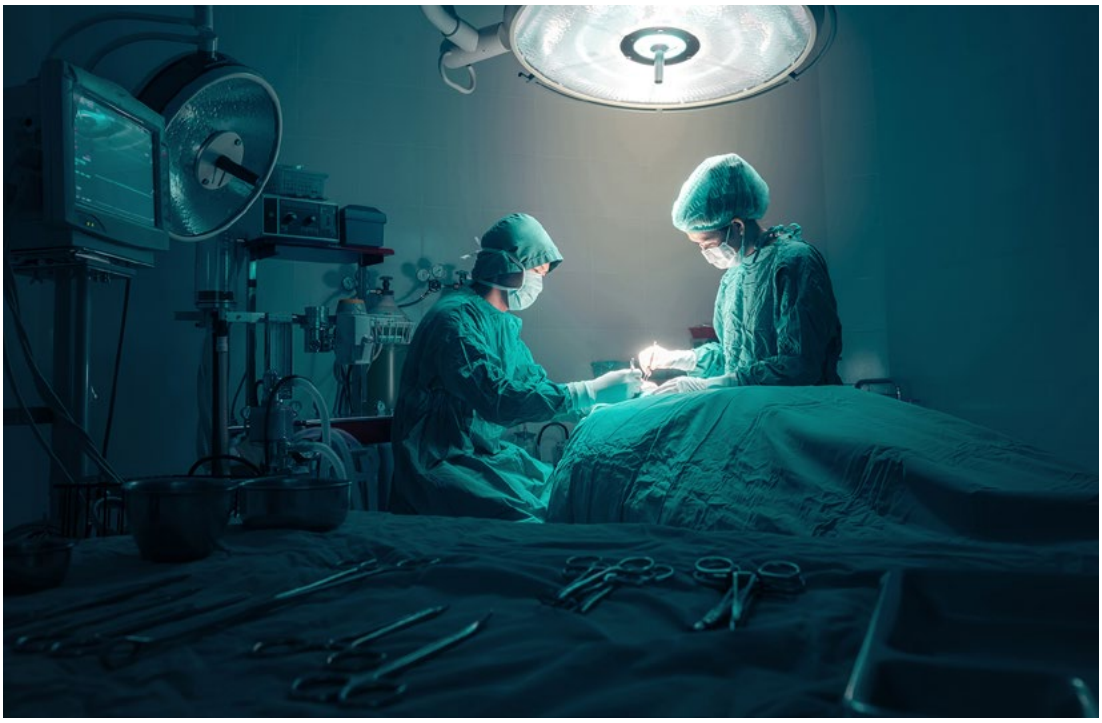


Written By Bruce Shutan

THE PRICE IS RIGHT

How to tame the beast lurking in hospital chargemasters

The federal government recently sought to shield consumers of U.S. health care from excessive out-of-pocket costs and surprise bills in a hospital setting.

But in spite of the Hospital Price Transparency and Transparency in Coverage rules, many industry observers believe that ending these practices and replacing them with meaningful price transparency will continue to be an uphill climb. Just 14% of 1,000 hospitals recently reviewed by Patient Rights Advocate were fully complying with an order to publicly post their prices.

Large self-insured employers also lack enough market firepower to effectively negotiate hospital prices in most metropolitan statistical areas, according to a study published last summer in *The American Journal of Managed Care*.

As such, the team of researchers behind this conclusion recommended that they consider teaming up with state and local government employee groups to establish purchase alliances to help negotiate lower prices for hospital services.

The hope is that rules requiring hospitals to display their prices on shoppable services in a consumer-friendly format or face large penalties will finally tame the beast lurking in chargemasters.

But until that time, self-insured health plans still have options with the help of valuable data and information technology. Some service providers have managed to crack the code on the most common hospital procedures.

Healthgrades lists them as cataract removal, C-section, joint replacement, circumcision, broken bone repair, angioplasty and atherectomy, stent procedure, hysterectomy, gallbladder removal and heart bypass surgery.

The trick is to determine reasonable fees from wild price variations on the biggest pain points and steer health plan participants to the highest quality providers and facilities, which will improve clinical outcomes and lower costs.

As more data becomes available, the expectation is that health care consumers will become more knowledgeable and make wiser choices – a change that is likely to be evolutionary.

CASH IS KING

Most hospitals use the chargemaster number as their default option, explains Jeff Toewe, founder and CEO of Medxoom, whose pricing database of all U.S. hospitals compares typical BUCAH rates to Medicare, cash and reference-based pricing (RBP). He says only some of them have taken the initiative to publish a favorable cash price.

"Every front-desk clerk in every finance department knows that magic secret number that they'll accept from a self-pay-at-time-of-service rate," he says. "It's out there, but it's just not always available as an official data point."

