Health Care Strategies for Political Subdivisions

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Changing the Paradigm of Health Care Delivery & The Politics of Change

By Bill Rusteberg

Introduction

In 2009 I wrote a White Paper entitled *Health Care Strategies for Texas Political Subdivisions*. In my introduction I wrote:

"The cost of providing health care benefits to employees of political subdivisions within the State of Texas as well as legislative obligations to provide health care to indigent citizens, continues to soar with double digit increases……This report focuses on and identifies what we perceive to be some of the key cost driving issues within our health care delivery system as well as common sense solutions…….these solutions have reduced health care costs 40% or more without reducing benefits or access to care."

A lot has changed since. The passage of the Affordable Care Act (ACA) is one example. But what has not changed and continues to this day for most political subdivisions in Texas is the continuing phenomenon of ever increasing health care costs, lower benefits and less choice.

The exception is the opposite for those who have adopted some or all of the strategies outlined in my 2009 article. These early adopters have beaten medical trend while improving benefits at the same time. Significant savings has enabled them to enhance benefits rather than reduce them, while keeping health care costs essentially static. They have learned that solving health care includes more choice, better benefits and lower costs.

A common thread of these early adopters was summed up at the end of my article:

"*Texas political subdivisions can significantly reduce their health care costs but will need the expertise required to successfully implement a wide ranging strategy as well as the political courage to prevail."*

It is beyond a doubt politics can play a dominant role in health care delivery decisions. Strategies based on reason and logic often flounder when political dynamics are ignored. Invariably political hurdles come to surface. Gaining political support is absolutely essential towards changing the paradigm of health care delivery.

Changing the Status Quo – Politics & Resistance to Change

In order to stop rising health care costs, eroding benefits and less choice, health plans must accept the precept that change is absolutely necessary. Instead of raising premium rates, cost shifting to plan members, implementing wellness programs along with other ineffective and failed strategies, health plans must assume a different approach to succeed. However it must be acknowledged and accepted that change brings chaos and confusion especially after the comfort of 40 years of doing the same thing over and over again.

Change means paying less for health care, not more. Change means more choice, not less. Change means controlling the parameters of health care transactions, not ceding responsibility to third party intermediaries who have no accountability and whose vested interests are not always aligned with the interests of plan sponsors. Change means transparency in pricing, not the opaque world of managed care contracts.

Texas political subdivisions adopting the strategies which I outlined nine years ago have succeeded in solving health care.

How was that possible?

Strategies for Change

There are certain essential strategies that have proven to work that I will discuss here. Please know these are not all the strategies to be employed, and there are different flavors and colors to choose from. Risk tolerance assessment is an important first step we undertake on behalf of our clients before making the journey towards lower costs and better benefits. Not all plan sponsors are the same. A risk tolerance assessment determines whether they are ready to break away from the status quo, and if so, to what extent.

The first strategy involves tackling the opaque world of managed care contracts.

Managed care contracts (PPO Contracts) are agreements set between a provider of health care (hospital, doctor, etc.) and third party intermediaries such as an insurance companies. These contracts are proprietary and secretive. Both parties agree collaboratively to never reveal terms of their agreements. Texas counties, cities and school districts access these agreements as third party beneficiaries only, precluded from reviewing the terms of these agreements. Instead they simply rely upon the representations of third party intermediaries warranting they will receive preferential pricing. However, since these agreements are cloaked in secrecy, it is impossible for most to determine the true value cost basis of these managed care contracts. Not so our clients. They understand that when you are not able to review a contract you are probably paying more than you should.

In effect Texas political subdivisions accessing PPO networks are gifting public monies through third party intermediaries for health care expenses to which they have no idea of the cost basis upon which claims are paid. Common sense dictates this is a breach of fiduciary duties of the first degree.

Managed care networks, on the other hand, will argue plan sponsors receive preferential pricing through significant discounting that they could not achieve on their own. A matter of semantics and fuzzy math may seem to "prove" their claim, especially when consumers see billed charges versus PPO allowed charges.

The reader must understand billed charges are arbitrary and have nothing to do with costs whatsoever. Discounts applied to billed charges can be manipulated in any number of ways creating a "spread" spawning a billion dollar honey pot for a swarm of third party intermediaries. A fifty percent discount off double the price is a not a sign of a good business transaction since only one side benefits while the other side loses.

Billed charges can be has high as 1,000% of Medicare reimbursement rates, or more. So in that case, a 50% discount would mean a consumer under a managed care plan would end up paying five times more than what would be paid under their grandfather and grandmother's Medicare benefit plan using the same hospitals and doctors.

