NiiS 25th Annual Medical Excess Claims Conference

Medicare Based Pricing

May 7, 2014

Moderator: David W. Ives, CPCU
Panelists: Edward Day, CEO, HSTechnology Solutions, Inc.
Jennifer Hill, Preliminary Claims Manager, HCC Life Ins. Co.
Joseph M. Zerega, President, Preferred Network Access, Inc.

The session was moderated by David W. Ives, CPCU CEO, Northshore International Insurance Services, Inc. and Panelists: Edward Day, CEO, HSTechnology Solutions, Inc.; Jennifer Hill, Preliminary Claims Manager, HCC Life Insurance Company; and Joseph M. Zerega, President, Preferred Network Access, Inc.

David began the session by introducing the panelists. Opening remarks by the Panelists set the context of the discussion.

David then posed the following questions to the Panelists:

1. From your perspective, what have been your experiences that have demonstrated the needs and benefits related to referenced based pricing?

    - We are seeing egregious charges that Providers aren't entitled to.
    - The market is dysfunctional.
    - Starting to use referenced based pricing when negotiating contracts.

2. When you are asked to analyze hospital and physician billing practices, what process do you follow?

    - We are like "CSI". We review all pages of the itemized bill, verify all costs by revenue code. For labs, radiology, pharmacy, we review a sample of 30 codes, benchmark them using 300% of Medicare allowable and look at the mark up. We also review operative reports and anesthesia reports.
    - We look at Medicare versus Medicaid cost structure for that particular facility in that geographical area. We look at what competitors are charging in the same area.

    Question: Does 300% of Medicare allowable sound reasonable?
    Answer: Yes. This is what is called the "tolerance level".

3. From a claims perspective, how do your approaches differ when you are presented claims on a paid versus unpaid basis?

- We have been receiving batches of claims from a BUCA that are in excess of a million dollars. We have been looking at the referenced based pricing, charges versus discounts and the paid and report back to the broker, the value of the BUCA and what referenced based pricing is. The broker is now considering referenced based pricing instead of using network discounts.

4. When discussing cost transparency and referenced based pricing, how have the responses differed by provider (e.g., hospital versus physician)?

    - It varies. We have had success dealing with the CFO or whoever the decision maker is at a hospital. These are the people that understand Medicare and referenced based pricing. If you speak with someone in patient accounts, you will get nowhere as they don't understand.
    - Centers of Excellence understand the process.
    - Make sure you are dealing with a "decision maker" who is familiar with CMS/Medicare allowable.
    - Hospitals will make it difficult for you to determine what is right and what is false. They play off the PPO and will tell you that the claim must be paid within 30 days or you will lose the 10% discount.
    - Another challenge is that they (hospital) will remove CPT codes and won't provide operative reports.

5. When dealing with ASO plans, how have carriers responded?

    - We have not have favorable responses. They are used to things being done "their way". The key is communication. Communicate with all parties involved to make them understand what it is you are trying to do.
    - You have to get to the right person. Usually they are very interested in optimizing the value of your services.
    - ASO plans are less willing to go to Medicare based pricing as they have their own network and don't want to admit that their network is "messing up" and that the discount in not adequate.

6. Do you recommend modifications to the contract language appearing within Plan Document and excess policies? If so, what changes would you specifically advocate?

    - There are problems with loose definitions in Plan Documents of UCR/R&C, this is why providers are getting away their billing practices.
    - You will need to make sure your Plan Document contains wording regarding referenced based pricing.

- Also make sure your Plan Documents contain wording regarding "clean claim".
- Make sure your Plan Document is in sync with your Stop Loss policy.
- Plan Documents need to be reviewed carefully because providers will find loop holes so that they are getting the maximum reimbursement.
- It is important to educate the payer, employees and participants in the plan.

  Question: How does sign off fit in?
  Answer: With no sign off, you will have an adverse outcome and you will be challenged.

7. Are there lessons to be learned from the Baylor Hospital cases arising a few years back? What happened and how can it be prevented in the future? Could there be similar fall-out for reference based pricing?

   - With the Baylor Hospital case, the approach was adversarial.
   - You will need to get dialogue going, communication is the key.

8. In terms of establishing referenced based pricing as part of a benefit plan and excess coverage, what are the obstacles to implementation?

   - Inadequate wording in Plan Documents and Stop Loss policies.

9. If you were to dust off your crystal ball and look to the future, what claim trends do you see for the next 12-24-36 months?

   - Referenced based pricing will be the standard for reimbursement in healthcare. We are projecting this will happen within the next five years.
   - We need to all be on the same page, payers, brokers, TPAs, PPO networks, and say no to the provider that we will not pay that $500,000 claim. We need to stand united.
   - The providers need to be held accountable.

   Question: Why have you chosen the Medicare Plus 150% - 300% as opposed to comparing the cost of public information that hospitals are publishing?

   Answer: We are looking at cost, Medicare allowable is less so that's why cost plus. The transparency of Medicare, hospitals and physicians understand and they are comfortable with that.