Medxoom helps self-insured health plan members determine what it will cost them at the time of service and learn a good target price from an RBP-derived price point. Payment is then authorized for the agreed amount, which is always cheaper than a post-paid claim.

Jeff Toewe

"Forget about what the negotiated rate table is because that's where the scam is," notes Toewe, whose clients are often TPAs. "Even if the rates have yet to be published by a particular hospital, we see them. We know exactly what's going on to the penny where they have audit rights."

Medxoom has a proprietary mechanism that determines how different factors are weighted, the variety of providers and cost spreads seen in the market. Clients set their maximum outlay, then the target price is calculated with automatically geo-adjusted rates.

In addition, quality data from the Centers for Medicare & Medicaid Services (CMS), Quantros (which was acquired last year by Healthcare Bluebook) and Embold Health is analyzed for clients, some of whom have licensed their own source of information.

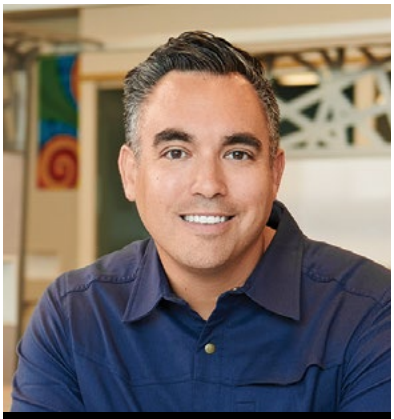
"We can tell them which providers are, in fact, more cost effective, and we can offer pre-negotiated, favorable arrangements as well," Toewe explains. "Some people call them bundles. Some call them direct contracts. Some call them cash payment at time of service. I don't care which method it is, but it's that service for as close as possible or below our target price."

INTEREST-FREE CREDIT

While cash is king at the point of service, it's not always readily available for a vast majority of health care consumers who end up rationing, deferring or skipping important medical care.

Another solution to the high cost of hospitalization beyond educating health plan members about their options and helping them find lower-cost quality care is to turn unexpected out-of-pocket costs into an easy and affordable payment plan.

Some self-insured employers and health insurers are offering interest-free credit without any fees to plan members layered on top of their flexible spending accounts (FSAs) and health spending accounts (HSAs).



Brian Whorley

"Knowing the price and being able to afford care are two different challenges," observes Brian Whorley, CEO of Paytient, which for a small subscription fee enables self-insured employers to fill voids created by larger deductibles and help broaden access to important care. "I think that we have to fix the liquidity crunch that too many folks are in."

His company seeks to equalize the playing field so that low-income working Americans can access cash for medical care. More affluent households also enjoy an alternative to triple tax-advantaged HSA dollars that they can invest and grow rather than burn through for uncovered health care expenses. "If somebody has an FSA, they should use that first," Whorley suggests.

That suggestion is conveyed to the employee populations he serves, along with other educational resources that include access to educational blog posts and on-site employee training. "We believe that having the ability to better access and afford care empowers members to become more engaged consumers in their health care journey," he says, "which leads to better health and cost outcomes through earlier care, prescription adherence and care-selection at more optimal providers."

Paytient's business model is different from CareCredit, a division of publicly traded Synchrony Financial whose pioneering provider-originated credit card comes with a catch. "Most of that revenue is coming when people don't pay off their service or treatment in that promotional period, and they get hit with a 28% interest rate," he says. "They're clearly creating value for providers and unlocking demand that otherwise wouldn't occur."

Paytient card holders pick a payment plan that works best for their budget through payroll deduction or a bank account link.

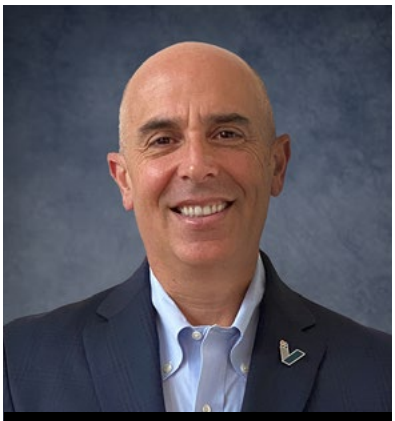
In addition to hospitalizations, which are the largest single transactions, these credit cards are used for other smaller medical bills, as well as mental health, dental, vision, pharmacy and even veterinary expenses. And, in fact, those ancillary costs are showing up more than Whorley expected.

"When I came into this, I thought that we would see large, infrequent transactions," he reports. "In reality, what we see are monthly or very frequent $100 or $200 transactions at the emergency room where they're asking for a $200 copay. It is also a mental health visit that's not covered by insurance. It's copays at the pharmacy, which accounts for nearly 30% of all our transactions."

