappropriate medical care in each geographic area of the state. The coalition will work with the specialty organizations that establish the medical guidelines in areas such as cardiac, orthopedic and gastroenterology care to try to change the behavior of providers that are not in compliance. Members of the coalition hope that medical professionals will pay more attention to the appropriateness standards if they come from their own professional organization rather than from an outside party.

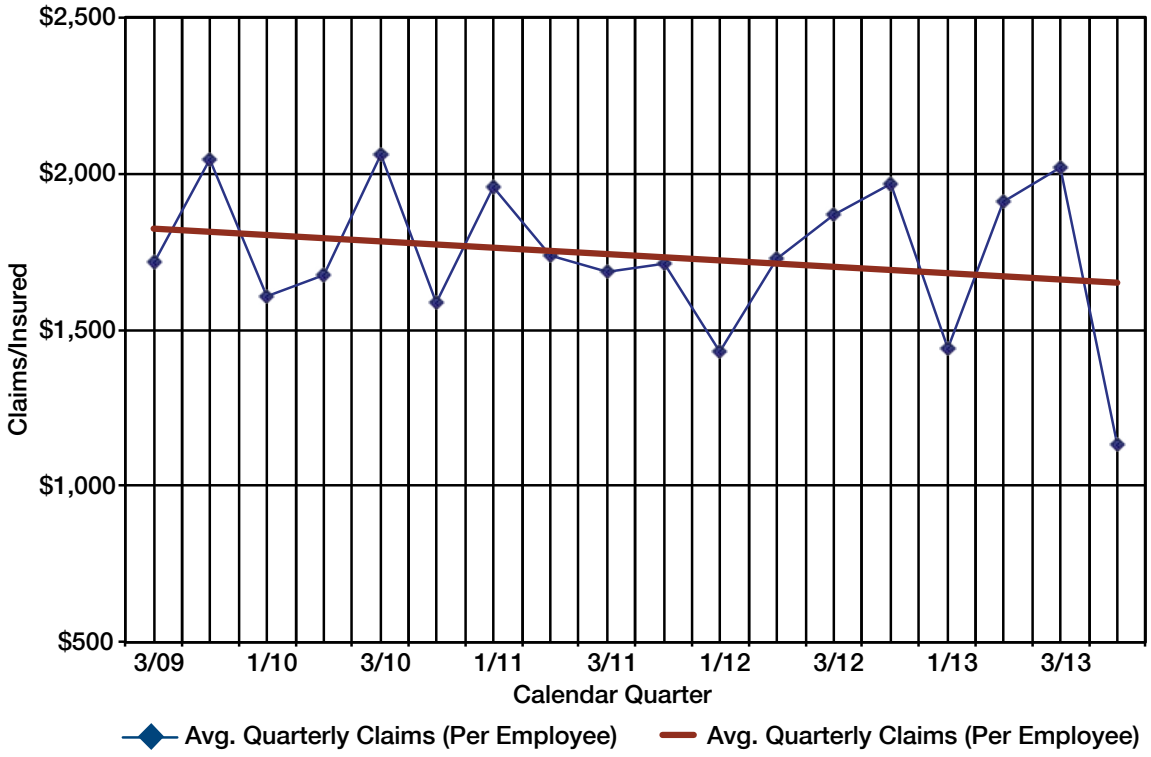
In San Diego, the California Coalition of Employee Benefit Plan Sponsors is rolling out a medical appropriateness program that focuses on identifying the highest quality and most appropriate service providers in the greater San Diego area. Ultimately, the goal is to incorporate the cost of services into the equation and establish a network of service providers that deliver high quality and appropriate care with the best medical outcomes at the most reasonable range of fees. This would be considered to be achieving "true value."

takeaways >>

- The way insurance companies and medical plans contract with health care provider networks can result in predatory claims pricing and fail to address issues of poor quality and inappropriate care.
- Sometimes health plans don't apply nationally standardized code edits, which are designed to protect against improperly constructed claims and excessive charges.
- To keep large health systems in their networks, health plans tend to agree to higher allowable charges for larger health systems than for independent providers.
- Plan sponsors may need to demand that their health plans allow into their networks only medical providers that demonstrate they deliver high-quality and appropriate medical care.
- Through plan design, plan sponsors can steer participants to the providers the plan sponsors would prefer they use.
- Coalitions can aggregate claims data, helping to identify the physicians and hospitals delivering appropriate care, and can help give plan sponsors a voice in negotiations with service providers.

FIGURE

San Diego Electrical Health and Welfare Trust Self-Funded Medical Plan Trend Analysis



How Can Plan Sponsors Integrate High-Quality Providers Into Their Plan Design?

