

Free-Market Medicine Reduces Healthcare Costs

Ralph F. Weber

Healthcare costs have been rising at a rate outpacing wage inflation for many years. Starting January 2014, this trend will get even worse as some of the costly mandates of the Affordable Care Act (ACA) take effect.

Under ACA, deductibles must decrease, cost reductions for healthy groups will vanish, and competition will be reduced among healthcare providers as well as healthcare financing companies. Many have already experienced up to double-digit increases in their health insurance premiums.

For decades we have focused on the cost of insurance rather than the cost of care. Since 2002 payment rates under Medicare (and therefore all private payers) have been scheduled to decrease almost every year, but these rate decreases have never been implemented. Still, we continue to work in a system that is based on price fixing and lack of transparency.

Since the cost of health insurance is based on the cost of medical care multiplied by the number of times we use it, focusing on reducing the cost of insurance is a strategy that will never be effective no matter how many times we try.

Successful chief financial officers (CFOs) usually tender out large purchases in a "Request for Quote" (RFQ), or competitive bidding process. Each bidder is given the same specifications, and submits a silent bid based on known variables. Business knows that competitive bidding with transparency is the best way to keep costs down.

If used in healthcare, this approach would focus on the cost of care, not the cost of insurance, and provide transparency of quality and cost (i.e. value) and competition among providers via RFQs. Middlemen would be cut out of the equation, allowing further cost reduction. Employees would be given the tools and the financial incentives to make value decisions that reduce costs.

In order to rein in costs, it is necessary to know what drives them. By far, the largest drivers are mandates and coverage, waste and abuse, and the cost of medical care. Others include taxes, sales charges, administration, and access or PPO (preferred provider organization) fees.

Mandates are set by legislation, and little can be done by employers to change them. Waste and abuse results from plan inefficiencies, and poor incentives and controls. The cost of medical care is actually driven up by PPOs.

PPOs give plans "negotiated discounts" with certain medical providers. The question that few ask is: "Discount versus what?" Medical care is usually billed by doctors and facilities at rates between 300 percent and 1,000 percent of Medicare rates. Insurance companies "re-price" these claims and give an artificial discount. Carriers don't always pay the providers the discounted rates. Sometimes they "down-code" to a procedure that carries a lower reimbursement, or they charge a hidden "access fee." Other times they deny or decline the claim, which can even happen after the employer and employee have been billed. Since payers

have one contract with providers, and another with employers, they can pay the provider a lower amount than they bill the employer. This could represent a loss of millions of dollars to large employers. Sometimes payers simply bill the employer and employee based on one price shown on the explanation of benefits (EOB), yet pay a lower rate to the provider. Blue Cross was exposed for this practice in a recent court case in Michigan (*U.S. v Blue Cross Blue Shield of Michigan*).

The amount of care used is increased by low deductibles, poorly designed plans, inability to benefit by economizing, and annual plan deductibles, which once met, eliminate consumerism. This item is a multiplier of care cost. In other words, the greater the cost, the more this driver increases costs.

Fraud is not always detected, especially in government plans. CFOs must demand plan audits, especially in self-funded plans governed under the Employee Retirement Income Security Act (ERISA). The plan administrator should act as fiduciary to protect plan assets. Note that it may not serve the purchaser to have the administrator audit the plan.

Administration, taxes, and sales charges combined generally amount to only 15 percent to 20 percent of the plan costs. Premium taxes vary slightly from state to state and have been increased by ACA. Self-funded plans do a good job reducing all of these charges, yet very little can be done to reduce them in fully insured plans.

Access or PPO "rental fees" are generally charged by commercial health insurance companies and third-party administrators (TPAs) as the price of access to the PPO network, a selected list of doctors and facilities that have agreed to provide services at certain rates. Contrary to the way it is positioned, these fees actually increase the cost of care. They provide artificial discounts on artificial prices, much like a store that marks up prices in the fall, just to put them on sale for Christmas, creating an illusion of a good deal. This practice is misleading and creates opacity for the consumer. These "discounts" often have variations of up to 1,000 percent in one network in one city for one procedure. PPO discounts usually increase costs, since the employee rarely knows what the reimbursement level is for the provider. It is usually better to save the access fee and choose a schedule that reimburses on a fixed scale.

Many years ago the product we purchased was medical care. Today the product is "healthcare," which is simply medical care financing. Too much time and emphasis has been placed on attempting to reduce the financing costs, while there has been no focus on the cost of care. This is like trying to reduce the cost of a car by spending 80 percent less on the tires, and still expecting the car to drive safely and efficiently.

Ralph F. Weber is the founder of MediBid.com and president of RouteThree Insurance and Financial Services. Contact: Ralph@MediBid.com.