

MANAGED CARE

FOR MANAGED CARE INSURANCE PROFESSIONALS

FORUM

Volume 2 • Number 3 • December 2000

Profiting from Future Trends in Managed Care

By Laurence Gelman

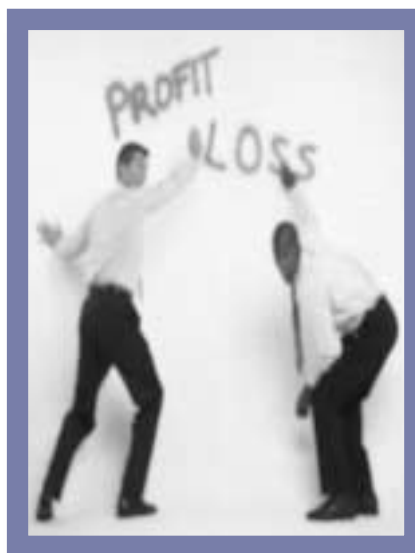
"The report of my death was an exaggeration." —Mark Twain, after reading his own obituary, June 2, 1897

Like Mark Twain, the managed care industry has of late been busy refuting reports of its own demise. But, for the first half of 2000, the profits of four of the five largest managed care organizations (MCOs) are up. Clearly, managed care is far from dead.

While the situation is far from terminal, it would still be premature to pronounce the managed care industry "cured." So how can managed care not only survive, but prosper as well? Here are some suggestions.

Don't Panic

Symptoms of panic disorder in MCOs may include hastily conceived mergers, wholesale layoffs, and/or accounting gimmicks. Remember the parable of the two hikers who encounter an unfriendly bear: One hiker starts



changing his boots for running shoes. The other hiker says, "You can't outrun the bear!" to which the second hiker replies, "I don't have to outrun the bear, I only have to outrun you!"

So, instead of panicking, use this window of opportunity to reinvent your organization based on the present market, and to decide what future shape your organization will take.

- Scrutinize everything, including networks, processes, personnel, marketing, etc.
- Assess competitors, resources, major purchasers and objectives. Conducting focus groups of major purchasers might be helpful in designing more targeted products and programs.
- Evaluate the impact of government

initiatives on administration and funding.

- Reshape or jettison products that don't fit the new organizational profile.
- Consider writing a business plan. This is a must for start-up companies, but mature companies rarely have them. Think of your organization as a start-up, and justify capital expenditures, outline a contingency plan, etc.

Return to Your Roots

In the early days, MCOs believed success would come from controlling costs through early disease intervention, health promotion and case management. Over the years, many MCOs have focused instead on shifting risk to providers and managing costs through fee negotiation. As a result, the distinction between MCO models has blurred. Many purchasers view MCOs as expensive TPAs that add little value in terms of cost or care management. In many markets, reimbursement has leveled off and MCOs no longer enjoy a reimbursement advantage over other forms of health care.

If MCOs are to survive and prosper, they must return to their roots by developing care management strategies differentiating them from other healthcare models. Integrated data techniques offer the opportunity to

IN THIS ISSUE:

- 1 Profiting from Future Trends in Managed Care
- 2 Value and Impact of Repricing and Fee Negotiation Services
- 4 Upcoming Managed Care Meetings

Continues on page 4

Value and Impact of Repricing and Fee Negotiation Services

By Richard A. Orland, M.D.

A critical need for any health plan is the development and maintenance of its provider network to cover most of its members' needs. This network should include the necessary types of providers, as well as appropriate geographic coverage.



However, even plans with comprehensive networks will experience out-of-network and out-of-area claims. Repricing and fee negotiation services are valuable in these instances to reduce the expenses associated with such potentially costly exposure.

In this article, the term *repricing services* is used to refer to the services offered by a vendor that has contracts with providers, and where these contracts offer a discount on incurred billed charges to payors. Similarly, the term *fee negotiation services* is used to refer to the services offered by a vendor that will negotiate for payors, on a case-by-case basis, contractual arrangements resulting in a discount on incurred billed charges. If a vendor offers one of these services, chances are it offers the other service as well.

A word of caution: because out-of-network and out-of-area claims are by nature unpredictable, the world of repricing and fee negotiation services is a vendor-driven market, with a high degree of variability. The health plan or payor would be wise to learn and understand the finer points and differences about

repricing and fee negotiation services, which are summarized in this article.

Role of Repricing and Fee Negotiation Services

Repricing and fee negotiation services are a stopgap measure, used to help provide some discount when expenses have been incurred with an out-of-area and/or out-of-network provider.

Of course, it is almost always preferable for payors to have their own contracts for discounted services with a provider, rather than relying upon the services of a repricing and fee negotiation vendor. Why? First, having a direct contract with a provider allows greater control over contractual terms and conditions. Second, there is no access fee when charges are paid per a discounted arrangement that is predetermined directly between the payor and provider. Third, when a payor has a contract and an ongoing relationship with a provider, the payor is able to derive quality and outcomes data. For these reasons, payors are advised to attempt arranging their own contracts with providers, rather than relying on repricing and fee negotiation vendors.

