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TPA Administration of Out-of-Network Claims Should Alarm Self-Funded Employers

Knoxville, Tenn. (September 12, 2019) – Understanding and navigating today's healthcare cost maze can be challenging for professionals and nearly impossible for employers and employees. A recent *BenefitsPro* article noted the "surprisingly big effect" of out-of-network charges on the high cost of healthcare in the U.S.

Charges for out-of-network care are a problem for all employers, but they are particularly challenging for large, multi-state employers. Often, the carrier (payer) does little to challenge the claims – even the most unreasonable ones – and some providers even design their contracting tactics to create out-of-network claims opportunities in order to capture greater revenues.

Absent regulations designed to prohibit such billing, the financial rewards to providers are so significant that the issue will continue to grow unabated. When a provider can realize a payment that may be 10, or even 50 or more, times greater than the provider's usual fee for such a service, the financial gain can be too tempting to ignore.

Providers know that any portion of the claims not paid by a third-party payer can be billed to the patients, a practice known as "balance billing." Additionally, providers recognize that many large self-insured employers will pay the balance to protect their employees from potentially devastating financial consequences.

Health insurance companies have little motivation to help resolve this issue either. For their fully insured customer, they just limit their payments to those defined under plan coverage. Claim amounts above covered charges are the patient's responsibility – no harm, no foul to the insurance company. However, if the patient is covered by the employer's self-insured plan, adverse incentives arise that benefit the insurance company serving as the

third-party administrator (TPA) for the employer that make it a "no lose" situation. The TPA can pay the entire out-of-network claim and may actually realize a higher administration fee, but, at a minimum, incurs no additional cost. That provider is also less likely to drop out of the carrier's at-risk insured product networks. In addition, if the TPA negotiates the out-of-network charge to a reduced amount, the TPA will most likely charge the employer a "success" fee as a percentage of the negotiated "savings," again charging the employer on claims they were contracted to pay correctly in the first place.

> "We routinely find such 'success' fees to be in excess of 30 percent of the so-called savings. In reality, it's not a savings at all but an unnecessary cost."

Large employers struggle to solve this problem because their primary opportunity to address it comes *after* care has been provided. Refusing to pay the claim exposes the employee to large financial claims and, possibly, legal action to collect the claimed amount. In today's economy with its record low unemployment, employers loathe to take actions that could disgruntle their employees. And so, the issue continues and grows more widespread.

Case Study

Healthcare Horizons frequently encounters the following example of out-of-network billing practice. A patient undergoes a routine surgical procedure. The primary surgeon utilizes a second surgeon – not selected by the patient – to assist in the operating room. The assistant surgeon is not "in network" under the patient's insurance plan coverage. The primary surgeon is paid the appropriate professional fee, as defined by the plan agreement. So far, so good. However, the assistant surgeon may file a professional fee claim that is 20 or more times higher than the primary surgeon's fees. For example, Healthcare Horizons identified a claim in which the primary surgeon was paid $600, and the assistant surgeon was paid $22,000 for an appendectomy with no complications that was not surgically difficult. Another example involved an "in network" surgeon performing surgery at an out-of-network ambulatory surgery center (ASC). The surgeon was paid a professional fee of $350, based on the in-network fee schedule, but the ASC was paid $254,000, as it was out of network. Had the ASC been in network, it would have been paid approximately $10,000. The payer was adamant that the claims were paid correctly.

Employers must recognize the implications of this growing issue, and the impact it has in driving healthcare costs ever upward. Human resources professionals, whose roles are to manage employee benefits, typically resist efforts to challenge such claims for fear of adverse impact on the employee involved. They usually fail to consider the macro impact on all employees,

contributing to declining benefits for all employees due to unsustainable increases in health insurance costs.

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About Healthcare Horizons

Ed Pershing is the founder and principal owner of Healthcare Horizons Consulting Group, Inc. Healthcare Horizons is a leading expert in providing advanced healthcare claims audits for self-insured employers. Since 1999 our audits have been protecting the financial interest of some of the world's largest self-insured employers. For more information, visit www.healthcarehorizons.com or follow us on https://twitter.com/HealthcareHoriz and https://www.facebook.com/HealthcareHorizons/.