100% Copay Market Overview

When consumers have an unknown financial responsibility at the point of service [as experienced under all 100% copay programs and plans that include Cash Discount Programs, and all High Deductible Health Plans (HDHPs), including the alphabet soup of Consumer Driven Health Plans (CDHPs) before they have met their deductible], they are vulnerable to health care providers circumventing the adjudication process and assessing a "what the market will bear" fee that is greater than the discounted, contract rate. HDHPs and CDHPs are, effectively, cash discount programs with consumers paying 100% copay until their deductible is met. The only noteworthy difference between HDHPs/CDHPs and cash discount programs is that HDHPs/CDHPs have a deductible that, once met, automatically converts to a cost-sharing arrangement with the consumer's health plan that eliminates the problem.

When health care providers receive pricing edit responses from healthcare claims processors during the adjudication process that indicate consumers are financially responsible for the entire cost of their services or products (100% copay), health care providers recognize the opportunity to charge and collect more than the pre-negotiated, discount reimbursement rates under the applicable plan or program without detection at the point of service; and detection at a later date is highly improbable. *Healthcare claims processors include any entity that performs the function of receiving and adjudicating (or pre-adjudicating) electronically submitted claims and returning pricing edits which identifies the financial responsibility of consumers, and if applicable, the financial responsibility of their health plans.* Pharmacy Benefit Management firms (PBMs) are good examples of healthcare claims processors because 99.999% of claims are submitted electronically for adjudication, but the MBRx services are also applicable to medical claims.

Discounts that providers have felt forced to accept under managed care plans have spiraled down over time and are now well below their preferred margins. This has led health care providers to subsidize those discounts by charging cash paying consumers more than the health care provider's "managed care" contracted rates when consumers are financially responsible for the entire cost of their services or products (100% copay). Health care providers can be expected to continue this practice as long as there continues to be very little risk of being caught, and applicable penalties, if any, have not eliminated this problem.

Unlike any other segment of the economy, the consumer who walks into a health care provider's practice, and pays cash (i.e. debit/credit card, check, etc.) pays the highest fee for the products and services received. Health care providers, for fear of losing volume, have accepted deep discounts below their preferred margins from managed care entities (insurance companies, HMOs, etc.). As a consequence, cash consumers can expect to be treated as "cash cows" and charged significantly more in order to subsidize managed care reimbursement rates. *This practice is the norm, rather than the exception*. Cash consumers may be defined as the uninsured, cash discount card members, and members of account-based and non-account based HDHPs prior to meeting the deductible because in each case, the consumer is paying the full amount at the point of service. Currently, every time a consumer pays the full amount at the point of service, that consumer is unknowingly vulnerable to being treated as a "cash cow" since no real-time quality control protection is provided to the consumer. *MBRx removes this vulnerability under all 100% copay situations.*

Account-based health plans, commonly referred to as CDHPs, are the fastest growing segment of healthcare coverage; and this trend is expected to continue in the foreseeable future. The cost to provide traditional health insurance to an aging population coupled with governmental regulation/health reform is expected to cause traditional health insurance premiums to continue to increase at an alarming rate. Add a struggling economy, and an ideal scenario is created for the explosive growth of CDHPs. In order to secure lower premiums, almost half of the market has already shifted to HDHPs with a deductible that is just a little under that required to qualify for a HSA. The premiums for CDHPs tend to be considerably less than for traditional health insurance. The healthier population, that historically has subsidized the sicker population under traditional insurance programs, will gravitate to a CDHP in order to lower their total cost of health care as traditional health insurance premiums continue to climb. This will generate a subsidy loss and traditional health insurance premiums will increase even more. This adverse selection cycle is expected to continue over time with the net effect of a higher CDHP population than traditional insurance. This trend is expected to continue, if not accelerate, in the foreseeable future.

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As the Affordable Care Act transitions consumers without insurance to adopting HDHPs, which include CDHPs, because of their greater affordability, health care providers' "cash cow targets" will be transitioning from consumers without insurance to those consumers utilizing insurance products that have a deductible attached. The bottom line is that, because of cost differentials in traditional health plans and various types of HDHPs, including all CDHPs, HDHPs/CDHPs can be expected to grow by double digits annually. This growth increases the identified risks/problems to increasingly more consumers. Unfortunately, this major transition places consumers in the vulnerable position of easily being treated as "cash cows" by health care providers who can circumvent the adjudication process to secure their preferred margins without detection at the point of service. Consequently, consumers are vulnerable to being charged more than contracted rates without their knowledge or consent.