The interest-free line of credit for Paytient members includes care at eligible out-of-network and mental health providers. The No Surprises Act and Non-Qualified Treatment Limitations requirements pertain to the employer group and/or individual health insurance benefit.

'DEFENSIBLE REIMBURSEMENT RECOMMENDATIONS'

RBP is often the foundation for building a better plan to combat wild price variations and shield members from unaffordable medical bills that may cause financial ruin.



Rob Gelb

Elevating the concept so that it's more collaborative and less adversarial can not only replace opaque hospital pricing with fair and transparent rates, but also please multiple stakeholders and stay out of court.

Most RBP companies adopt an aggressive approach to cutting claims, cautions Rob Gelb, CEO of Välenz, whose transparent solution helps ensure that medical-service charges are appropriate and accurate along the road to finding optimal care.

"They don't really communicate with the provider until the explanation-of-benefits statement goes out and the provider gets a surprise," he opines. "We actually try to speak to the majority of our providers, particularly on larger-dollar claims, and say, 'here's the methodology. Here's what we're going to recommend for reimbursement.' We're already beginning a process of open dialogue and collaboration with the provider versus really just sending it out and saying, 'hey, take this reimbursement, or else.'"

His company's next-generation version of RBP features a methodology that transcends the Medicare multiple in setting up what he calls "defensible reimbursement recommendations."

Two usual and customary datasets are used alongside Medicare, as well as both scrubbed customer claims and acquired paid claims data in jurisdictions that Vālenz may not have any specific personal repricing experience in. "Our algorithm inside that system will then really try and contract a payer all three datasets to make a recommendation for reimbursement," Gelb adds.

For claims with up to $2,000 in billed charges, an aggressive recommendation is made for reimbursement on all bills that are non-contracted. If the provider pushes back and wants to start an appeals process, then Vālenz will take care of the additional dollars and go at risk.

What this does is remove 91% of the volume of claims out of the risk category of balance-bill friction, he explains, providing peace of mind to both health plan members and sponsors because the remaining 9% tend to be about 60% or 70% of the charges.

"In the end," Gelb notes, "we're measuring outcomes along three continuums: quality, advocacy and the total cost of the experience for the member. The other thing that we do is we balance our approach to reimbursement across all the parties: the payer, provider and patient. We make sure that everybody feels good about what the reimbursement recommendation looks like."

Quantros quality metrics also are loaded into Vālenz's database and available to both health plan members and navigators. Since much of parent company Healthcare Bluebook's data is weighted toward Medicare, Gelb says the quality scoring has a heavier tilt to CMS than it does to the commercial market.

But the latter category is being fleshed out with the help of Turquoise Health, which is still building out its data set for quality scores that aren't yet widely seen.

"We've done the credentialing of the provider and the health system, and we've negotiated a contractual rate with them for services," he says, also noting the presence of a concierge navigation solution that embeds and integrates with the network offering. "We also have non-contracted networks."

POWER OF TECH SOLUTIONS

There's power in policies such as RBP, but perhaps nowhere is the path of least resistance to securing reasonable rates for health plan members on a myriad of hospital services easier to navigate than in the growing use of advanced technology.

One such avenue is deep learning, a subset of artificial intelligence and machine learning, which is a broader category in the field of computer science.


Edmundo Gonzalez

The focus of this emerging technology, which is becoming an integral part of health care data analytics, is on processing massive amounts of information and spotting data patterns.

By developing more reliable prediction models, the hope is that earlier intervention will help halt the progression of chronic and costly diseases as well as better anticipate high-cost surgeries.

"Let's say that our algorithms, based on all of the data we have access to, are saying that I'm at risk to end up in the ER

in six months," explains Edmundo Gonzalez, CEO of Marpai Health, which uses deep learning to predict near-term health events, reduce chronic conditions and costly procedures.

"The counter to that is preventative care," he continues. "If I go to my doctor tomorrow and get on a maintenance drug that may be $50 a month, I may avert that hospitalization in the many, many thousands. In the case of surgeries, our job is to get in front of that event six months and educate that member that there's options."

When it comes to measuring quality, Gonzalez cites two critically important benchmarks: the fewest number of hospital readmissions and number of times a procedure has been performed. While those areas are straightforward, there are others that represent varying shades of gray.

For example, he says "you may have a tremendous orthopedic surgeon. He may just not be excellent in the knee or rotator cuff." Therefore, the aim is to cherry pick those areas of expertise.

The same thinking applies to facilities. In predicting as many events as possible and getting out in front of them, Marpai Health's job is to essentially educate members to use, say, Facility A vs. Facility B. But it's not a black-and-white choice.

Where this mission gets tricky is that no one facility is the master of all medical care. Of the thousands of unique procedures at different facilities, he says the objective is to find ones with the best outcomes at a reasonable price. Bottom line, he explains: "You have to look at stuff by procedure." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.