Repricing Services

With repricing services, the vendor's contracts with providers are either a percent off billed charges or a per diem arrangement. Per diem arrangements may offer greater savings for inpatient charges; however, these are now infrequent.

A high degree of variability often exists in the vendor's contractual arrangements with providers. One vendor may have different contracts with different providers at the same institution. For instance, a vendor may offer a 15 percent discount on the billed charges for emergency room fees at one facility, yet may offer a 35 percent discount on the billed charges for outpatient radiology at the same facility.

Another point of variability is that the repricing vendor may offer different contracts at different facilities for the same service, even though those facilities charge the same amount for those services. For example, a vendor may offer attractive per diem rates for ICU charges at one facility, yet may only offer a 3 percent discount on the billed charges for ICU charges at another facility.

An additional inconsistency is that a vendor's contracts with a given provider may vary according to the service. That is, a vendor may offer a 30 percent discount on billed charges for ICU charges at one facility, yet only offer a 5 percent discount on billed charges for general medical/surgical charges at the same facility.

There also are local, regional and national geographic overlaps and gaps between vendors. In some parts of the country, there may be no vendor that offers repricing services. Not every vendor has contracts covering the desired geographical areas.

Fee Negotiation Services

With fee negotiation services, the vendor negotiates in an attempt to obtain a discounted payment on behalf of a payor for certain specific incurred charges. Such charges may include inpatient stays, emergency

room services, outpatient radiation therapy and other services.

These negotiations are performed on a case-by-case basis and may be performed retrospectively, concurrently or prospectively. Of course, performing such a negotiation prospectively offers the greatest chance for discounted charges.

Significant variation is common. The discounts, whether a percent off billed charges or a per diem, will vary according to the facility or provider, the type of service rendered, the total charges and other, sometimes unpredictable, factors.

Because these negotiations are usually performed on a case-by-case, one-time only basis, the skill and experience of the fee negotiation service is critical.

Advantages and Costs of Repricing and Fee Negotiation Services

The most prominent benefit of these services to the payor is financial savings, and these can indeed be significant. (See sidebar.) A health plan that is able to benefit from these services may see profit margin improvements, loss ratio reductions and possibly even avoidance of reinsurance claims.

The direct cost of using repricing and fee negotiation services is usually a percentage of the savings. The vendor usually takes this before the savings are sent to the payor. If no savings are realized, no charges should be incurred.

An indirect cost of using repricing and fee negotiation services is the turnaround time involved in contacting the vendor, accessing the service, waiting to see if repricing or a fee negotiation can be realized and then paying the provider according to the repriced or negotiated fee. If the turnaround time is long, the payor's cash-flow accounting is thrown off and the provider is kept waiting for payment.

When Not to Use These Services

As discussed above, it is always

preferable for a payor to have its own contracts with providers rather than to rely on repricing and fee negotiation vendors. Therefore, when a payor does have its own contract with a given facility or provider, it should not, and most likely cannot, use the services of a repricing and fee negotiation vendor — it must use its own contract.

Here's an example of how the use of repricing and fee negotiation services can yield significant savings. In 1997, one managed care reinsurance client consistently experienced out-of-network claims. The client was able to access repricing and fee negotiation services at a low threshold of billed charges and realized more than \$200,000 of net savings for that contract year. This amount was almost *half* of the total reinsurance premium that the client paid during that contract year!

Additionally, repricing and fee negotiation services may only be used *before* a bill is paid; very little can be done after a payor has already reimbursed a facility or provider for a service. So, if a discount is to be used via a repricing and fee negotiation vendor, this process must be completed before any payment is made by the payor to the provider.

Some procedures, such as organ transplantation, are highly specialized, complex, long in total duration and expensive. For these procedures, repricing and fee negotiations vendors may only be able to offer a percentage off billed charges, whereas a direct contract between the payor and the facility may allow for a base payment rate with outlier per diems and other favorable contractual terms. Therefore, for such highly specialized, complex and costly procedures, payors are

encouraged to either contract directly with the facility performing such procedures or to use a network specific to that procedure and specialty.

Most repricing and fee negotiation vendors will only offer services for claims above a certain dollar amount; this amount is variable from vendor to vendor. Therefore, for claims below this threshold, the use of repricing and fee negotiation services is not an option.

Other Problems

Occasionally, the contracts that a repricing service has with its providers may change without notice to user plans and payors. On-line accessibility to these contracts can help to reduce this problem.

Balance-billing of the patient by the provider is rare, yet does occur. When this happens, the repricing or fee negotiation service should be promptly informed and should take quick action to rectify such an error.

Occasionally, the provider will not honor a predetermined discount arranged by either the repricing or fee negotiation service. If so, there should be no cost to the plan, as there are no savings. The repricing or fee negotiation service may be reluctant to work with that provider thereafter.

