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Does Insurance Cover Influence A Patient's Hospital Charges

The Covid-19 Pandemic, albeit temporarily, changed the utilization of hospital services across India with an increasing number of hospital admissions, often a result of the sick needing hospitalization. Hospitalization during the pandemic meant a higher use of medical resources including critical care beds, isolation units, drugs, oxygen, ventilation, etc.

This change in consumption of healthcare services across the hospital ecosystem begged to ask a question. **Would hospitals cross subsidize the uninsured population by up-charging the insured?** In light of this we set out to describe the possible forces, if any, that influence a hospital's choice and what should insurers be looking out for when examining a hospital bill.

Factors that could impact a hospital's charges:

1 The method of packaging when a hospital bills affects the total gross charges to a patient with different sources of payment could be explained by:

a) Patient receives more (or more expensive) products and services

b) Conditional on utilization, some products and services may be bundled or unbundled to increase their total charge, and/or

c) Conditional on utilization, patient could be charged for a greater proportion of the products and services they consume

2 The method of reimbursement for a hospitalization also differs substantially for different insurance companies.

a) It's not just that the rate is different for each service, but that different insurers will reimburse different services

b) Most insurers, for example, bases their reimbursement rate predominantly on the patient's diagnosis. Other insurers could pay by the day or for each individual service

c) But hospitals do all their billing the same way, no matter who the insurer is. So the best way for them to get paid is to put anything that might be reimbursed by any insurer on every bill

d) Inflation of treatment cost are observed more commonly in reimbursement bills as compared to cashless service

In other words, there is no penalty for billing too much for a service. The only potential penalty would be for billing for a service not provided or a diagnosis not justified.

What all this means for Insurers and TPAs, going forward?

When a hospital sends a bill an insurance company often pays the hospital based on pre negotiated rates, no matter what the bill asks for. The hospital can turn away all patients with that insurance, of course but for each insurance company that would mean turning away a lot of patients. The hospitals know that they might get less than what they bill, the process of hospital billing could possibly become just a game between the hospital and the insurance company.

Supporting this intent for a need to change an Insurers/TPA's contracting approach is a publication titled 'Health System for a New India: Building Blocks – Potential Pathways to Reform' by NITI Aayog, in November 2019 covers topics vital to improving the efficiency and quality of our health system. Importantly, chapter 3 of the publication draws reference to the need for 'Strategic Purchasing from Network Providers'. Additionally, the IRDAI in its List of expenses generally excluded (non-admissible expenses) in hospitalisation policies demonstrates its intent to reduce the number of instances that a hospital bills for items separately that are integral to a service delivered to a patient.

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Looking ahead

As we build health systems of tomorrow, there is a need to develop a framework for harmonization of the approach to strategic purchasing for all populations, insured, partly-insured or uninsured. Some of the opportunities that need be addressed by insurers/TPAs include:

With asymmetry of information, payments by insurers are often linked to outputs from a hospital which are more easily observable and verified (by both parties), as compared to the attainment of health outcomes or policy objectives, such as improved efficiency or equity.

While each insurer/TPA might have their re-priced tariff arrangement with a hospital, it is important to define a minimum-data-set (MDS) that will act as an enabler for settlement of claims.

It is essential to establish systems and processes for tighter monitoring of performance to deliver quality care with a provision for escalation in case of lack of performance. These indicators should include:

- **Length of Stay (LoS):** Measures the length of time between a patient's admittance to and discharge from a hospital. This metric is most often tracked over months and annual quarters, though it can also be tracked over the course of a few weeks. Length of stay measurement can be used throughout a hospital or for a specific therapy area, such as acute myocardial infarctions.

- **Readmission rates:** Readmission Rates track the percentage of patients that are admitted into the same or another hospital within 30 days of being discharged for the same condition or a complication from the original episode of care. This metric measures quality of care given to patients. High hospital readmission rates indicate that physicians and other care providers are not delivering the proper care to patients, overlooking complications or relevant patient data. Lower hospital readmission rates, by extension, indicate a strong quality of care.

