

The High Cost of Healthcare Dissected

By Adam V. Russo, Esq, Ron E. Peck, Esq., and Jon Jablon, Esq.

The Phia Group, LLC

February 10, 2016

I. The Cost of Healthcare in The US is Arbitrary and Out of Control

It is no secret that the cost of healthcare in this country is out of control. It is true, of course, that providers' costs of doing business increase within a normal distribution – but that certainly cannot account for the abnormal and indeed exorbitant markup that most medical providers place on their services rendered.

In truth, the provision of medical services is difficult to quantify. In many service markets, the price is determined by what the market will bear – although in the medical service market, the market will bear a nearly infinite charge, primarily because consumers have limited choices, aren't paying the price (directly), and have no incentive to be selective as it relates to price. The unregulated market is truly scary, since the individuals consuming the services have (they believe) pre-paid for their medical care in the form of insurance, and fail to see how excessive pricing impacts them financially.

A 2013 article¹ has revealed many instances of inadequacies in the pricing market in this particular area. A 1,000% mark-up on generic Tylenol, a blood test costing about 1,400% of what Medicare would pay, \$77 for a box of sterile gauze pads, \$18 for a single diabetes check strip sold elsewhere for \$0.55, and \$7,997.54 for a stress test that would be paid by Medicare at \$554 are examples listed to illustrate the impropriety with which many hospitals conduct their billing. This is not confined to one particular hospital or even one geographical area; these results seem to be the norm throughout most of the urban and suburban United States. The official record of a Congressional hearing – “Pricing Practices of Hospitals”² – contains a submission quoting:

- \$57 for a FRED (Fog Reduction Elimination Device--a 2X2 gauze used to wipe moisture from lenses in the operating room (not even a billable item);
- \$200 for a bag of IV solution that costs the hospital about 25 cents;
- \$985 pair of scissors (which is not a billable item);
- \$1,028 for a contrast solution that CMS deems not chargeable as it is included in the cost of the procedure;
- \$11 for a mucous recovery system (also known as a box of tissues);
- \$350 for an IV kit that is not billable in the operating room, and in any event costs less than \$2;
- Thousands of dollars per day for “nursing services” that CMS mandates as incorporated into the daily room charge and is not separately billable.

The law doesn't help either. Providers are required to file their pricing parameters – albeit parameters that are arbitrary and without basis. This is the charge master, and the charge master can specify that – for instance – one single off-brand Tylenol pill costs as much as 100 of the same pill at a local drug store –

¹ “Bitter Pill: Why Medical Bills Are Killing Us,” by Steven Brill, Feb. 20, 2013; <http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/>

² <https://www.gpo.gov/fdsys/pkg/CHRG-108hrg99670/html/CHRG-108hrg99670.htm>

but as long as a charge master is filed, the hospital has complied with its legal requirements as far as the state is concerned.

The market is unregulated both by the government and by consumers. This is especially odd given that consumers have no knowledge and no power when they are in need of medical services; if one expected the government to provide some sort of regulatory scheme for ensuring that consumers are not grossly mistreated, one would be sorely disappointed.

II. How Do Market Forces Control Prices?

Price is ordinarily arrived at by the interaction between supply and demand. Price is dependent upon the characteristics of both these fundamental components of a market. Demand and supply represent the willingness of consumers and producers to engage in buying and selling. When a product exchange occurs, the agreed upon price is called an “equilibrium” price, or a “market clearing” price, which exists at the intersection of demand and supply. At this point, supply and demand are in balance. When the quantity demanded is greater than the supply, a shortage exists. In this event, consumers would choose to pay a higher price in order to get the product they want, while producers would be encouraged by a higher price to bring more of the product onto the market. The end result is a rise in price, until demand shrinks, resulting in supply and demand being in balance. This natural equilibrium between supply and demand is the essence of a free market.

Ordinarily, if a price is set too high, consumers will choose not to purchase the good; the market would be in surplus, and there would be too much supply relative to demand. If that were to happen, producers would be willing to accept a lower price in order to sell, and consumers would be induced by lower prices to increase the volume of their purchases. Only when the price falls would balance be restored.