Adjudication circumvention is an industry-wide deficiency for both pharmacy and medical claims. Currently, in 100% copay situations, there are no published statistics on the frequency of claim adjudication circumvention. There is no way to track, measure, or prevent its occurrence at the point of service because consumers, healthcare claims processors and/or health plans do not know if the health care providers have circumvented the claim adjudication process to: 1) collect higher reimbursement fees, 2) avoid paying fees to the healthcare claims processors that are commonly associated with cash discount programs, or 3) some other reason (drug incompatibilities, prices higher than consumers are willing to pay etc.). Under cash discount programs, the vulnerability is greater because health care providers may not even submit claims when such programs are identified upfront; or they may reverse a submitted claim to avoid paying a fee that is assessed by healthcare claims processors for providing "steerage" to the health care provider. *Significantly, under CDHPs, approximately ninety percent (90%) of plan members never meet their deductible and under traditional HDHPs, approximately fifty percent (50%) of plan members never meet their deductible. This further reduces the potential for health care providers being caught; because before deductibles are met, consumers in these plans experience the same vulnerability as they would under cash discount programs.* Additionally, those with pharmacy cash discount cards experience claim reversals 4 – 10 times that of traditional, fully funded copay plans with comparable experience expected under all other 100% copay situations.

On the medical side of the HDHP/CDH market, healthcare providers have to wait up to 120 days to collect funds from consumers, and a significant percentage of providers never receive payment, resulting in write offs. This has created a market dynamic where providers "overestimate" the amount owed and collect it from consumers at the point of service, leaving consumers to seek reimbursements from their health plans. Health care providers engage in this practice because experience indicates that, once consumers leave the point of service without paying for the service or product received, providers are at-risk of not being able to collect the balances owed. Furthermore, health care providers often write-off unpaid balances because pursuing collections of unpaid balances often cost more than the unpaid balances owed by consumers. The preceding is a widely acknowledged problem; and just like the pharmacy market, when given the opportunity, health care providers will circumvent the adjudication process in order to collect their preferred margins.

Circumventing the system on 100% copay programs (i.e. cash discount cards and HDHP/CDHP claims prior to the deductible) may not be illegal, but this behavior is not consistent with the terms of their respective contracts. Unfortunately, the currently applicable repercussions, if any, in the highly unlikely event a health care provider is caught, have not eliminated the problem. Therefore, providers can be expected to consider the relative "risk" of being detected against the "reward" of being able to charge their desired, higher price. When it is easy to exploit a system for financial gain, with very little chance of being caught and limited to no penalties, it is logical to conclude that a significant percentage of providers will take advantage of the opportunity!

Adjudication circumvention enables health care providers to: 1) charge "what the market will bear" rather than the pre-negotiated, "managed care" discounted prices as determined by healthcare claims processor edits, or 2) avoid paying a fee that is assessed by healthcare claims processors for providing "steerage" to the health care provider providing a product or service. At the point of service, the health care provider's actions are undetectable because the healthcare claims processor is not aware that claims have not been submitted, and if claims are reversed, the reason for the providers' reversals are not known. For example, there could be a logical, clinical reason for reversals or the cost may exceed the Consumer's ability to pay. Therefore, in all 100% copay situations, consumers and the healthcare claims processors are completely vulnerable to health care providers unilaterally circumventing the claim adjudication process without their knowledge or consent and charging "what the market will bear".

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Providers have been confronted with ever decreasing reimbursement rates from health insurance/cash discount program entities; and consumers who are totally responsible for providers' charges (100% copay) provide an opportunity for providers to charge their preferred rates rather than the health plan/program "managed care", discounted rates they have been "forced" to accept. Unfortunately, when providers circumvent the adjudication process, pricing is only one of five significant problems that are experienced under HDHPs and CDHPs, the fastest growing segment of health care coverage - growing annually at double digits. **The five (5) problems experienced when the claims adjudication process is circumvented are:**

1. Consumers paying more than the contracted, discount rates for their products and services.
2. Claims not being counted toward consumers' deductibles when applicable.
3. Deductibles, if applicable, not being tracked at the point of service. This means, if consumers would hit their deductible with the service or product then being provided, they would not receive the benefit of a reduction in their financial responsibility at that time, with their third party picking up the difference.
4. Claims not being included in medical profiles which limits the ability to manage patient care. For example, consumers can not receive concurrent Drug Utilization Review (DUR), when applicable, on all prescriptions, thereby making them susceptible to drug therapy related problems that otherwise could have been avoided. Concurrent DUR decreases the potential for meeting consumer deductibles, thereby minimizing the underwriting risk.
5. Data required for accurate actuarial and clinical analysis, risk prediction, projected outcomes and optimal provider compensation under pay-for-performance (P4P), or value-based purchasing models are incomplete. Consequently, any results derived from available data would be inaccurate.