ReliaStar's Resources

Used wisely and well, repricing and fee negotiation services can be of significant value to a health plan and to payors. As part of the value-added resources of the ROSE program, ReliaStar offers repricing and fee negotiation services for its clients' use. During 1999, ReliaStar's clients saved \$934,486 through the use of these services.

For further information about these services and how they may be accessed, contact your ReliaStar Health Service Consultant.

Richard A. Orland, M.D. is board-certified in internal medicine and is a consultant in life and health insurance and in occupational medicine. He can be reached via e-mail at RichardOrland-MD@worldnet.att.net, or at 615-297-6289.

PROFITING FROM FUTURE TRENDS

(Continued from page 1)

identify chronic disease states; health risk appraisals can identify high-risk cases; and much can be done to improve provider practice patterns with profiling and education. If you can prove to your clients that you add value to, your organization is likely to thrive in any business climate.

Reinvent the Organization

The organization you will have in the future depends largely on the programs and products you will offer in order to be differentiated from the competition. As part of the reinvention process, assess your organization's core competencies. If a department is underperforming, decide what makes better sense: revamping the department or outsourcing. Departments with significant strengths should be considered new business opportunities. Opportunities abound if you see your organization as a series of assets, rather than the sum of functions necessary to deliver your products and services.

For example, you may have a strong information management services department. You could sell these services to other non-competing businesses. Or, you may have a strong marketing department with representatives calling on brokers, consultants and prospects in your area. Life and disability insurance companies are staffing marketing departments for the same area, often calling on the same people. Consider contracting for your marketing department to represent non-competing carriers in your market service area.

Develop Strategic Partnerships

Henry Kissinger once said, "Countries do not have allies, they have interests." The same is true of companies, which need to identify organizations with compatible interests. Businesses often fail to capitalize on existing relationships, thus missing opportunities to leverage broader expertise, resources and clients.

For example, pharmacy vendors can use their clinical resources and systems to identify opportunities to manage disease states and costs. The only cost to you may be an agreement to continue listing their drugs on your formulary. In addition, major purchaser clients often have a wealth of managed care experience. Typically, they are happy to assist in designing programs, evaluating costs and providing free advice on initiatives they see as being successful with their other plans. If you adopt some of their recommendations, they may send you more members for free. Also, stop loss carriers are constantly looking for ways to improve loss ratios and rates. By partnering with your stop loss carrier, you may be able to leverage their expertise to improve your own loss record.

Summary

Although it may not look the same, or represent the same products, managed care will continue to exist. But the need to control rising health care costs and promote good health is a never-ending battle. The winners will be those organizations that accept the challenge to adapt, reinvent and grow. The others will be lunch for the bear!

Laurence M. Gelman is a principal with NuMarket Resources, L.L.C., a managed health care consulting firm headquartered in Walled Lake, Mich. Gelman's experience includes five years as senior partner at Coopers & Lybrand, L.L.P. and four years as principal and Detroit Office Health Care Practice Leader for William M. Mercer, Inc. Prior to entering the consulting business, Gelman spent eleven years in a variety of regional management roles for John Hancock's group health division. He is a member of the Healthcare Roundtable; has written many articles on managed care issues and has been a speaker at the national ASHRA convention. His education includes an MBA from St. John's University and a bachelor's degree in law from Long Island University.

UPCOMING MANAGED CARE MEETINGS

Following is a partial list of industry meetings dealing with a variety of managed care topics. If you know of any other managed care conferences that could be added to the list, please let us know.

CFO Exchange (HFMA)

Las Vegas, NV March 4-6

13th Annual National Managed Health Care Congress (NMHCC)

Atlanta, GA March 19-21

The IPA Association of America Annual Conference

Washington, DC March 29-31

2001 AAHP Managed Care Institute & Display Forum

Los Angeles, CA June 10-13

Annual Employee Benefits Symposium (ISCEBS)

Boston, MA September 19-21

Medicare & Medicaid Conferences

Washington, DC October 14-17

MANAGED CARE FORUM

Managed Care Forum is published by ING Re and ReliaStar Managing Underwriters, Inc. This publication's mission is to provide news and information to managed care professionals and thereby advance the knowledge regarding managed care insurance. The information contained in the articles repre-

sents the opinion of the author(s) and does not necessarily imply or represent the position of the editors or ING Re. Articles are not intended to provide legal, consulting or any other form of advice. Any legal or other questions you have regarding your business should be referred to your attorney or other appropriate advisor.

©2000, ReliaStar Life Insurance Company. No portion of this publication may be reproduced without permission from the publisher.

For more information about articles, contact Ray Ayotte, Newsletter Editor, ING Re, P.O. Box 20, Minneapolis, MN 55440-0020; telephone 1-800-378-6965, or via e-mail at ray.ayotte@ingre.com.