- **Mortality Rates:** Patient mortality rate measures the percentage of patients that die in a hospital's care before being discharged. This metric is a strong indicator of providers' ability to stabilize a patient's condition following surgery or another procedure.

- **Bed Utilization Rate:** Bed Utilization Rate (also called Bed Occupation Rate) refers to the number of hospital beds being used at any given time. Knowing bed demand in real time is important to insurers who need to know the difference between available beds and patients awaiting care.

- **Incidents:** Hospital incidents include unintentional consequences or side effects of hospital procedures, including conditions like sepsis, postoperative respiratory failure, pulmonary embolisms, hemorrhages, and other reactions or infections. This metric measures the ability of healthcare professionals to provide comprehensive, high-quality care to patients without triggering an adverse reaction.

- **Average Cost per Discharge:** Tracking the average care costs per patient discharged can aid in understanding of which therapy areas see overspending. Similarly, this metric shows where hospitals make the greatest profit as well as whether the costs associated with patient care actually improved the patient's outcome. Cost per discharge is a dynamic measure that can be adjusted for a hospital's case mix and other patient population demographics.

- **Disallowances:** Refers to revenue loss that occurs when a hospital requests payment from a patient for care provision and does not receive the full amount from the insurer. This is often measured as a % of the billed amount.

How other ecosystems responded?

USA: According to a number of studies conducted in the US providers do not charge every patient the same price for medical care. Uninsured patients and those who pay with their own funds are charged 2.5 times more for hospital care than those covered by health insurance and more than 3 times the allowable amount paid by Medicare (a form of subsidy that the Federal Government gives to families with low incomes and no assets). Further analysis on these studies as to why the overcharging suggests that uninsured patients do not benefit from discounted rates negotiated on the patient's behalf by insurance companies and Medicare. Hence they are charged the full, undiscounted rack rate for services set by the hospital.

Hong Kong: When it comes to squaring up payment for care received, there are a number of practices followed by hospitals while billing, in all it is still widely agreed that the population is segregated into 2-decisions namely a) government-subsidized treatment and b) private charges. Eligible people access government-subsidized treatment through public facilities. The subsidies are very generous and highly controlled by the government. Public in these cases can avail reimbursement through their insurance, the Hong Kong Government provides a waiver mechanism for vulnerable groups and people that may experience financial hardship through the payment of hospital fees and charges. People who do not qualify for government-subsidized treatments have to pay charges that are significantly larger compared to their eligible counterparts.

Summary

It is evident that there is a global disparity between hospital billing between insured and uninsured patients. Although universal health schemes like Ayushman Bharat do help close this gap and give advantage to the general population there is a need to address this issue.

Authors:

Satish Gidugu
CEO, Medi Assist

Nikhil Chopra
CBO, Medi Assist

Manish Vij
Vice President, Operations

Akshay Singh
Program Lead, Medi Assist

About Medi Assist:

We are India's leading HealthTech and InsurTech company, specializing in health insurance administration for employees, retail members, and government health plans. We constantly work to drive change and invest in such programs with a focus on reducing healthcare costs.

Our Health Benefits Administration model is designed to include the tools required for a health plan to succeed, whether it's our modular claims management system, technology that exposes data to make critical decisions, or service strategies built around the voice of the customer. In a nutshell, we want to link our performance to a successful healthcare journey for our members.

We incorporate talent and technology in our claims research to assist our members in defying national claim cost trends. Internal processing is augmented by advanced surveillance software, and once a claim is identified as potentially saving money and qualified medical experts investigate the claim for cost-saving opportunities.

Benefits Administrators traditionally demonstrate their provider network repricing, capitation, packaging of procedures, or a reduction in administrative costs as proof of their willingness to help improve the bottom line; however, at Medi Assist, our comprehensive approach to benefits administration offers a positive environment for our clients while aiding employers and members in lowering, often hidden healthcare costs.

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Medi Assist plays a crucial role in the health insurance ecosystem: