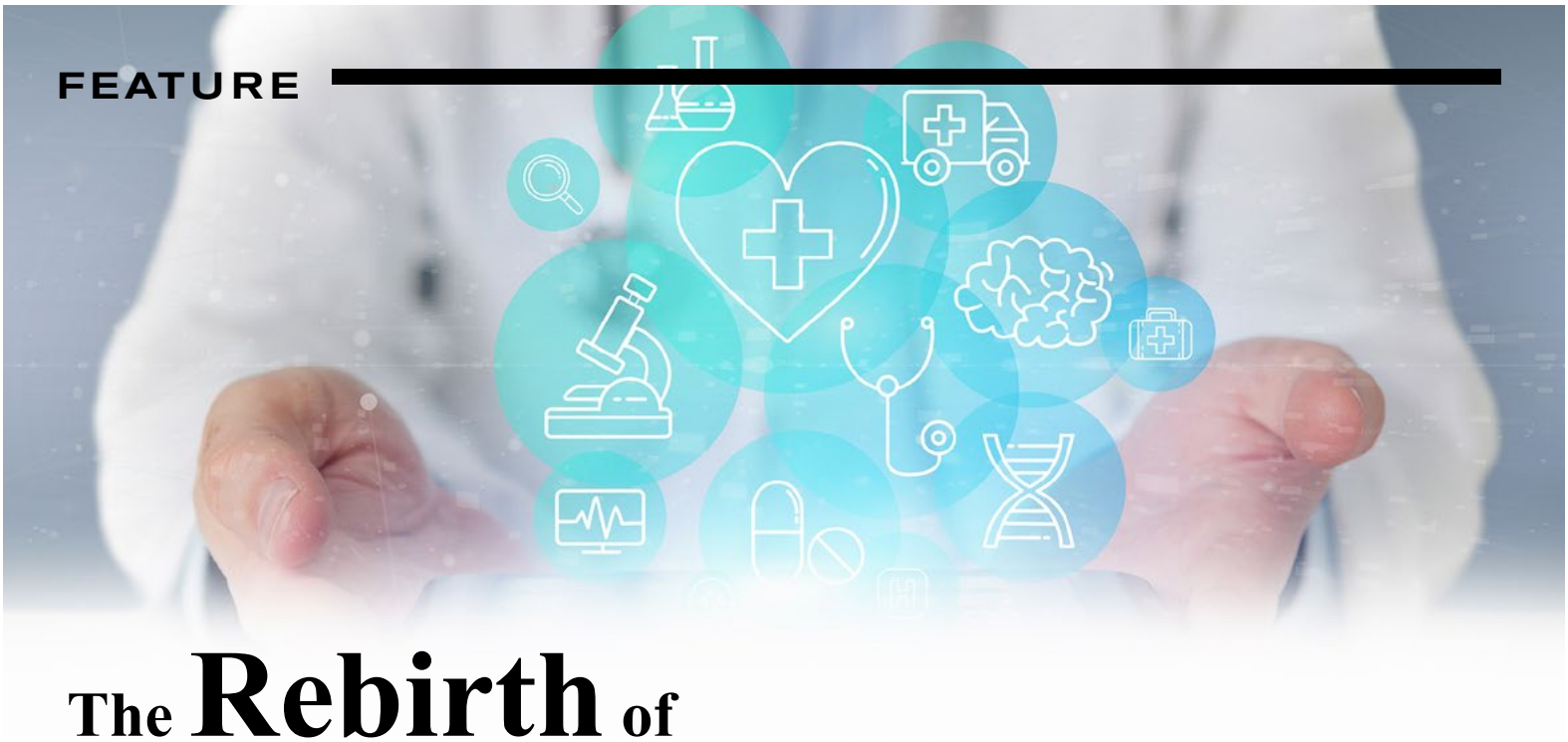


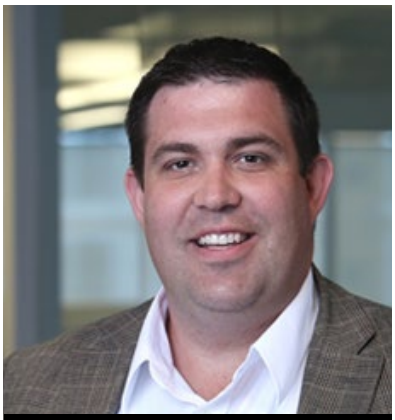
The Rebirth of Health Care Consumerism

New rules designed to spotlight transparency and eliminate surprise bills open the floodgates to information, but how can self-insured health plans help members understand the flow?

