Cost Containment: Trends in "Reasonable and Customary" and "Non-Par" Claims

By Colin Plotkin, MD

In the U.S., healthcare providers are not governed by any Federal Law restricting what they can charge for a service. Certainly there are guidelines, but that is all they are intended to be, and they are not rigorously enforced. That is why we often see a wide variance of charges for the same procedure from facility to facility, even in the same locale.

Reasonable and Customary Issues

Increasingly, insurers offering medical coverage are attempting to enforce the wordings *"reasonable and customary,"* which, for a long time, have been in their policy language relating to the rate of reimbursement for medical service. For some time, each insurer has created its own dictionary defining exactly what *"reasonable and customary"* means, and the definition can change depending on which side of the fence you are on, i.e. payer or provider.

At the one extreme, we have the Medicare reimbursable amount. This translates to the lowest rate of reimbursement that a provider will collect through the largest payer of insurance, namely the Government. It is well-known that hospitals in the vast majority of instances lose money when being reimbursed at the Medicare rate. It therefore becomes unreasonable for an insurer to expect the interpretation of *"reasonable and customary"* to translate to the Medicare reimbursable amount for a commercial insurer. The question that arises is, "What then can an insurer expect to pay for a service?"

Although they may be compelled in some instances, many medical providers have long since given up on the philanthropic component of their existence. While some claim *"Not for Profit"* status, every provider has to be financially viable in order to survive. Understandably, some are more concerned about profit then others.

The bulk of medical billing incurred by a commercial insurer will, in the majority of cases, have ties to a domestic preferred provider organization (PPO) – this is in its most sophisticated form. The alternative, reimbursement by an insurer, will occur through some form of volume based re-pricing provider. Due to pockets of greater utilization, none of these companies will have universal coverage from East to West, nor would they include every hospital throughout the United States.

COST CONTAINMENT

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More Non-Par Cases

The issue of "**Non-Par**" (the term used by these companies for a non participating medical provider) is becoming increasingly common. This in itself is due to a variety of reasons, one of which is greater travel by members of a particular insurance program. This may be in the form of work related travel, as well as holiday travel where an insured member gets ill. In many ways, this is almost analogous to an international traveler, say from Europe, traveling to the U.S., where bills submitted by a provider to an insurer appear high in the extreme. Often, the extent and magnitude of such bills are unparalleled by anything seen in the usual daily flow of bills to an insurer coupled with its local PPO arrangement.

How then does a local domestic insurer deal with these circumstances? Its local PPO provider may have no relationship with the actual facility, and may try to negotiate the bill directly with such a provider. Alternatively, the local PPO provider may attempt to sublease a secondary contract through an analogous organization in the area of occurrence that has a contract with that particular provider.

Either way, the results are never as good as one would hope. The base reason for this is that, to start with, these bills are of previously unseen proportions. A standard 10 or 15 percent discount does not translate to much on a bill of $500,000, that is invariably unaccounted for in an insurer's underwriting forecast. A not infrequent example would be that of an insured member pregnant with twins, traveling at 22 weeks pregnancy, and giving birth to preterm babies in a distant state. Premature birth ICU charges are the highest costs of any medical admission, and final charges can end up being millions of dollars.

What can an insurer do under these circumstances? The basis of any insurance is to *mitigate the loss*. Transferring the patient to a contracted facility in a long term hospitalization stay, is the obvious first step. Many insurers also choose to work with a company specializing in dealing with this type of catastrophic situation to mitigate the loss. The objective is for the hired company to settle a catastrophic situation at a level which an insurer can reasonably expect to pay for the service received, and at which a provider can reasonably expect to be reimbursed for the service provided. A multitude of factors come into play within this given framework of reasonableness. The age of the bill, the extent or size of the bill, the length of stay, the type of admission, the cost to charge ratio of the provider, and many other factors all come together to produce a reasonable settlement.

An insurer has to realize that in a "Non-Par" situation, leverage such as volume steerage of patients are not mitigating factors, and in most instances, neither can prompt pay be used as a negotiating tool. Bills of large proportions rarely fall into a prompt pay scenario.

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Badgering tactics, such as threats of non payment, delay of payment, calling for audits, reporting, and a host of other aggressive and questionable methods will work against a favorable outcome in the settlement of the claim. One also must factor in the distinct possibility that a specific insurer may well have another admission at the same facility in the future. The subleasing of remote second layer networks exposes an insurer to the specter of balance billing, based on a questionably and illegally sourced discount.

Choosing a partner to assist in claims settlement and resolution should be considered a very important decision by insurers. Working with an entity that can obtain secure, legitimate, reproducible, consistent, and favorable results without any disputes by the provider, is vital to managing and reducing an insurer's loss ratio. Once the decision has been made in the selection of a company to settle "Non-Par" bills, it is important to make sure that the chosen company is held accountable in their own name for all settlements and "discounts" obtained. Any disputes and balance billing should remain the responsibility of the company sourced for settlement of an insurer's bill. ■

Dr. Colin Plotkin *established Dr. Plotkin Consulting to provide insurers locally and abroad with expert knowledge and understanding of the medical provider market worldwide. Dr. Plotkin graduated with a MB.B.Ch degree from the world renowned University of the Witwatersrand Medical School, Johannesburg, South Africa and has a unique 17 year post secondary academic education in the Professions of Pharmacy, Dentistry, and Medicine.*