The magnitude of the problem in the pharmacy benefits sector alone is illustrated by the fact that it is not uncommon for cash discount programs to experience reversal rates ranging from twenty percent **(20%)** to fifty percent **(50%)**. Those reversal rates range from four **(4)** to ten **(10) times** that experienced under traditional, fully funded pharmacy benefit plans when consumers' (cost-sharing) copays alone are approximately the same amount as the average prescription cost under the cash discount programs. Therefore, the cost of the prescription is *NOT* the reason for the increase in claim reversals under cash discount programs. Under traditional prescription drug plans that utilize a cost-sharing copay structure, provider self-serving claim circumvention is not possible because plans (insurers) are responsible for a share of the cost. **Experience in 100% copay situations in other segments of the health care industry is perceived to be comparable.**

Pricing is not the only issue, the problem of a health care provider reversing a previously submitted claim under HDHPs/CDHPs is that the problems identified in items 2 – 5 above, continued to be experienced even if the health care provider has assessed the consumer the correct pricing at the point of service. Securing a higher profit margin is not always the sole reason for circumventing the adjudication process. Health care providers may opt to circumvent the adjudication process under cash discount programs to avoid being assessed a fee by the healthcare claims processor, a common practice in that market. Therefore, preventing health care providers from circumventing the adjudication process not only benefits consumers, but also healthcare claims processors because, by forcing compliance with their health care provider agreements, they increase their revenue.

Based upon the significance of this problem, the following question should begin to appear as a minimum criterion in every Request for Proposal: ***"Please explain the real-time, quality control measure that you can provide to prevent health care providers from either circumventing the adjudication process or reversing claims without the patient's consent or knowledge when the patient bears the full financial responsibility for the cost of the product or service."*** (Medical Banking Rx grants permission for any reader to use this question in any RFP/RFI) How would you answer this question?

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Medical Banking Rx services are integrated, but outsourced, components of a healthcare claims processor's real-time claim adjudication process to meet the needs and objectives of plans, programs and the consumers they serve. Medical Banking Rx provides two approaches to eliminate: **1)** the ability of health care providers to "game" the system by circumventing the adjudication (re-pricing) process by either failing to submit claims or reversing submitted claims when they realize the responsibility for payments is entirely that of consumers at the point of service and **2)** the resulting five significant problems.

1. **MedConfirmation**[SM] is a new, *patent-pending,* real-time messaging solution which enables consumers to audit health care providers for adjudicated charges at the point of service, and optionally, their claim reversal actions, if any, in order to prevent claim adjudication circumvention. When health care providers receive their adjudicated pricing edit, consumers also receive it. MedConfirmation[SM] confirms the submission of their claim, provides price transparency, and alerts the consumer if the provider subsequently reverses their claim.

2. **Patient Driven Rx**[SM] enables healthcare claims processors to initiate payments to providers on behalf of consumers to prevent both health care provider claim adjudication circumvention and overcharges. Patient Driven Rx[SM] is an award winning, real-time medical banking solution that is specifically designed for the healthcare industry to eliminate the deficiencies that currently exist when the patient bears the full financial responsibility for healthcare provider reimbursement. Medical Banking Rx is a recipient of the Healthcare Information and Management Systems Society (**HIMSS**) **Medical Banking Project *"Disruptive Innovator"* Award** *(best potential to transform healthcare using disruptive innovation)* for creating a truly unique process that provides a real-time solution to the deficiencies inherent in all 100% copay situations (High Deductible Health Plans, Consumer Driven Health Plans, and all Cash Discount Programs).

> **"The MBRx medical banking solution is the closest thing I've seen to the Holy Grail."**
>
> *B. Greg Buscetto, Former Segment President, Strategic Solutions, CatamaranRx, and Consultant, Leading Business Consultants*

MedConfirmation[SM] and Patient Driven Rx[SM] force providers to submit every claim for adjudication in all 100% copay situations. **Under cash discount programs, healthcare claims processors are able diminish their typically high attrition rates and recoup previously lost revenue (20 – 50% for PBMs alone) caused by adjudication circumvention.** These solutions effectively transfer control of the claims submission decision from the health care provider to the consumer to prevent claim adjudication circumvention and preclude provider self-serving pricing.

Additionally, Medical Banking Rx provides **MedNotification**[SM], a service that enables health care claims processors to send real-time messages to Consumers under all types of health plans and programs by using Consumers' preferred method of communication or notification to communicate relevant information to them.

Those healthcare claims processors that don't have an ability to prevent adjudication circumvention and inappropriate reversals in real-time can expect to be severely disadvantaged. The MBRx solutions can be expected to change the terms on which healthcare claims processors and health plans can win and retain business by altering the acceptable expectations of their clients and the consumers they serve. The Medical Banking Rx solutions generate a significant value proposition that enhances not only health plan and cash discount programs, but also employers' and consumers' perception of provided value and satisfaction.

The MBRx solutions enable healthcare claims processors providing cash discount programs to effectively combat their typically high attrition rates and significantly increase their revenue by preventing claim adjudication circumvention. For example, claim reversals under the pharmacy cash discount card programs of numerous PBMs are *four* to *ten* times that experienced under traditional fully funded (cost-sharing) programs. Again, since both HDHPs and CDHPs are essentially cash discount programs until deductibles are met, and approximately 90% of CDHPs and 50% of HDHPs do not meet their deductibles, the preceding applies to all such programs.

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