Plan sponsors can ask that health plans establish a narrower network of providers consisting only of those that deliver high-quality and appropriate medical care. Doing so could go a long way toward eliminating ineffective, inappropriate and improper care and dramatically reducing plan costs.

Another option purchasers/plan sponsors can consider is contracting directly with local service providers known to be of high quality and appropriate standards.

Once a narrower network has been created, plan design features can be established that provide incentives to participants to use those providers while passing on a greater share of the costs to participants who do not. Participants who continue to choose to use lower quality providers expose themselves to a lesser quality of care. They also expose their group health plan to potentially higher costs because of less-than-optimal medical outcomes.

The purchaser/plan sponsor must routinely monitor the performance of service providers to determine whether those in the network continue to deliver services at the desired level of quality and appropriateness. Plan sponsors also should identify providers that have improved sufficiently and add them to the network while removing those that no longer perform at an acceptable level.

What Is the Ultimate Goal?

It is imperative to the financial stability of any employer-sponsored group medical program that participants are given the opportunity to receive optimal medical outcomes. That means eliminating the adverse impacts of both poor quality and inappropriate medical care. Plan sponsors should do business only with health plans that demonstrate that their clients' interests are more important than those of network service providers. Health plans need to aggressively eliminate advantages being afforded to service providers that dramatically increase costs to their purchaser/plan sponsor clients.

Following are seven suggestions for actions plan sponsors can take now to achieve that goal:

1. Where an insurance carrier pays claims, request confir-

mation that all nationally accepted code edits are being applied to incoming claims as part of the carrier's claims adjudication process. If the answer is "no," seek an explanation as to whether it is due to internal policy or contractual limitations. It's possible that service providers are being rewarded for improper billings and/or excessive charges.

2. If a third-party administrator pays the claims, ask whether it has implemented a prescreening process to apply all such code edits as a means of preventing improperly billed claims and/or charges exceeding usual, reasonable and customary from being paid that were not picked up by the health insurance plan. If the answer is "no," make a formal request to do so or seek a claims payer that is committed to protecting its client's interests.
3. If a plan is self-administered, consider adding a fraud, waste and abuse program to the claims adjudication process to prescreen claims that may have already been prescreened by a health plan in order to identify what charges may have been improperly allowed.
4. Ask the health plan(s) what procedures are in place to identify which providers in their network(s) deliver medically appropriate and high-quality medical care. Suggest that plans establish a narrower network featuring only providers of this caliber.
5. Build a local coalition of purchaser/plan sponsors (private, public, municipal) to communicate to their health plans and local health systems a desire to reward plans that provide access to service providers that deliver the most appropriate and high-quality medical care.
6. Build or support a statewide coalition of purchaser/plan sponsors and partner with the largest health plans to promote ways in which their interests will be better protected. Options include aggregating claims data to identify inappropriate medical care and which service providers fail to conform to established medical guidelines in specific geographic areas.
7. Use this information to build effective incentives and disincentives into the health plan design to put plan participants in the best position to receive optimal medical outcomes that will contribute to keeping plan costs down.

An example of how the above process can positively impact a self-funded, self-insured plan's cost trend line is shown in the figure.

Conclusion

If purchaser/plan sponsors can change the culture of dealing with health plans as well as identify those service providers that deliver high-quality and appropriate medical care at the most reasonable cost, they will have successfully achieved "true value." That means their participants will routinely receive optimal medical outcomes, and the cost to provide the best comprehensive group medical coverage will be far more reasonable.

<< bios

George McGregor, CPA, is president of McGregor & Associates, Inc., in San Diego, California, which provides administrative, consulting and financial services for employer health plans for public sector trust funds, charitable organizations, union and nonunion coalitions, and prepaid self-directed plans. He acts as general manager of the California Schools VEBA trust, managing the care of over 125,000 covered lives. McGregor also is a founding director of the California Health Care Coalition. He earned an M.B.A. degree from the University of Southern California and a B.S. degree in accounting from Arizona State University.

Ken Stuart is CEO of the San Diego Electrical Industry Administrative Corporation. He has 40 years of experience in administration and consulting for employee benefit plans, having served as the administrative manager of the San Diego Electrical Health and Welfare and Pension Trusts since 1990 and administrative manager for the NECA/IBEW Drug-Free Workforce Program since 1997. Stuart has been an active board member of the California Health Care Coalition and currently serves on the boards of the California Hospital Assessment and Reporting Taskforce and the California Coalition of Employee Benefit Plan Sponsors. He earned a B.A. degree from the University of Massachusetts.