III. Why are These Forces Absent from Healthcare?

As already described, prices charged by providers are excessive and arbitrary. The amounts charged differ from provider to provider, and even the same provider will charge different amounts depending upon who is paying the bill. How is it that prices can continue to skyrocket? Unique to the healthcare market, increases in price fail to impact demand. Until the payer and consumer are one, and they cease purchasing the good when priced unreasonably, equilibrium cannot be reached.

Despite insurance carriers’ deep pockets, they do not print money. Eventually, the cost of care will be so high that even insurance carriers will not be able to afford the coverage. We are already witnessing this today. Plans are featuring high deductibles, carving out or limiting coverage for high-cost items, and applying objective price modifications to the maximum payable amounts (using things like MSRP, Medicare rates, cost to provider to supply, and other references to determine fair market value and thus maximum payable amounts). The root of the issue can be found in the fact that the payer is not the consumer in a health insurance arrangement.

IV. Absence of Contract Law in Healthcare

A contract consists of three things: offer, acceptance, and an exchange of consideration. In the context of a provider-patient relationship, the provider offers to treat the patient, and the patient accepts said offer. The treatment is in and of itself the consideration supplied by the healthcare provider. In exchange, the provider accepts monetary compensation as payment. To be a valid exchange, in almost all other contexts, the parties must dicker the terms of the agreement, whereby they agree upon what the consideration shall

consist of, and confirm that they do indeed approve of the exchange. In the realm of healthcare, however, the patient has no idea what the provider expects by way of consideration. In other words, the patient agrees to accept the provider's consideration (services), in exchange for an unknown sum of money. No other industry besides healthcare could legally enforce contracts such as this. This should be especially true in a scenario where one party has all of the power, and undue influence, over the other party. In healthcare, it is impossible for the patient to decline the offer. To decline the offer, in most healthcare circumstances, is unthinkable and can even be literally life-threatening.

The issue is then compounded by the health insurance payer system. The reason open-ended contracts such as the one described above could not survive in any other industry (besides healthcare) is because the consumer, upon seeing these terms, would refuse to accept them. These open-ended agreements are allowed to thrive in the healthcare industry, however, because (1) as explained, the provider has all of the power (the consumer is powerless to say "no"), and (2) the consumer is not directly responsible for payment. Instead, the bill is directly forwarded by the provider to an insurance carrier or other third party payer. The patient never sees the bill. The patient may be advised of the matter post submission, and then only in the form of an explanation of benefits (EOB). The consumer is unlikely to examine the EOB, however, as it clearly states in bold letters "This is Not a Bill." Like many consumers, when something is not a bill, it is not read. The only time the consumer feels the effect of these open-ended agreements is when their premiums rise, or if they are balance billed.

This leads into the next issue, which relates to how billing is accomplished. With every other form of insurance claims are processed in the same fashion. First, the insured suffers a loss. Next, the insured reports the loss to the insurer. Next, the insurer assesses the damages, and provides compensation to the insured, with said compensation equivalent to what the insurer feels is the fair market value for the loss, based upon industry accepted parameters. Finally, the insured either uses the compensation to address the loss or not. How the insured uses the funds is of no concern to the insurance carrier.

As an example, consider a motor vehicle accident. The insured is struck at a busy intersection. The insured calls their automobile insurance carrier. The carrier has an examiner view the vehicle, and he then assesses the value of the loss. The value of the loss, and thus funds available, are based on standards set by the industry and the particular carrier. The insurance carrier sends a check to the insured for that amount, (minus a deductible if applicable). The insured may then: (1) choose to have the carrier's preferred mechanic repair the car, and pay said mechanic the amount advanced by the insurance carrier, (2) find another mechanic that will fix the car for less, with the insured then pocketing the difference, (3) choose not to repair the vehicle, and pocket the full amount paid by the insurer, or (4) select a mechanic that will charge more (but presumably do a better job). If the insured selects this fourth option, however, the insured – not the insurer – is responsible for paying the difference. The responsibility to "shop around" and act as an informed consumer falls squarely upon the shoulders of the insured. The risk of loss (or reward of gain) goes to the insured; the insurer pays what it pays, regardless of the insured's decision.

