Health Care Strategies for Texas Political Subdivisions

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Introduction

The cost of providing health care benefits to employees for 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. With the current atmosphere of uncertainty of proposed federal legislation to expand health care to the nation’s uninsured, many political subdivisions are seeking and preparing for alternatives. With unprecedented budgetary constraints, and a restive electorate, political subdivisions within the state are peeling back the onion of health care cost drivers, and seeking common sense remedies. This current environment has intensified the scrutiny of purported managed care savings impact on health care in general as well as the role of health care intermediaries.

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 that have been implemented with success by certain political subdivisions within Texas. These common sense solutions have reduced health care costs 40% or more without reducing benefits or access to care.

Preferred Provider Organizations (PPO) – Cost Savers or Cost Drivers?

Since the early 1980’s, the health care delivery system has been driven by the concept of managed care. Preferred Provider Organizations (PPO) were launched by third party payers and enterprising entrepreneurs to provide lower cost through a select grouping of health care providers. The premise was valid – in return for increased patient load, participating providers agreed to lower their fees.

To provide steerage to these lower cost providers, health care plans began offering a two tier benefit program. Accessing a preferred provider would reward the patient with a lower out-of-pocket expense while accessing a non-network provider would “punish” the insured with a higher out-of-pocket obligation. Managed care ushered in an era of low co-pays, first dollar coverage and low out-of-pocket exposure. Little effort was expended in maximizing medical care outcomes. Economies of scale became the accepted underlying scheme.

Initially, the PPO concept worked efficiently to the benefit of the parties involved. Employees were content and supportive since their out-of-pocket expenses were limited to small co-pays, such as $15 for a physician office visit. Plan sponsors were supportive since empirical data appeared to show real savings. PPO contracts proved to be “cost savers” in the eyes of many. However, the opposite would become clear as PPO’s morphed through the late 1980’s and into the 1990’s. “Managed Care” became synonymous with “Managed Money.”

PPO’s eventually transformed from “cost savers” to “cost drivers.” Managed care began to have a pernicious influence based on synthetic reasoning.

With consumer demand to expand their networks, PPO’s began contracting with every willing provider in every geographic area. As a result, providers became less inclined to significantly discount their fees for service. Why should they, since almost all providers were joining PPO networks, and steerage became problematic and illusory.
Proprietary PPO networks owned and operated by several major health insurers, not only contracted with willing providers, they also contracted with non-willing ones. Those who agreed to “play ball” and discount their fees for service, were designated “Participating Providers”, or “Par” providers. Those who were not willing to discount their fees for service (mostly rural practitioners) but willing to accept assignment of claims only, were labeled “Non-participating Providers”, or “Non-Par” Providers. This strategy gave the carrier’s a distinct marketing advantage without giving their clients a financial advantage. With the advent of these APO’s (All Provider Organization) costs increased despite touted PPO discounts.

Consumers became immune and isolated to the costs associated with receiving health care. Enhanced PPO benefits incorporated a co-pay system wherein the consumer was obligated to pay only a small fee for services. (For example, physician office visits access for $15). The consumer was thus shielded from knowing the true cost of care and had little incentive to question costs and shop for services. We have documented average charges per encounter exceeding $750 (per visit) or more with health care plans sponsored by political subdivisions within the state. This is not uncommon.

Unfortunately, as third party beneficiaries of PPO contracts, consumers were precluded from knowing the cost basis for their health care negotiated upon their behalf by health care intermediaries. Contract negotiations between providers and PPO networks took place behind the curtain and were deemed confidential by the parties involved. As a result, Texas political subdivisions relied on the representations of health care intermediaries, accessing PPO contracts without knowledge or understanding of the true cost basis for claims to be paid. Prevented from reviewing specific PPO contracts, these plan sponsors in effect were “gifting” public funds through confidential contracts to which they were not a party.

Since PPO contracts are proprietary and confidential, beneficiaries, such as political subdivisions within the State of Texas, may be surprised at some of the common elements within these contracts. These serve to drive costs up, year after year, guaranteed. Parties to the contract benefit primarily, with secondary regard to the financial well being of potential third party beneficiaries i.e., a county government which provides a health care benefit plan to their employees. PPO’s do not want the public to know what is in their contracts and guard these secrets aggressively. They have a vested and financial interest in continued secrecy.

For example, every PPO contract we have reviewed has an annual escalator clause averaging 8-12%, although we have seen several at 4-6%. Through an Evergreen clause, on each contract anniversary the provider is assured of increased revenue for each fee for service. Since medical trend has averaged 10-12% consistently, common sense would dictate that PPO contracts are a significant contributing factor. Over a five year span, the compounding effect of medical care costs can increase as much as 75%.