Written By Bruce Shutan

With reams of data available from hospitals and insurers under Transparency-in-Coverage (TIC) rules and the No Surprises Act (NSA), a twofold challenge awaits employer-provided health plans. One is to avoid overloading members with too much information now that hospitals are required to display their prices on shoppable services in a consumer-friendly format or face hefty penalties. The other is helping them understand the complexity of various treatment options so that they can make more informed decisions.

When used in the right way, this data can help health care consumers gravitate toward high-quality providers, which in turn, will improve clinical outcomes and lower the cost of care. The question is, will they fully understand or even use all this information? Another concern is whether consumers will ever move beyond convenience or name recognition even if they have data showing alternatives are just as effective.


Dennis Charland

In order to optimize health plan member experiences, it's best to present data in a single resource as part of a hierarchical structure "so the most relevant information floats to the top, and you're not hitting them with 50 data points," says Dennis Charland, SVP of sales for Sapphire, a division of Zelis. Indeed, members want the process to be easy and personalized. He says they're less concerned, or even confused, by detailed clinical metrics, but do find comfort in aggregated quality scoring or badges.

Seeking to connect health plan members to the right care, at the right time and right place involves a series of steps in the evolving era of health care consumerism, Charland explains. It starts with searching for providers and facilities, then pricing out services that take into account their benefits, network restrictions and out-of-pocket costs.

What's also important is an ability to evaluate patient ratings and reviews, as well as allow members the opportunity to post their own opinions. Ironically, he reports that providers have resisted displaying reviews out of fear that patients will air their grievances when more than 80% of reviews are overwhelmingly positive. "Things like bedside manner, average wait time and cleanliness of a facility really do matter to people," Charland notes.

There's quite a bit of intersection between these key elements and what both the TIC regulation and NSA are requiring, he says. Namely: timely updates of data in provider directories, suppressing providers that haven't validated their data, advising members of protections against balance billing, giving them personalized cost estimates based on the terms of their coverage and even the creation and hosting of machine readable files.

ALWAYS ASK QUESTIONS

Irrespective of how consumers respond to all this information that will be shared, the need for clarity cannot be underestimated. Health care consumers need to ask questions about how they're being charged, and must always request an itemized bill, says Stephen Carrabba, co-founder and president of ClaimInformatics, a payment integrity firm that identifies when a self-funded health care plan has been overcharged because of improperly billed or adjudicated claims. His company is the only one of its kind that also identifies health plan member overpayments, which might have been in the form of overcharged co-pays, co-insurance, or deductibles. He cites Marshall Allen's book "Never Pay the First Bill" as a source of inspiration.

But forcing more skin in the game won't be an easy undertaking. Since the new federal rules lack specificity, hospitals that are reporting do so in different ways, which makes the information difficult to compare, explains Cheryl DeMars, president and CEO of The Alliance, a cooperative of self-insured employers. And between spotty compliance and low penalties for noncompliance, she believes it's going to take a while before hospitals comply in a meaningful way.

