Why Are Hospital Charges So High? Because Nobody Questions Them.
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When the Consumer Doesn't Care What it Costs…

When a friend of mine with quality health insurance received his hospital bill, what did he do? He opened the statement and looked at one thing – his amount due. This dollar figure isn't $30,000 or even $8,000; it's the amount of the co-pay or deductible on his in- network claim. Typically, we are talking about anywhere from $5 to $250 – this is all he cares about and also why we have major problems with our healthcare system today. He doesn't know or care that the charges were $140,000 and that his self-funded health plan (even after the great discount) paid $110,000, even though the actual cost of the hospital services was less than $20,000. If he had walked in with a Medicare card, the hospital would have been paid $25,000. The worst part of this horror story was that he complained to me for having to pay a $200 co-payment even though he has full health insurance coverage.

This is why our system will not change – my friend doesn't care; in fact nobody does. The actual consumer doesn't know or even want to know what the costs of the services are. He just looks at his co-pay and deductible and never examines or sees the entire bill. Hospitals know this, the networks know this, the large insurers know this, and this is why nothing will fundamentally change. The user of the facility – the consumer – doesn't look at the sticker price. Therefore, there is no sticker shock! This is a major problem, but it doesn't just end there. Imagine if you could buy a new car and never pay for anything but the oil changes – that's our current system.

This friend of mine works for a self-funded employer that has about 120 employees. The employer cannot afford to take on all of the risk associated with being self-funded, so the plan purchases stop-loss coverage with a specific deductible of $50,000. Therefore, they pay a premium to the stop-loss carrier for claim reimbursements for any member after they pay the initial $50,000.

But How Much Does the Plan Truly Care?

So, it's funny to me when a TPA and the plan complain that all the members care about are their co-pays and deductibles when they are often doing the exact same thing. Instead of being upset with why the hospital is charging $140,000 and being paid $110,000, they only look at the $50,000 they have to pay and could care less about the rest since the stop-loss carrier is there to cover the loss. They just don't want any noise from anyone or as I am often instructed – just get the claim paid. The facilities are aware of this as well since they use the threat of balance billing the patient and ruining the member's credit as a means to put pressure on the employer (and its human resources department) to have the claims paid.

Think about it…if the human resource department of the employer starts getting noise from the employees about balance billing, they report it to management who then says, "Wait a minute, didn't we purchase stop-loss to protect us from these large claims? Why aren't they being paid?" The facilities really don't expect everyday employees to have $100,000 sitting around. They balance bill in the hopes that the employee will bring the collections notice to the employer to take care of the bill. This is especially true with generous self-funded plans, such as unions.

The Real Entity that Cares About the Cost But Isn't a Health Insurer

That brings us to the one entity in the self-funded space that always cares about the entire claim and this is the stop-loss carrier. They take on the risk of the entire bill and over and over again, I receive calls and comments from stop-loss carriers complaining that TPAs, employers, and brokers just want the claims paid and for them to reimburse the facility whatever it feels it wants without justification. So, any educated reader would assume that since the stop-loss carrier controls the purse strings, they can just pay what they want to pay. The answer, surprisingly to many, is no. The carrier doesn't usually

control what is paid to the facility. This is a special arrangement that pleases providers, but is necessary in order for stop-loss carriers not to be viewed as health insurers and thus subject to ACA rules and regulations.

The stop loss carrier has no contract with facilities, networks, or the members. The plan employees have no idea that a stop-loss carrier is picking up the tab. The carrier has a direct contract with the employer to reimburse claims to the plan that are payable under the terms of the plan. If the claim is payable under the terms of the plan, then the carrier must reimburse (unless they have a gap in coverage, which is another story for another month). The plan is governed by its plan document and by any preferred provider and network contracts that it signs. While some stop-loss carriers fight the fight, often times they are just causing potential loss of reputation if plans and TPAs begin to give them a bad name across the industry. In the end, the stop-loss carrier is footing the bill, but they cannot and will not act as a health insurer – thus the rub.

Brokers Just Want Things to be Quiet

That brings me to the brokers, who have one primary role and goal, and that is to keep employers happy in the short term and for the great brokers in the long term. In the short term, the brokers are allies of the facilities because they just want the claim paid, so that their paying customer – the employer – is happy. However, in the long term, when that broker is looking for affordable stop-loss coverage and premium for their employer the next year, they will have an extremely tough time because of the large dollar amount of claims being paid by the plan the previous year. The premium will get more expensive, ensuring that the employer is not as happy as they were in year one.

If more and more brokers took a long term perspective on payment of claims and what facilities charge, the system would be much better. Brokers must advise their beloved clients to fight back a bit more and not allow facilities to get away with their charges and to realize that even though stop-loss is there for them, the more stop-loss is exposed, the harder it will be to purchase a reasonable contract the following year. This is what great brokers do. Unfortunately, not enough of them take on this challenge.