Other cost drivers within some PPO contracts include provider re-pricing fees. These fees are as high as 4%. PPO’s track claim utilization by provider and an accounting is performed periodically. For example, PPO “A” tracks re-priced claims for their members at Healthy Clinic Incorporated. In the month of September the PPO books $10,000,000 in gross claims at this clinic, re-priced down to $5,000,000 as per the PPO contract with the clinic. An invoice is then generated for 4% of the re-priced amount. The clinic
kicks back to the PPO $200,000 for the month of September. Of course, the unsuspecting consumer has no idea of this expense since it is buried in the claim side of the ledger.

Outlier provisions within hospital contracts provide increased reimbursement once a hospital claim reaches a certain level of “billed charges.” We have seen outliers as low as $50,000. What this means is that once billed charges hit the outlier, in this case $50,000, the contract reimbursement reverts to a simple percentage off billed charges, back to the first dollar. Billed charges have no correlation to cost, and may differ from payer to payer, although hospitals will dispute this.

Many marketers fail to mention the outlier provision in their PPO contracts, and instead represent that their contracts are superior to others since they include low per-diem reimbursements, are DRG based or include low case rates, or a combination of all three reimbursement methodologies. But, with an outlier provision, all of these attractive reimbursement methods are null and void and the entire claim is simply discounted off an inflated number that has no correlation to costs.

Other hidden expenses within these contracts are numerous. Some carriers who have proprietary networks charge their access fee as a claim charge rather than identifying a fixed per employee monthly fee. Their charge for accessing the PPO can amount to as high as 28% of projected net paid claims (including non-PPO claims). In one case reviewed, the charge amounted to $28.43 per employee per month. In comparison, most rental networks charge $3-$6 per employee per month. So in effect, these carriers are taking a portion of the “discount” to pay for their fixed costs of providing insurance and increase their retention.

Other PPO networks sell access by charging a percentage of PPO savings, averaging 30%.

Ultimately, the question that should be asked by political subdivisions should be “Will we ever actually receive the full value of purported hospital contracts or physician discounts?” Many have found that the answer is probably no.

Primary Care: On-Site Medical Clinics

With primary medical care increasing at the rate of 10-12% per annum, the compounding effect has had a significant impact on costs. With the advent of low co-pays, utilization and costs have increased dramatically. While higher utilization can be construed as a good development, i.e., identifying and treating conditions before they become major, preventative care, etc., the cost factor involved has caught the attention of underwriters and plan sponsors alike. The belief that primary care physicians have been given a blank check through lucrative and secretive PPO contracts is a real perception among many plan sponsors. We have interviewed physicians who admit they join and agree to most PPO contracts knowing that they can run as many tests and procedures as they like to make up for loss of income through discounted fees.

Aggressive risk management adopted by some Texas municipalities has successfully addressed these runaway costs. The emphasis became one of control. If primary care services could be provided in-
house, with referrals carefully monitored in partnership with selected specialists within the community, control could be obtained and cost contained within budgetary constraints.

Pioneering cities like Amarillo, Odessa, and San Angelo among others, with strong political backbones, took the on-site clinic theory to practical use. Success was immediate and impressive. As a result, on-site medical clinics have become a viable and politically acceptable alternative for a growing number of Texas cities, counties and school districts.

The City of San Angelo was one of the first Texas municipalities to implement one. Mark Barta, a former hospital administrator and now independent consultant, set up an in-house clinic for the City of San Angelo in 2004. In the first year of operation, the clinic reduced the city’s employee health plan costs by +$1,000,000 and saved the city’s Workers Compensation Program over $575,000. This had an immediate and positive impact on the city’s tax rate.

Brian Kersh, a Dallas based consultant has experienced similar success in working with political subdivisions around the state and the country. His documented success in controlling and reducing rising healthcare costs for his clients is compelling. He states “under our model, your in-house doctor becomes your gatekeeper for referrals to specialists. The ability to both manage and measure these referrals allows our clients to perform direct contracting for some services that are 50-60% lower than your plan can obtain through preferred provider contracts. Such services include radiology, CT Scans, MRI, etc. “

Some Texas municipalities have implemented in-house clinics to include in-house management in lieu of utilizing an outsourced independent consultant, and have enjoyed similar successes. In every instance, taking control of primary care through in-house clinics or outsourced clinics through capitation agreements have had an immediate and dramatic impact on claim costs. Our studies show that on-site clinics can deliver primary care costs that are between 30-40% less than identical services delivered through existing PPO networks.

As a rule of thumb, all inclusive costs associated with an on-site clinic range from a low of approximately $18 per employee per month to a high of $42 per employee per month. The cost differential is impacted by various factors such as size of the employer group, steerage, demographics and cost of management. Salaries and wages make up to 90% of the costs.

Based on empirical data obtained from various entities who have either set up their own in-house clinics or professional outsourced clinic management firms, to sustain a 40 hour a week clinic and receive a satisfactory return on investment requires a population base of 1,000 to 1,500. Hard dollar savings are realized on reduced costs for primary care visits, reductions in emergency room visits, specialist referrals along with pass-through costs associated with pharmacy and other services and supplies rendered. Soft dollar costs include increased productivity due to on-site access, reduced absenteeism, and early intervention through on-site disease management and coaching.
Common Sense Solutions

It is our opinion that PPO provider pricing based on contracts that are proprietary, inflate medical care costs to the detriment of the consumer. Despite representations related to “aggressive” PPO discounts made by insurance company salesman, brokers, and “expert” health care management consultants, medical costs continue to rise at double digits year after year. Are there common sense alternatives?

