Inspire

Thoughts on Anthem's Decision

By Tim Smith, ASA, MAAA, MS

Is this a case of short-term gains at the expense of long-term progress?

The recent announcement by the Blues insurer Anthem that they will no longer reimburse for CTs and MRIs in the hospital outpatient setting touches on a variety of interesting topics. The thoughts that come to mind all relate to some ongoing limitations and lack of forward progress within the health care space:

- **Consumers still do not know what services cost.** If they did, a consumer could make a financial decision regarding an MRI in their favorite hospital vs. using an imaging center. Creative benefit designs that cover the freestanding price, but allow the consumer to spend it where they wish (called "Reference Pricing") would provide a more convenient alternative if the patient had the right tools.
- **Hospital pricing with insurers is often inconsistent and incomprehensible.** Why haven't hospitals made these "shoppable" services cheaper, meaning setting the price for these services to match the freestanding center? Often the hospital has little say in how a contract is structured, and cannot customize the contract to raise prices in areas where they are losing money and lower them in areas where they are making excessive margins, like imaging. Or, often, there is not a great deal of understanding on which services earn which margins, by payer and product line. Hospital pricing is done with a broad brush while benefits are increasingly designed with a narrow or fine brush.

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- **What about the ACO?** With all the talk of insurers and providers coming together to lower the cost of care through ACOs and other value-based arrangements, does this action by Anthem signal that Anthem doesn't believe in a future where the provider can manage the total cost of care, without the help of their insurance "hammer"?
- **Leverage wins.** In the end, will a hospital system with significant contracting leverage due to their market-position just replace these margins with higher prices on other services in future contracts? And where does this leave the hospital just getting by in a highly competitive market?

These topics and questions can be explored through looking more in depth at price transparency, hospital-based billing, and the provider led ACO. I will also touch on hospital contracting leverage.

Transparency

I just asked Siri for the "cheapest MRI near me", and "Quest Diagnostics laboratory testing" was the response. It's a start, I guess. The wrong service line, but at least I was provided with a low-cost setting for health care! In this age of smart phones, many of us have probably wondered why price transparency in the healthcare space has not been tackled in a more effective way. If Siri knew my insurance carrier and all local provider prices and could give me a quick and accurate answer, would Anthem have gone to this extreme measure of a benefit exclusion vs. a more customer-friendly "reference price" or other creative benefit option? While web-based transparency tools are improving, they are still not widely used, and are difficult for consumers to interpret when a procedure may involve multiple physicians and facilities.

Hospital-Based Billing

Thank you, federal government, for creating crazy economic incentives in our already confusing health care world. I am speaking of hospital-based billing, which allows a hospital to build a freestanding imaging center (or lab draw site, or surgery center, or even a physician office) and, if it met certain criteria and distance from the hospital, could be treated as an extension of the hospital, and bill it as the hospital. (CMS discontinued this option in 2015, but only for new facilities.) A topic that many hospitals are now discussing is this. If they once opened an imaging center as hospital-based, should they now consider converting it back to free-standing? This will be especially important if this move by Anthem starts to spread to other payers.

A lot of money could be on the line. Many insurers will pay only close to Medicare rates for services in freestanding centers, while in the hospital two-to-four times that much. Through the history of hospital and payer contracting, contracts have grown to be extremely inconsistent across payers and hospitals. Some strictly base contracts on Medicare multipliers. Others have case rates or fee schedules attached to certain services, like CTs and MRIs. Still others are based on a percent of "whatever the hospital wants to charge". And margins for the hospital across these payer contracts and service lines vary greatly.

Within this crazy world, Anthem has decided to carve out these specific services and no longer allow them. Some hospitals had already worked to cut prices for these "shoppable" services, and will lose the volume and customers. Others had very high prices to subsidize other service lines, and will need to scramble to find these margins in other ways. But without "right priced" contracts between payers and providers, where prices are all consistent and make sense from a price and margin perspective, Anthem's strategy of "no MRIs or CTs in the hospital setting" is a simple and straightforward approach to savings. In addition, it is administratively efficient for Anthem to adjudicate claims.

The Provider-Owned ACO Dilemma

The importance of right priced contracts and transparency tools can extend into the world of ACOs and value-based deals, including shared-risk and total cost of care arrangements.

I have worked with hospital systems in developing fair ACO deals in partnership with payers and employers. The key here is finding the "win-win", where the hospital knows they will lose volume through their improved care management efforts, but can get some of those margins back through the shared financial success of the ACO and in keeping once fragmented care within the system. The dilemma I am referring to occurs when the conversation in the ACO leadership turns past reducing admissions and ER visits, and beyond better managing diabetes and other chronic conditions. The topic is now commodity services like CTs and MRIs, and dealing with the high cost in the hospital setting. The physicians are being asked to keep care coordinated within the system, but prices are such that they are impacting overall PMPM by keeping them in the system, vs. sending them out to a freestanding center.

If payer-provider partnerships were truly partnerships, a future value-based world would include conversations about including contractual prices in the discussion, and coming up with contracts that make sense, and support the mission of future value-base care.

The Reality of Hospital Market Share

In the cat-and-mouse game of payer-provider contracting, the reality is often that when the hospital is the sole provider in a community, or has gained a reputation of "must-have", all payers in the market accept the price offered and hope that their payer competitors received the same price so insurance premiums remain competitive. The main pressure on hospital prices comes from employers in the community, who want their health care premiums to remain affordable, and the hospitals themselves, who may want to keep costs low. But in the case of this Anthem move, I believe that those hospitals with significant leverage are not just going to let Anthem eliminate all of that volume and margin and not try to get much of it back in their next contract negotiation.

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On the other side of the equation is the hospital that competes in a competitive market. The hospital has less leverage, especially against the largest insurer in the market which is often Anthem. In this case, the Anthem move will likely work in keeping costs lower in the region. These hospitals will have current margins squeezed even more, and will either need to be more efficient or, in some cases, look to be acquired by a larger system in the market with greater pricing leverage.

Summary

In summary, I see this move having an immediate savings for Anthem overall as care moves from the “more-expensive on average” hospital to the “less-expensive on average” freestanding center. Consumers will be inconvenienced, but just as in the HMO days when these types of practices were common, they may not like it but will get used to it. Other payers may follow. Hospitals will need to make more strategic decisions around their future of hospital-based billing vs. conversion to freestanding centers. In the long-term, hospitals with negotiating leverage will look to get their margins and volume back. Hospitals with less leverage will continue to find ways to achieve the margins they need to survive, including becoming more efficient, if possible, or potentially selling, if not.

But, overall, this decision will not force the market towards a better solution on true pricing transparency and tools to make transparency easy, which would allow benefit designs to become more innovative and creative. And this is not a huge vote of confidence for the future of ACOs and value-based partnerships between payer and provider. A payer sharing the responsibility with providers in managing care, but telling them they cannot perform a test on their patient in their own hospital, seems to go against the future of partnering and back to the insurer-provider cat-and-mouse days of old.

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