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When Hospitals and Provider Groups Break Fee Agreements, Consumers Pay the Price by Fred C. Garfield, CFP, ChFC, CLU

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Some 20 years ago when I started in the business of providing health insurance and employee benefits, all that was offered were straight indemnity plans with an annual deductible and 80% co-insurance. Providers accepted the offered amounts, the patients paid the difference, and everyone seemed happy with the system.

But as medical costs began to rise as fast as inflation through the 80's, at rates of 12-15% per year, health insurance companies developed preferred-provider networks. These allow providers, for discounted fees, to become "recommended" by the insurer; their benefits are paid at a higher rate than those paid to non-preferred providers. In the late '80s, managed care programs such as HMOs and point-of-service plans appeared. These require the use of a primary care physician (coach) who should make sure the patient efficiently receives the care needed. They provide more comprehensive benefits than indemnity or PPO plans, and are intended to get people healthy while controlling unnecessary use and costs. Yet our medical costs, and health insurance premiums as a result, have continued to significantly rise. This inflationary trend is a product of many things: longevity, medical technology, advances in care for many chronic and life-threatening diseases, and new, more costly prescription drugs. In the next few years it is predicted we will see advances in care including cameras you can swallow, permanent artificial hearts and a wide range of genetically engineered medications. Industry studies show that prescription drugs were alone responsible for more than 25% of all insured costs last year, a result of higher utilization and more expensive medications. It's no wonder that drugs are now directly advertised to U.S. consumers for the express purpose of telling their physicians what new, and usually expensive, drug they think they should be taking. Employers and insurance companies are being forced to ask employees to make cost and expense choices among generic, preferred and non-preferred brand. Where does society stand when these marketing efforts dramatically increase our ultimate costs?

However, we now have a serious new threat to our system, one that may increase costs far faster than anything else: hospitals and physician provider groups breaking discounted fee agreements and demanding significantly more money from insurance companies and provider networks. If these higher fees are not received, they are dropping their members' access to these facilities. Independent physicians are also participants through their efforts to break the capitation system established by HMOs to manage these cost increases. This is a national problem, but one with immediate local impact.

The November 27, 2000, issue of Crain's Chicago Business featured an article on how one Chicagoland hospital group, ENH (made up of Evanston, Glenbrook and Highland Park), as well as some affiliated provider groups, approached health insurance companies last year and demanded increases in their fees by 60-100%. Much of these increases were to come from ending "per-diem" reimbursements, or level average daily use costs, and return to billing unbundled individual service fees. I can only assume that ENH figured that the pressure created by this action would force the networks and insurance companies to capitulate. In fact, many employees and employers I represent have blamed the insurance companies for the loss of ENH, assuming they were somehow at fault. Some employers approached us to move their insurance coverage because of the loss of specific physicians or the access to an ENH hospital. Some reasonable increase in fees is justified. The private insurance payment system must not only cover its own costs, but also shortfalls in Medicare and Medicaid prospective reimbursements and the cost of care of the indigent and uninsured. Unfortunately, the high standard of care in this country is mostly based on our ability to pay for, and thereby afford to insure, our growing health care needs. What consumers of health care don't realize is that these same insurance companies, through their network contracts, may be the last line of protection from being overcharged for hospital services. Physicians alone cannot provide the necessary level of patient care without gaining access to these facilities. It would be like going to a mechanic without availability of a garage and tools.

However, every insurance company representative I spoke with about these contracting problems stated they had offered reasonable increases in reimbursement levels (especially after studying closely whether their contracts were profitable to the hospitals), but that they did not want to lose all control of fee and expense management. They know they are caught in a squeeze and cannot afford to lose geographic access to care -- one of the key issues employers evaluate when deciding to renew or change health care plans. To add more pressure, should one hospital or chain of hospitals gain an advantage through this effort, others will follow and our system of health care will suffer as a result.

Since then, United HealthCare has announced their separation from the Chicagoland Rush network of hospitals, and a number of their affiliated physicians, over similar fee renegotiation. Problems have also been rumored between insurers and a number of other Chicagoland hospital and provider groups. This comes at a time that many of these hospitals and physician provider groups are spending significant money to build new surgical specialty centers or health clubs as revenue sources. In Illinois, a State Review Board must approve any hospital additions or physician-built facilities such as these specialized treatment, surgical or health club facilities. Approval of some of these building projects has been denied or delayed (such as one suburban physician-sponsored cardiac surgical center) because there was either an overlap of services (as alleged by other neighboring hospitals in this case) or insufficient proof that the need for these services existed. This review process may come from watching what happened in Massachusetts and New York, which both now assess large surcharges on in-state hospital care, largely because of their risk of default on government bonds used to build underutilized facilities in the 70s and 80s.

I would suggest that the same State Review Board that reviews and approves expansion plans should consider getting directly involved in reviewing these demands for such sizable increases in fees. This situation raises concerns of cost-fixing and antitrust issues. In an age when we are

considering nationalized health care and community-rating schemes, why not use the same regulatory review to considering demands for increasing hospital and provider fees? This situation also comes at a time when many employers and employees are having great difficulty managing the costs of health insurance as it is. Any attempt to hold access to care hostage for money is a crime against those who need medical care the most, regardless of our ability to pay for or obtain insurance coverage. This plays on the fear of the consumers who (when it comes to health care) wants what they need, when they need it, regardless of the cost. And, unfortunately, patients don't shop for value and purchase care the same way they buy commodities or appliances. Some employees see group insurance plans as an entitlement and additional compensation to be used now or otherwise lost forever. It is very difficult to present a loss of access to certain providers, or reductions in benefits, as methods to control insurance costs when an employer is competing for staff in a competitive high-employment economy.

Hospitals and physician provider groups have created monopolies in their regions, and some are behaving like they are untouchable in their negotiations with insurance carriers. Most people want to go where they perceive the best care exists, regardless of whether other hospitals or providers might be more convenient, better priced or available in their carrier's network. This threat of limiting access to care over negotiated discounts on fees is both socially and economically irresponsible. Hospitals and provider groups need to understand that the increased fees they want can only be passed ultimately to the employer and employee through higher insurance rates. As a result, more employees may end up with sharply reduced benefits or no coverage at all. By the way, what ever happened to the competitive marketplace for small-group health care? First, the numerous mergers, acquisitions and elimination of many alternative markets have adversely affected us all. In addition, HIPAA, all of the state small-group mandates, guaranteed-issue legislation, renewal rate caps and other risk-pooling rules have driven a number of companies out of group health altogether. Some are instead continuing to only offer individual coverage, where they can still underwrite, rider or decline applicants.

As a result, today we have less than half the number of insurance companies and HMOs in the fully insured group-health business we had only five years ago. Even as many of our clients have considered and moved toward various levels of self-funding, we are seeing a shakeout of available reinsurance carriers, and with it a corresponding jump in renewal premiums, accompanied by higher aggregate claim cost limits. This situation is quickly becoming a vicious cycle that could potentially wreck our system of health care. I would ask that hospitals and physician provider groups reconsider their tactics in contracting with insurance companies, and instead find ways to work together and show more concern about the public's access to care and the quality of its delivery. The alternatives (including governmental intervention) will be nothing that the providers, the insurance companies or the public want. Pull quotes: Crain's Chicago Business featured an article on how one Chicago hospital group approached health insurance companies last year and demanded increases in their fees by 60-100%.

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