Tyler Independent School District discontinued their PPO program and hired a former hospital administrator to negotiate directly with medical providers on behalf of the district. Providers were encouraged to compete for the business through a Request for Proposal process. The end result provided the Tyler Independent School District direct contractual access to a local hospital which agreed to charge the district health plan less than Medicare, with local physicians signing up at fee levels below what the prior PPO network had negotiated. In the first year, Tyler Independent School District achieved savings of over 40%. In the past three years the district has been able to maintain current benefits without increasing contributions to the plan.

Steve Kelly, President of ELAP Inc., a health care consulting and auditing firm, has been assisting employers like Tyler Independent School District in negotiating direct contracts between employer groups and the medical community. He writes “In one case we took a school district on as a client about a year ago. After some fighting over reimbursement with a local provider system, we arranged a meeting between the school district and the health system. Within a few minutes, it became obvious that the school district and the health system had never had a direct conversation. Same community, same churches, temples, Little Leagues, etc. In the years and years of treating patients from the district, there had always been a wall of intermediaries between the parties.”

Political subdivisions in Texas are beginning to understand that there are alternatives to accessing cost effective medical care other than through PPO networks as well as the value proposition of on-site medical clinics. San Patricio County, located near Corpus Christi, Texas, is a perfect example of what can be done to keep medical care costs down on employee health insurance, workers compensation and indigent care for county residents.

San Patricio County made the decision last year to discontinue their PPO plan and instead adjudicate claims using 2008 RBRVS (Medicare fee schedule) as a benchmark, other than facility claims. Using a direct approach with area physicians, San Patricio County reimburses primary care physicians based on 115% of RBRVS and specialists are reimbursed 125% RBRVS. Many area physicians supported this initiative and have signed a Letter of Agreement with the county to accept this reimbursement level as payment in full without recourse to patients. We have arranged similar relationships between providers and payers in other parts of Texas, with some regions accepting Medicaid rates in return for steerage.

San Patricio County reimburses facility claims on a cost-plus basis. Unknown too many, hospitals are required to file a report annually with Centers for Medicare & Medicaid Services (CMS) attesting to their costs. Using this documented and public data, San Patricio County reimburses facility charges cost-plus 12%. Fiduciary responsibility is shared on an outsourced basis with the co-fiduciary duty to provide and
defend both on the appeal level as well as responsibility for legal defense of Plan and participant, contested claims.

In comparing claim costs, it has been determined that historically San Patricio County has been paying significantly more on facility claims than they are now paying on a cost plus approach. On the physician side, their costs have reduced on average 20%.

In the first six months San Patricio has reduced their employee health care costs overall by +40%. After one year, they improved their benefits to take advantage of the savings realized and maintained current funding for another Plan Year.

Since San Patricio County is too small to support an in-house clinic with a satisfactory return on investment, the county contracted with a Corpus Christi clinic to provide primary care on a cost basis below Medicare reimbursement rates. Steerage is provided by way of waiving all co-pays and deductible requirements for employees and their dependents who seek care there. This has had a positive impact on claims in and of itself. However, additional and significant overall savings have been realized through specialist referrals who have agreed to cap their fees at 125% of RBRVS.

The county has aggressively taken control of their indigent care program as well, with stiff internal checks and balances in place. Direct contracting with area providers, at rates well below the commercial market, has allowed the county to extend benefits on average longer than most Texas county governments.

The San Patricio County success in reigning in health care costs has received state-wide attention. County Judge Terry Simpson has taken numerous calls seeking more information on their program.

There is strong and growing interest among some political subdivisions in Texas to initiate a hub and spoke approach to health care, utilizing strategically placed clinics. The concept is to provide a string of co-op clinics allowing access only to employees and their families of participating political subdivisions. These subdivisions would include cities, counties, public school districts, housing authorities and other entities. However the main road block is having the clinics built and in locales that match the demographics of potential participants. Instead, efforts are underway by one large national third party administrator to contract with existing primary care clinics on a capitated basis for the benefit of designated political subdivisions by way of an inter-local agreement structured through a cooperative.

**Summary**

Moving away from PPO networks and directly partnering with the medical community is catching on in Texas. Cost plus reimbursement on facility charges is proving to be a cost effective, fair and equitable method to pay providers. We have found that the medical community will compete for business and generally applaud the concept of dealing direct with an employer instead of through intermediaries.

On-site clinics have proven a cost effective means to keep health care costs down on both group medical programs as well as workers compensation claims. With a combination of direct contracting with area
providers, cost-plus facility reimbursement, and on-site medical clinic, health care costs have been reduced on average 50-60%.

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.