Cost Containment in Healthcare

Speakers:

JT **Jeffrey Toewe** – Co-founder of Medxoom

MA **Marshall Allen** – Founder of Allen Health Academy, Author of "Never Pay the First Bill: And Other Ways to Fight the Health Care System and Win"

JT Hi I'm Jeff Toewe, the CEO and founder of Medxoom. This is the second installment of our podcast series. I'd like to introduce you to Marshall Allen, some folks watching the podcast probably know him already. He is well known figure in the space and today we're going to be talking about the No Surprises Act and the macro level impacts that it is having on the health benefits space. Marshall, welcome. Can you give us your background?

MA Absolutely. Yeah, my background is unique. I actually started my career in full time ministry. I did full time ministry for five years. And I say that because when I became a journalist, and started doing investigative reporting about healthcare, I really looked at our healthcare system through a moral and ethical lens. And what I discovered as I did investigative journalism about healthcare, which I've done now for 17 years, I found that the way our healthcare system is treating individual patients is often unethical and immoral. And I say that because Americans, especially working Americans, are paying so much more money for their health care than the citizens of any other nation around the world. And they are getting less and less for their money as the years go on. This is something I know that you are working to disrupt. I know there's a lot of other solution providers out there who are who have found solutions to these problems.

> **The cost of health care does not have to be this high and so my investigative journalism led me to write a book called "Never Pay the First Bill and Other Ways to Fight the Healthcare System and Win"**

and the "and Win" part is really the most important part of the entire title and subtitle of my book, because individuals if they become informed, and educated and empowered healthcare consumers, they can navigate the healthcare system and save hundreds or even 1000s of dollars per healthcare encounter in some cases. So my book has three chapters

dedicated to employers. It has eight chapters, dedicated individuals. And it's really a how-to guide it's how to win against these unreasonable, outrageous and often unethical, high health care costs. And so I'm trying to now you know, spread this message. So I launched a company called Allen Health Academy, which is a health literacy organization. So now I'm trying to share this message more, and I'm doing that through my book. I'm doing that through a lot of speaking and I'm also doing it through a new series of health literacy videos. The videos are called the "Never Pay Pathway" based on the book "Never Pay the First Bill" and it's taking information from the book and presenting it in a really engaging way. And so it's shorter videos now instead of expecting an employee to read a book, the employer can roll the videos out to their health plan to equip their employees and help them learn how to navigate the system.

JT

So this content is geared towards employees in snippet format, where you're having light bites, a few minutes each. Absolutely have to use that, that's great. I'd like to just jump into what the most recent mandates and legislation are doing to help further our effort. So as you know, there were two executive mandates. First, hitting the hospitals for them to publish their negotiated rates with different major payers for I believe it was one 150 CPTs and discretionary list of other ones. And then second, was the carriers doing the same for all the NPIs that they have negotiated rates for. That data is being pulled out into the sun now and then we also have the CAA Consolidated Appropriations Act and the the transparency requirements that really touched on all different facets of the ecosystem, right. There's a provider advanced EOB requirement in there. There's a network Good Faith Estimate. And you know, all these things in unison. What do you see is happening now, does this this this represent a new real? Does it have efficacy?

MA

Yes, it does. And I realize it's limited right now. I realized that the adoption of the hospital price transparency rule has been minimal, you could even say, but here's what we're now seeing that we had never seen before. We are now seeing hospitals publish their prices, not their chargemaster rates, the fantasy numbers that they make up, we are seeing them publish their negotiated rates with all of their insurance plans. And I know it's only a few hospitals right now relatively one study I saw said 15% of hospitals are complying but penalties have started. Again, the penalties have been slow in coming. It's only two hospitals that have been penalized so far, but once this information gets out, it gets downloaded, it gets cleaned up and it gets packaged in a way that's more presentable to the consumers. Then the employees and the employers can see the frank absurdity in our health care pricing, they will see the absurdity in the prices that have been negotiated by the insurance carriers on their behalf. Often we're seeing cash prices that are much lower than the discounted negotiated rates that the insurance companies have. We're also seeing that verification that the Medicare rates are, you know, half or 1/5 or 1/10, of what working Americans are paying on commercial insurance plans. There is no justification for this price variation. And yet now that we're being able to see some of this data, let's call it what it is.

There's no justified reason that the prices should be this very varied.

And what I'm showing people how to do as individuals is, negotiate, check your bill like my book is called "Never Pay the First Bill" it doesn't mean don't pay your bills. It means check your bills to make sure they're accurate and fairly priced.

Now when you can look up some of these prices, even if it's not a price at your own hospital, you can see okay, I got a colonoscopy. They're charging me $5,000 for that? This other insurance plan at the hospital is paying $2,000. That gives patients a tremendous amount of leverage to negotiate their own bills. And so again, naysayers can say, oh, patients can't understand this, it's too complicated. Not true. Many patients can't understand it, but many of them can. They're very smart. They're very motivated, and they're paying so much out of pocket that they have a great incentive to understand these things. So I think there's a tremendous change happening.

JT

Historically with our clients, you know we're a white label platform that powers plans and TPAs -- we're focused on the independent TPAs, because they can help you improve the cost overall. We've always been privy to those major spreads when it comes to the the variation in negotiated rates, one facility in particular, next I'll focus on facilities because that's they're really the guilty parties here. These are trade secrets previously. We weren't able to write about it. We weren't able to publish it and we know that people are going unbeknownst to them to this particular facility, and they're spending three times as much there versus the same procedure elsewhere. What's more frustrating for me is that there's a perception that you're paying more sometimes and there's a prestige associated with paying more. 80% of Americans don't think like that, they don't operate like that. And there's, there's no correlation or little correlation essentially between cost and quality. We know this and this has been pretty well proven overall.