Hospitals Want to Keep Things Just the Way They Are

So at the end of the day, if I am the CEO of a hospital and I need to make as much money as I can, then I love the current scenario – we are all in. The people that need the services don't care about the overall price; the employer who buys the coverage only cares about the claims up to a certain amount, but since I make my big money on the large dollars, the employers really don't matter to me. The only party that can fight me since they hold the purse strings have no agreement with me and don't want to push back too much because they are afraid of being viewed as a health insurer and therefore, subject to the ACA. This is not that bad of a gig if you can get it. Providers love the fact that they do not have to justify their charges and they will continue to take advantage as long as the players don't agree that the overall costs of medical care are the real problem.

Audit Right, Yeah Right!

Under the current healthcare environment, many provider networks limit or just outright deny self-funded plans and members the right to audit the claims. The way they see it, the less you know, the less things can change. If nobody knows or cares that the charges are very high, then things will just stay the same. I am not stating this to spark a controversy, the language is right in the agreements that networks sign with self- funded employers and their administrators when contracting for access to the networks. Look at the language taken from a network contract with its facilities:

"Payer may audit provider bills for duplicate billing and/or inaccurate coding, provided payer has first paid the repriced bill in full in accordance with the terms of the network provider agreement. In no event may the payer audit or reduce the contracted provider billed charges based on its own "usual and customary" or other clinical provisions."

So this basically states that a self-funded plan and its TPA cannot audit a claim until they pay the entire amount first. After paying in full, they can do an audit to see if they overpaid and attempt to get the money back. I don't know about you, but I learned early on in law school that possession is nine tenths of the law, so good luck getting that money back! In what other industry do you have to pay an invoice in full before questioning it? You are correct if your answer is none.

Doctors Not Allowed to Be Transparent

The current industry norm is not just painful to plans and their administrators as providers that want to change the system are affected as well. Just look at the following provision from a provider agreement with a powerful network:

"Participating provider agrees to keep and hold its fee schedule confidential. Participating provider shall not disclose such fee schedule except in standard billing to patients or the administrator, or as otherwise necessary to ensure payment. Confidential Information includes contracted rates and contracted provider will not disclose any payment rates at all except as necessary to obtain post service payments."

Basically, if a facility or a doctor wanted to place their actual prices online, they would be barred from doing so if they want to be a part of a national or regional network. So here is the dilemma, either follow the network rules and keep quiet or attempt to build a business where access to patients is limited to those willing to go "out of network". For those brave souls willing to make the jump just know that more and more doctors are following suit as they are getting sick of the bureaucratic network rules and focus on actually taking care of patients. Let's just hope that the momentum continues. Otherwise, the status quo will continue. I truly don't blame those doctors and hospitals that are afraid to place their prices online. I mean it can't be easy to give up simple access to patients that can choose your name from a preferred provider book or an online website portal. The marketing is done for them as they don't need to attempt to attract new business. All I know is that the membership at the Free Market Medical Association has more than doubled from its first year of existence. Thus, hope exists.

How Do We Change this Dynamic?

The only way anything changes is if we can get patients, employers, brokers, TPAs, and stop-loss carriers aligned and this can only occur through true transparency. So how do we get true transparency? Let's start with the employees and their dependents. How do we get them to care about anything other than their co-pays and deductibles? How do we ensure that they care about the entire bill? There is only one way and that is money! If patients have an incentive to save money for the plan, then they will look for ways to reduce the overall cost of their own care while not sacrificing the quality of the care.

If employers believe that their employees will attempt to save money for the plan based on altruism, they are kidding themselves. The good news is that this is not hard to do. You just need to draft the plan document and the schedule of benefits to reward patients for choosing providers and facilities that save the plan money while ensuring lower out-of-pockets for patients as well as cash rewards. While this may be harder to do working with a national carrier that owns its own networks, this is a very real opportunity for those employers working with TPAs. In today's environment, TPAs are looking for ways to differentiate themselves from the ASO carriers – this is a powerful way to do so.

The easiest opportunity that can be implemented involves having the patients actually audit their own claims. While my firm audits bills and negotiates claims on behalf of self- funded plans, the reality is that the best entity to actually review the claims procedure is the actual patient who received the care.

Under your current plan design, what incentive does the patient have to identify errors and duplicate charges within their claims? There is none! The best way to ensure that members care about the costs of the overall self-funded plan is by rewarding them handsomely to do so. We are seeing many more self-funded employee benefit plans adding this simple incentive into their plan designs and the lower plan costs are starting to reflect this partnership. The fact remains that there is a growing movement of immense change. Yes, it is slower than many would want, but it is happening and the networks and large insurers are taking notice…finally.