Political subdivisions employing our strategies have reversed medical trend, improved benefits with essentially static rates. (*We have the empirical evidence to prove it*). Rather than paying providers a discount off an arbitrary inflated number these early adopters are instead paying for health care based upon benchmarks such as Medicare reimbursement rates, cost-to-charge ratios and other data points. These payments are defensible, fair and transparent across the board for all providers of care. On average, these pricing strategies lower costs as much as 30-40% above and beyond opaque pricing in managed care contracts.

Additional strategies include direct contracting with community health care givers, cash pay claim transactions, quality metrics and centric primary care models.

The Resistance Movement

These changes bring pushback which must be addressed and understood before any serious attempt is made to solve health care. This is where politics enters and logic and reason oftentimes takes a back seat.

Pushback centers on two things. Will hospitals and doctors accept plan members for treatment, and if they do will they accept less in payment than they are receiving now?

There is no definitive answer to either question. Medical providers don't have to treat patients (*unless for emergencies*) and they certainly can charge anything they want to charge. However, we have experience of ten years in managing these types of plans upon which we can draw general conclusions.

First, we know medical professionals (doctors) like being paid quickly and fairly. Early on we found the professional community strongly supportive of our strategies. They have become our biggest proponents. In the past ten years I cannot think of a single medical professional who has turned a patient away for treatment. I can find none who have refused payment based on our payment method. Few, and I mean very few, have balanced billed their patients. In fact, balance billing is about on par to what it was back in the 70's under the indemnity plans of those days.

Secondly, as industry insiders, we know important findings of fact unknown to most. We know what hospital's costs are since they file their cost-to-charge ratios with CMS every year, and attest to them. We know Medicare's reimbursement levels are based on a cost-plus approach. We know what managed care contracts, specific to each, pay hospitals through extensive data available through claim payers across the country. We know what hospitals typically accept in reimbursement in each geographic region of the country. And, most importantly, we know what is in managed care contracts because we have copies of most gained through our due diligence efforts.

Consequently, we have good data to determine what a prudent consumer should expect to pay hospitals in relation to what hospitals have been known to accept historically. *And we freely share our data with anyone wanting to know.* Yet those who consciously, purposely continue on the status quo course, eschewing proven strategies our clients employ, are allowing providers to remain at the managed care trough of never ending escalating health care costs.

Hospitals have historically accepted our plan members for treatment contractually through an Assignment of Benefits agreement. They cash the plan's reimbursement checks. On rare occasions have we experienced plan members turned away and refused treatment. However, in those cases a cash pay plan arrangement is in place wherein the hospital is offered a cash payment up front. In almost every instance a cash payment is *significantly lower* than what the plan would have paid in the first place. Providers simply do not turn down cash offers and they are quite willing to take much less than they do from insurance companies. When hospitals recognize our members as cash pay, we rejoice. *Cash Pay-Direct Pay Health Plans*are the next logical step in today's dynamic, innovative market.

Ten years ago when our approach was new to the market, we found a few hospitals would do their best to talk plan sponsors out of adopting these strategies before the plan actually moved forward with implementation. Hospital personnel were known to threaten plan sponsors informing them they would not accept plan members "*because we do not have a contract with your plan administrator"* or "*it's not insurance, we won't accept patients with that kind of insurance*." This tactic could have been very effective on the weak, timid and uneducated, but it had the opposite effect on our clients who were fully informed and knowledgeable on health care finance. We made sure they became well informed on health care finance as an integral part of our client's evaluation process prior to implementation.

We found that once a plan moves forward and ignores these threats, hospitals become resigned to accept patients and cash our checks. They understand that Joe Sixpack doesn't have the $35,000 balance bill and they certainly know the plan sponsor is not responsible for it. What they do know is they made money off the patient. They cashed reimbursement checks at a multiple of Medicare or a margin

above cost. They know, and we know, they profit on the care delivered though the strategies we employ and they know our reimbursement strategies are defensible.

Political Courage to Prevail

Changing the paradigm of health care delivery brings resistance from entrenched vested interests. But that's not the most important element of the resistance movement we face. We must understand it's the *politics of change* within organizations we serve that drives success or failure in structuring strategies others have implemented before them with outstanding success. Internal politics and self-interests often dictate how people weigh logic and reason against the status quo. Fear, fueled by ignorance, is their greatest motivator to joining the resistance movement in alliance with "friendly & trusted" vested interests within their respective communities.

The foundation of *Political Courage to Prevail* must be based on empirical evidence and education.

Irrefutable empirical evidence exposing waste, fraud, and overpayment of health care translates to a dollar value. A dollar value in the scheme of a tax based entity is necessarily an essential ingredient to public accountability and fulfillment of fiduciary duties to plan members and taxpayers.

Educating plan decision makers is of paramount importance. It is an essential first step towards change. Plan sponsors must be on board in breaking with the status quo and venturing out to where others have gone before them in solving health care. Internal politics must be aligned.

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