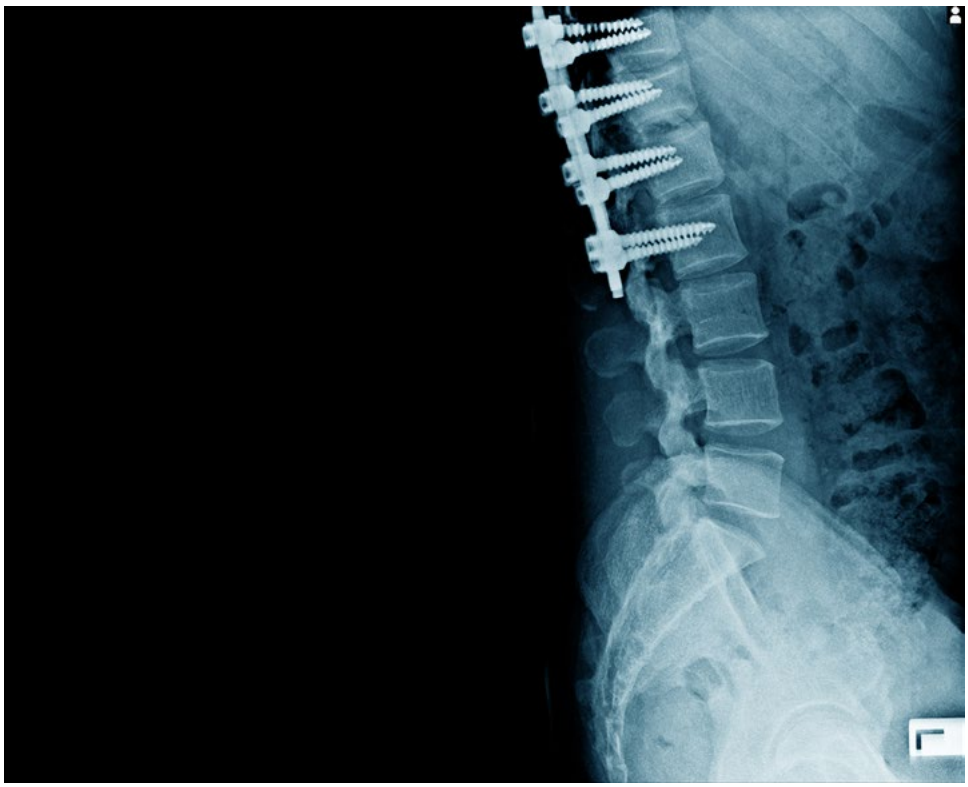
Left to their own devices, health plan members may find it challenging to process all the detailed material that they're entitled to without guidance or context. "If you just take it for face value and only supply the rates-based cost information to members, then you're going to lose them," according to Charland, noting the need to make it simpler for them to understand.

An orthopedic surgeon's rate for knee arthroscopy, for example, doesn't provide any additional context around where and with whom that service is provided, and how many procedures are actually performed. "Volume is important, too," he says.

Patient advocates can help draw attention to cross-promotional opportunities that will help members optimize the services that are made available to them. For example, someone who uses Sapphire's tool to search for a pediatrician may find that the availability of telehealth services also is highlighted. In addition, recommendations could be made for second-opinion or surgical guidance resources if someone is in need of knee or back surgery.

"It's all about using the partners that you have to help cross-promote those services at the time the member needs it," Charland says. "The more you can incorporate those solutions in the aggregate, the more valuable they become."

Still, consumers are expected to have a difficult time digesting the way hospitals report their information. "This is where intermediaries come into play," says DeMars whose group has provided its members with information to compare price and quality information for more than two decades. She expects entrepreneurs, and even health plans, to present the raw material in a format that's easy to understand, more actionable and relevant to the decisions health care consumers are making.



As part of that movement, DeMars predicts the emergence of more advocates who will serve as a coach or concierge to connect health plan members with all the information that will become available and use it in a meaningful way. Moreover, she says self-insured employers can use the information to design tiered networks featuring high-value providers at the top and lower-value ones at the bottom or excluded altogether.

"Employees could still go anywhere, but if they use this set of providers who we know do a good job and cost less, they may pay nothing out of pocket, or even get a cash incentive from their employer for using those providers because the savings are so tremendous,"

she envisions.