Not so in the realm of healthcare. In the realm of healthcare, health insurance carriers are charged vastly different amounts for the same service by similar providers practicing less than a mile from each other. These medical service providers even charge different entities different amounts for the same service. Moreover, the insurance carrier is expected to pay these varied charges in full, regardless of what the carrier believes is the actual, fair market value of the loss.

Unlike the automobile collision example, a medical provider bills the insurer directly. The medical provider will even pursue a claim against the insurer if they feel they are under compensated. Yet, what consideration has the provider provided to the insurer? The medical service provider has not provided

any service to the health insurer. The only consideration received by the insurer came in the form of premiums, paid by the insured – NOT the provider. The insurer therefore owes consideration to the insured – NOT the provider. Why, then, can the provider bill the insurer directly; and why, then, does the provider have an enforceable expectation of payment from the insurer? The answer is an assignment of benefits.

The reason patients don't care how much their provider charges their insurance, and thus feel like they have no "skin in the game," is because unlike the other scenario described above (the automobile example), a healthcare service provider accepts an assignment of benefits from the insured rather than bill the insured. The insured never sees the bill. Insureds have no incentive to seek out fair priced healthcare, and providers need not fear disgusting customers with unconscionable pricing.

V. Assignment of Benefits, Networks, and Other Elements Unique to Healthcare Eliminate Market Forces

One reason payers are willing to take such abuse is that to do otherwise would result in providers seeking payment from the patient – for amounts above and beyond what the insurance or health plan is willing to pay. This practice is called balance billing. Balance billing can be prevented by entering into a network agreement, and is the only real reason to access a network; (the discounts a payer sees via network participation is small and applied to arbitrary, excessive rates, making the discount worthless).

Balance billing can also be prevented by revising provider practices such that their bills do not exceed objectively reasonable amounts. Balance billing can be prevented by patients who negotiate with providers and ensure the charge amounts will not exceed eligible benefits available from their insurance carrier or benefit plan. If insurance carriers and benefit plans allow providers to balance bill, educated patients will push back against the providers. The fear - that patients will blame the benefit plan and insurance carrier for balance billing – is reasonable, until the plan and carrier educate patients regarding payment practices and the prevalence of excessive charging by medical service providers. When patients aren't well-informed, they often ally with providers – but when patients are told what is going on and why, patients tend to ally with their health plans and insurance companies. Since self-funded health plans are funded primarily by the patient's own employer (or the spouse or parent, in the case of a dependent) as well as the employee itself, these patients have every incentive to try to help the health plan lower its costs across the board. Education is the only way that patients will share ideologies with their health plans; patients who are uneducated regarding provider billing will side with the provider against the big bad insurance company or self-funded health plan.

If insurance carriers and benefit plans advise their participants as to why the eligible benefit amount is what it is, and the true nature of the billed amounts compared to the services rendered, the participant will come to realize that fault lies with the provider – not the payer. Once participants have some "skin in the game" a free market will force providers to compete, and develop strategies to keep costs down while improving the quality of their wares.

VI. Without PPOs, TPAs Cannot Offer Consistent Discounts, so Alternatives are Sought

The consumer doesn't care about the actual cost of care. This is why our system will not change unless the actual consumer knows or even want to know what the costs of the services are. Hospitals know this, the networks know this, the large insurers know this, and this is why nothing will fundamentally change.

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.

Within the current healthcare environment, many provider networks limit or just outright deny self-funded plans and members the right to audit the claims. The language is right in the agreements that networks sign with self-funded employers and their administrators when contracting for access to the networks. They typically state 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. The current industry norm is not just damaging to plans and their administrators; providers that want to change the system are affected as well, and there are certainly many providers that are as unhappy with the current market as are payers. Part of the problem is that if a facility or a doctor wanted to place its prices online – to add a much-needed layer of transparency to this market – the provider would be explicitly contractually barred from doing so if they want to be a part of a national or regional network.

