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The Dawn of Self-Insured Transparency:
Shining Light onto Fraud, Waste, Abuse, and Overpricing

Overview

Self-insured employers directly pay the claims for their employee's health care and have a responsibility to monitor the appropriate spending of plan assets, even when payments are administered by a third party.[1,2] Self-insured employers are therefore paying too much and not fulfilling their plan responsibilities if they are not watching for and addressing fraud, waste, and abuse, and overpricing – a task that recently became easier as a result of provisions of the Consolidated Appropriations Act (CAA) of 2021.

Prior to the CAA, very few employers had access to the claims data needed to identify fraud, waste, abuse, and overpricing – all of which involve overpayments to specific providers. Insurance carriers (supplying network access and administration) and stand-alone networks kept their provider reimbursement schedules secret and told employers "*You can have provider-identity or you can have claims pricing, but you cannot have both*."

Employers can now unambiguously have both. Per the "*Prohibition on Gag Clauses on Price and Quality Data*" section of CAA, effective December 27, 2020,[3] carriers, networks, and administrators must share comprehensive claims data, including both provider-identity and pricing, with self-insured employers.[4,5] The CAA makes it illegal to have a contract that restricts data sharing. This long-overdue legislation lets self-insured employers get the data that they need to monitor their health spending and to hold administrators and networks responsible for delivering financial value. While this is a momentous change, the reaction from the self-insurance oligopoly has been muted. Regardless of its initial welcome, the sun is up and ready to shine onto provider-identified claims data.

Sunshine is a big financial-win for employers, who can now obtain the data necessary to require that administrators reduce costly fraud, waste, and abuse and to hold network providers accountable for overpricing.

Fraud waste and abuse

Fraud, waste, and abuse (FWA) are overlapping concepts that describe healthcare spending for services that are misrepresented or don't benefit the insured. FWA hurts patients and self-insured employers. Furthermore, no one denies that healthcare FWA was substantial, perhaps 10% of total costs,[6] even before the Covid-19 pandemic created new FWA opportunities. For example, providers have been tacking bogus charges for physician consultations and other services onto Covid-19 testing.[7] It's well known, however, that administrators do too little to identify and combat FWA as doing so is disruptive to their provider network, has a potential to generate scandal and tarnish their image, adds to their administrative costs, and the end-savings accrues to the employer, not the administrator.[8] Administrators will more vigorously preempt and address FWA when self-insured employers start to independently identify potential FWA and demand action.

Overpricing

Overpricing occurs when the price (allowed amount) for a healthcare service exceeds what's paid to other providers and the price difference is not offset by enhanced quality. While no self-insured employer wants

to overpay, network providers are reluctant to address overpricing. Within the same network, prices sometimes vary several-fold from provider to provider, often with no relationship with quality.[9] While FWA is often perpetuated by marginal healthcare providers, overpricing is often seen from large and well-known providers, who are perceived by carriers and networks as essential partners – at any price. As long as a network can keep their secret prices and yet have employers pay the bills, the network doesn't gain by aggressively negotiating prices. Overpricing will be moderated only when self-insured employers examine prices and hold carriers and networks accountable for the unjustified prices they pay to specific providers.

Self-insured employers must lead

The burden is on self-insured employers to proactively demand the data available as a result of the "*Prohibition on Gag Clauses…*" section of CAA. Today's health insurance pricing system was built upon pricing secrecy and the assumption that the secrecy would continue. Carriers, networks, providers, and brokers are fearful of the potential negotiating havoc of price transparency and are not going to voluntarily yield their secrets. For example, a supermajority of hospitals have defied the hospital-pricing transparency requirement to post their prices on their websites and have chosen penalties over transparency.[10]

While obtaining comprehensive claims data is the necessary first-step toward employer empowerment, it's not the end-step. Expertise and work is required in order to identify FWA and overpricing within claims data. Most employers will need to partner with an analytics firm and the best firm is unlikely to be their big benefit consultant or data warehouse vendor. The big benefit consultants and data warehouse vendors have invested billions in systems and relationships based on the old constraints. Most don't have the expertise, tools, and willingness to deal with the disruptive new-world of transparency. If they had something to sell, they would be aggressively selling it – and they aren't.

Until the big benefit consultants and data warehouse vendors catch-up, employers wishing to reduce the cost of overpricing and FWA should partner with smaller, more nimble firms with deep claims data analysis expertise, a portfolio of claims analysis tools, and an in-house HIPAA-compliant data environment[11] and without legacy organizational conflicts that limit their pursuit of overpricing and FWA – a firm such as Teus Health.

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[1] Department of Labor, "Understanding Your Fiduciary Responsibilities Under a Group Health Plan", September 2019.
[2] SHRM, "Legal & Regulatory: What is a fiduciary, and what are 'fiduciary responsibilities' under an ERISA-covered group health plan?", October 6, 2016.
[3] US Congress, "Consolidated Appropriations Act, 2021", December 27, 2020, page 1711.
[4] Department of Labor, "FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49", August 21, 2021, page 7.
[5] Subject to applicable patient privacy protections.
[6] MHK, "Health-Care FWA May Be Much Higher Than Suspected in the United States", December 3, 2019.
[7] Forbes, "Covid-19 Testing 'Free With Insurance' – A New Form Of Health Care Fraud", June 3, 2021.
[8] ProPublica, "We Asked Prosecutors if Health Insurance Companies Care About Fraud. They Laughed at Us", September 10, 2019.
[9] Health Cost Institute, "The Price-Quality Paradox in Health Care", April 2016.
[10] Healthcare Executive Intelligence, "Hospitals Fall Short of Price Transparency Rule Compliance", July 22, 2021.
[11] The claims data will likely be classified under HIPAA as a "limited data set" (LDS). LDSs contain sufficient indirect patient identifiers that they must be stored and analyzed in a private and secure environment.