Another area where health plan members can benefit greatly from the growing emphasis on consumerism is in combatting overuse of resources, which DeMars describes as a quality problem. "You're exposing patients to unnecessary procedures, tests, etc. that they don't need to have," she cautions, "and so I also think that looking at resource use variation is a reasonable quality indicator."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SHIELDING CONSUMERS FROM FRAUD

Considering that as much as 25% of $4.1 trillion in U.S. health care spending is rife with fraud, waste and abuse, there has never been a better time to take consumer protections to the next level. On a prospective payment integrity basis, Carrabba encourages health plans to block access to providers or facilities that have been flagged as potential abusers, and to review their claims before they or the member pay.

"On a post-payment or even prepayment type of review, I can't tell you how many times we've seen invoices on claims where three-quarters of the stuff was for services that were never rendered," he reports.

His company has developed more than 600 proprietary algorithms that are identifying 5% to 15% of total plan expenditures as improperly paid in a post-payment environment and significantly higher amount in a prepayment environment.

Misaligned incentives on the provider side have given rise to a buoyant health care consumerism movement built around the need for transparency. When combing through what are in essence re-adjudicated claims, ClaimInformatics often uncovers excess fees tied to negotiations or self-dealings.

Stephen Carrabb

The problem, Carrabba says, is that physician practices, health systems, surgery centers and others are encouraged to overbill, by high-priced consultants who promise that implementing evasive billing practices can increase their revenue by upwards of 20% to 30%.

"How are they doing that legally?" he asks. "It's not just billing and coding. It's unbundling. It's claim splitting. It's fraud. It's upcoding. It's a laundry list of stuff that we see all day, every day."

Other obstacles that are baked into the system include medical claims being processed and subsequently paid in silos. Carrabba cites a big-toe amputation as an example of how billing errors seep into claims. In one review, the radiologist billed for a right-foot X-ray, while the hospital up-coded and billed for removal of the patient's entire leg.

Acknowledging that individual health care consumers may be overloaded with too many choices and information, Carrabba says they need to be incentivized to save on the cost of care.

"Some of our clients are of the mindset of, 'let's not just educate our members, but also share the benefits and savings with them," he notes. "We have one client where we proposed leveraging a charity care provision to substantially decrease the claim cost. And the client said, 'whatever the plan saves, we want to compensate our member to the tune of a third of those substantial savings.' That's significant dollars to a plan participant, and a perfect example of how payment integrity done right can be transformative for plans and members."

If done right, prompting the member with savings alerts, redirection opportunities to higher value care, and even overlaying member incentives, can combine to deliver better quality, lower costs and a more satisfied consumer.

An augmented algorithm will point members to more cost-efficient locations for centers of excellence, as well as lab work, imaging and other services, where Charland says it's more about impacting the quality of care vs. cost. However, members still want to be rewarded for making decisions that save their employer money, so he adds that overlaying incentives can be an effective way to engage them.

ENCOURAGING SELF-SERVICE

In the years ahead, there could be a fine line separating the value of advocacy from a need to empower people to become better health care consumers. Greater availability, accuracy and standardization of data should enable high-level questions from members to be answered digitally, which could open the door to more self-service, Charland observes.

However, that's not to take the need for advocacy off the table. In fact, he says, plans are requires to provide the same level of information that's available digitally via telephonic access. That means patient advocacy services can walk members through that experience, though in no way does he think it replaces the need to empower members to make sense of the data on their own.

What's likely to happen is the explosion of information technology will continue to help make critically important data more readily accessible. DeMars suggests that health plans can create an app with easy-to-discern information, better-and-worse symbols, etc. – all of which will help consumers who want to do quite a bit more of their own research.

The law of supply and demand could dictate the future of delivering health care information and paying for services rendered. If enough health care consumers actually make good use of the information made available to them and it reaches critical mass, then providers likely will offer more transparent and affordable services, she observes.

In fact, it's already happening. Adds Charland: Facilities that are embracing the transparency movement the right way will offer a mini-procedure bundle that will list exactly what the procedure will cost members in and out the door with no hidden costs. "You do have to make it simpler for them," he says, sanguine about the prospect for improvement. ■

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