A phenomenon called reference-based pricing (or “RBP”) is sweeping the industry. RBP is a plan design that entails a health plan paying not the provider's full arbitrary billed charges, but instead based on objective metrics such as a percentage (almost universally above 100%) of what Medicare would pay the provider. There are many different types of RBP plan designs and therefore different levels of success depending on the program. RBP is an innovative way to cut costs, and can ultimately be successful, but it depends on preparation, education, claims data integrity, plan document expertise, and proper claim defenses – notably including a health plan's willingness to negotiate with providers to eliminate balance-billing. When hospitals receive only a small percentage of their egregious bills from a health plan, they sometimes seek to recover the rest from patients, which creates a balance billing scenario. There are certain methods that can be used to combat such scenarios, and partnering with the right vendors in the industry is key.

Part of the confusion and anger from not only medical providers but from the Department of Labor as well stems from the harsh reality that networks have been so pervasive, for so long, that providers and the government agencies responsible for enforcing the Affordable Care Act's provisions simply cannot conceive of a world without them.

VII. As the Cost of Care Becomes More Relevant, Cost-Saving Alternatives Become More Desirable

Employers, administrators, brokers, and courts have begun to realize that determining the value of healthcare services must involve something more than considering only a provider's billed charges. More and more courts are limiting evidence based on the reasonable and customary value of the services rendered, and ignoring what the facility actually billed. The growing trend is finally a realization that provider billing is completely arbitrary, and egregious to boot – often at an unconscionable magnitude.

Where we truly are seeing a growth in RBP utilization is specifically on out of network claims. Where in the past a run-of-the-mill network plan would pay out-of-network claims based on the prevailing charge in the area for similar claims, more and more health plans are amending their plan language to pay based on Medicare rates. In this situation, the health plan is saving money and since the patient made the conscious choice to visit an out-of-network provider, the plan does not need to be concerned with patient balance billing.

In the larger picture, traditional networks have failed to stem the rising costs of healthcare. This has the overall effect of reducing access to healthcare. Further, networks have encouraged a pricing system where providers charge one amount for their services but accept an entirely different payment from plans they contract with based on some percentage of those charges – or even by simply not pursuing some health plans that do not pay the full bill.

Unlike network discounting from unrealistic gross charges, RBP plans use bottom-up pricing based on costs. As more and more patients begin to look at the overall cost of care and the actual billed charges, it is getting harder for plan administrators to preach the benefits of network discounts when compared with the alternatives.

The best RBP process involves implementing best practices for cost analysis, claim repricing, patient advocacy, plan design, balance bill protection, patient advocacy, and member education. Any other way will spell disaster for the plan, meaning they will have a bad taste in their mouths when it comes to self-funding and ultimately move plans to the fully insured carriers and the exchanges.

VIII. In Conclusion

The society we live in is capitalistic; it is driven by a not-so-complex system of supply and demand and charging based on what the market will bear. The health care market, however, deviates from the rest of the economy in a significant way, and it is apparent that this is primarily caused by the fact that consumers (patients) are not the ones who actually directly pay for their goods and services – instead, insurance pays. As a result, medical providers are able to charge literally any amounts they want, and patients are usually none the wiser. That paradigm, however, is beginning to shift, as health plans are getting increasingly unhappy with being taken advantage of and instead they are seeking other alternatives, such as RBP and various patient incentives to examine bills and seek less expensive treatment.

This paradigm shift, though, is not happening all at once. It is a slow transition, with many health plans still skeptical about its effects and the disruption it may cause. The status quo is therefore preserved for the most part, for the time being, and medical providers continue to be able to artificially inflate their already arbitrary charges. It is only a matter of time until we experience a regulatory or economic market upheaval in the health care industry – but until then, health care payers will still be taken advantage of, and those payers that push back against providers are punished anyway, when providers go after the plan members member instead. The status quo presents a no-win scenario for health plans, employers, and patients – but providers make a killing. Something needs to be done, and it is only a matter of time.