Back to News | Print News

State:
Calls Renewed for Managed Care Price Transparency in Comp: Top [2017-12-13]

Little progress has been made on managed care price transparency in workers' compensation, industry observers say, even though the issue has been debated for years.


Frank Pennachio

A presentation at the National Workers' Compensation and Disability Conference in Las Vegas this month has sparked the latest round of discussion on the topic. Frank Pennachio, cofounder of insurance advisory firm Oceanus Partners, posed the question, "Are 'cost containment' services actually containing costs?"

In an interview, Pennachio said payers contracting with third-party administrators typically focus on only one part of the equation: how much they're paying per claim or as a percentage of losses for the TPA to manage claims. Meanwhile, they tend to ignore what's happening on the medical treatment side, Pennachio said, such as whether those managing the medical care have revenue-sharing arrangements with providers.

"Nobody knows what the providers are getting paid," Pennachio said. "Where there's a lack of transparency, bad things happen."

Pennachio's take-home message was that workers' comp payers should require full financial disclosure from managed care companies on items such as marketing agreements, side agreements, commissions or administrative fees. However, payers should be prepared to pay more on their per claim or loss-conversion fee if the side arrangements are eliminated, he warned.

In a blog post recapping Pennachio's presentation, Joseph Paduda, principal of Health Strategy Associates, said the issues are not new.

"This has been a subject of conversation many times over many years, and yet, here we are. And here we'll stay until and unless employers demand something different," Paduda wrote.

David Donn, chief executive officer of managed care advisory firm Donn & Co., said that while some recent progress has been made in pharmacy-benefit manager pricing transparency, that hasn't been the case for most PBMs or for bill review, preferred provider organizations and utilization review companies.

"I'd say transparency in general is still given lip service and only discussed if brought up, and only addressed if pressed on by the client," Donn said. "It's a discussion not only worth having but worth fixing."

A client can help prevent overuse of UR by having clearly defined referral criteria for claims examiners, said Donn. He said overuse of utilization review is more common when the TPA offers UR services in a bundled arrangement.

A per-bill flat rate is one way to simplify payment for bill review services, Donn said. On the other hand, he said, "pegging the service providers' fees to performance can help to hold them accountable." The key is to have a clear definition of what constitutes bill review savings.

Pennachio also tackled the subject of bill review charges in his presentation, saying a bill review company's collection of a percentage of money saved through the review "should be outlawed." Adjusting a provider's bill to workers' comp fee schedule levels should not be considered saving money, he added.

"The payer is being duped," he said.

A National Association of Insurance Commissioners model regulation in 2011 addressed issues regarding TPAs, but Pennachio said the NAIC example has been mostly ignored.

The model regulation says in part: "A TPA shall not enter into an agreement or understanding with a payer or, with regard to workers' compensation, a payer, employer or co-employer in which the effect is to make the amount of the TPA's commissions, fees or charges contingent upon savings effected in the payment of losses covered by the payer's obligations."

Michael Marsh, president of Midland Claims Service in Montana, said the single-state workers' comp TPA has had success using a time-and-expense claims handling agreement with clients that comes with no "back door" income agreements involving bill review, nurse case management, durable medical equipment or other services.

"We do not need to overestimate the cost of handling to achieve a sufficiently large flat rate to support a profitable operation," Marsh said. "We then have the ability to go direct to the ancillary service providers and negotiate the best deals possible for our clients."

Like others, Marsh noted the reluctance of payers to scrutinize the total cost model of claims companies they are working with.

The revenue-sharing arrangements that Pennachio criticized are also the subject of a lawsuit filed this year by the Independent Physical Therapists of California against One Call Medical and Align Networks, now known as One Call Physical Therapy, alleging unfair business practices.

Among IPTC's allegations is that Align had a referral scheme in which the company demanded that physical therapists agree to significant discounts or potentially lose the ability to provide services to large numbers of injured workers. The complaint alleges that One Call referred injured workers to providers in its network who have accepted the lowest reimbursement rate, pocketing the "spread" between what it is paid and what it owes providers.

IPTC President Paul Gaspar said on Tuesday that the two sides have been in settlement talks for several months. Court records show that a fifth joint motion to extend time for One Call to respond to the complaint was granted, with a response now due by Friday. The case is in U.S. District Court for Southern California.

Gaspar said a problem in the workers' comp industry in general is that the largest discount networks pay less than half of the fee schedule for medical services, such as physical therapy.

And laws intended to protect injured workers in large part do not apply to the "middleman" businesses, Gaspar said.

"We feel this loophole allowing them to do the work without being licensed or regulated should be closed," Gaspar said.