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Out-Of-Network Claims Could Put Squeeze On Your Healthcare Costs

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In today's economic environment, most companies are being forced to look for creative ways to reduce medical costs and increase margins. Over the past decade, PPOs and HMOs have successfully ratcheted down provider fees and squeezed savings.

Likewise, utilization review and case management companies have eliminated most, if not all, unnecessary services, and have effectively directed patients to less expensive and less invasive modes of care.

Luckily, there are still a few relatively new frontiers of cost-containment that can generate significant savings for the employer or insurer while also saving money for the patient. One of these focuses on the ability to generate savings on medical bills from providers not participating with the PPO or HMO networks utilized by the employer or insurer. These out-of-area/out-of-network claims can be a significant source of cost for a plan, but alternatively an opportunity for savings.

No matter how effective your analysis and selection of PPOs or HMOs for your covered employees or insureds, there will be out-of-network claims. Even the best PPO configuration can leave 10 percent to 30 percent of claims out of network.

The result is that dollars are left undiscounted on medical claims and must be paid at retail or the usual and customary rate (UCR) is applied resulting in the patient being responsible for the balance.

What to do

First, check with your third party administrator, insurer or HMO to see if they offer out-of-network claim repricing solutions. If so, find out what percentage of your out-of-network claims are being discounted and at what average savings.

What to look for

1. Companies with several avenues for gaining discounts including wrap PPOs, supplemental PPOs, negotiations and bill audit/recovery

- Do they offer access to multiple supplemental PPOs for repricing?
- Do they rank their PPOs in each state by historical savings?
- Do they handle all service issues related to the discounted claim?
- Does the vendor have direct contracts with all the PPOs they are accessing, or are they using discounts through another source?
- Can the vendor confirm that their contract with the PPOs allows for supplemental discounts?
- Can they provide a detailed analysis of projected savings based on historical results?

2. Look at the percentage of out-of-network claims they are able to discount as well as average discount per claim

- Are they successful in generating discounts where your employees seek care?
- Do they negotiate on all size claims, or do they limit your savings?
- Do they have HIPAA-compliant electronic solutions or real-time Internet access?
- Can they deliver average savings per discounted claim of 20 percent or higher?
- Is their average success for discounting claims 50 percent or higher?
- Do they price on percentage of savings basis (no savings, no cost)?

One of the best mechanisms to determine if the vendor can truly provide value and increased savings is through a detailed savings analysis. This allows the vendor to take actual claims from your organization and run an analysis against historical data to determine the estimated savings through their services. This is an "apples-to-apples" comparison that will tell you immediately if there are additional savings opportunities.

There are no magical solutions for managing health care costs. However, we do know that through a wide range of services, companies can yield significant savings and increase margins.

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