MA

You see that variation. In the same hospital too with the different insurance plans. So that's even more ludicrous you know, when you have the same hospital, same doctor, same equipment, but that price variation is multiples depending on the insurance plan you're on.

JT

The notion that you can't affect cost outcome or people don't understand is a fallacy. 80% of care is finite and scheduled and known. It's not a trauma. It's not an esoteric sports doctor that are worth every every dollar. They don't have to negotiate. Right? I do agree that there's some efficacy overall. Some of the hospital files and the carrier files do have gaps. We've seen a carrier file that all over the field says "varies." Well, what are the rates why do they vary, what are the two different plan designs, PPO types that you have? Why does it say "varies"? You're punting intentionally right? So yeah, they are.

MA They're being gamed quite a bit. And this is where my goal is to educate the employers and the employees so they know this information exists. They know how to find it, and then they know how to use it. And frankly, if you're an employer in a city and your local hospitals are playing games with this data, it's easy for you to verify that and then it's easy for you to take action and the first action I would recommend employers take is called the board members of that hospital and demand that they comply with the federal government's hospital price transparency Final Rule. The board members are legally responsible for what happens in that hospital under state law. Put pressure on them, apply pressure, demand that they comply with the rule, not gaming the data. And then once that data becomes more available, it becomes more easy to operationalize.

JT Most hospitals that we've seen, they just published a chargemaster in that field because they haven't previously comprehended a consumerism aspect. There's always a payer involved or Medicaid which is also a payer, of course, and they, they didn't do anything with it, they put chargemaster out there. Some are intentionally doing that suggesting that they want to preserve the PPO structure and be paid their negotiated rates. Other more progressive, and perhaps "moral" institutions have used that opportunity to publish a reasonable cash rate. And what we're doing in that scenario is highlighting them to be the ones that actually took took the opportunity to show a reasonable consumer rate.

MA That's awesome that you're doing that, because I think what needs to happen now is we have variation in pricing. That doesn't mean that everybody's bad or that we criticize everybody. We criticize the ones who are overpriced, and then we reward the ones who are giving the fair prices. And so by showing people those cash prices, we then create the incentive for people to offer fair cash prices by rewarding them with with our business, just like we do in other industries, right just just hasn't hit healthcare yet. But healthcare is in the process of being disrupted. And that's why I feel encouraged because I know that there are caveats. You know, there are limitations. There's a lot of games being played but this is new territory we're in. We weren't in this territory five years ago, and it is a big deal to even be able to have these kinds of conversations.

JT Such a large problem that there's bipartisan support, a rarity in this country where there's consensus that these rules will help or at least it's a good start. My perspective is if this doesn't help create measurable results more and more states are going to do what Maryland did - capitate rates you're just not going to make $1 over this for 27447. And that's it. And that obviously has had measurable results for Maryland, right? There's some other gaming going on apparently, where they structure multiple visits and such but that's the alternative so the system is going to need to make itself more efficient. And if it doesn't, I don't believe that, you know, socialized medicine or single payer is in the future of the nation. There's too many powerful constituents and it's just not really the way that the US you know, behaves overall. But we need to, as an alternative make this a true open, functioning marketplace. And it's very promising. We see more and more favorable payment arrangements coming out in states, obviously Texas is leading the way.

JT Oklahoma also I think Oklahoma Surgical Center started a trend and that's in the central United States here. You're in Texas, right? So some of the metro areas their particular procedures are still more costly or challenging. But the next phase in my position, let's talk about certificate of need states. And I haven't seen data yet but we do have certain deserts where in certificate of need states it is extremely problematic. To be able to get basic care mammography type. Less services are charged 10x what Medicare pays. They know full well that the member's on the bubble as to whether or not they're going to need to speak to the financial aid office. They don't encourage or remind the member that they can do that. They just hit him with these massive bills. And is there anything at the federal level that can be done for these certificate of need states? You know, that's the next horizon.

MA No, that's certainly not my area of expertise. I know that those create a lot of problems in terms of allowing new providers to open up and create competition, but I don't have any expertise really on certificate of needs.

JT To be fair, I do think they serve the purpose when it comes to not over building hospitals and too many facilities, but that's not really what's going on behind the scenes, it's protecting pricing. You're completely banning surgical centers that are owned by doctors. Why exactly, what's the motive behind those rules? So I know I'm getting a little bit aggressive about that. People need to understand why certain hospitals and there's no competition and in certain areas is because certain health systems have geo monopolies still, and they can publish those rates. And they are what they are. People can't do anything about it until there's competition in the market. So that's why I'm bringing it up. What have you seen recently, when it comes to effectively helping a member and when they run into a problem with a particular facility, let's assume a facility over an individual provider.

MA The No Surprises Act is another one of these new laws that's been passed that you can be skeptical about it. You can always poke holes in it point out the limitations throughout the caveats. But I've been pleasantly surprised to see some of the things that are in the No Surprises Act that are really actionable for individual patients. And again, those are the people I'm trying to help the most the people who are either uninsured or functionally uninsured because their deductibles are so high and their benefits are so limited. You know that

> **No Surprises Act has a hotline that patients can call if they get hit with an out of network bill, and they can call that hotline and they can get advice about whether that bill is a violation of the No Surprises Act.**

And No Surprises Act protects patients in emergency situations. And also in situations where maybe you go to an in network hospital and get treated by an out of network doctor. And then there are some other scenarios where the No Surprises Act applies and there are some scenarios where it doesn't apply. And honestly I'm not that concerned about the fine print of whether the No Surprises Act applies or not.

Because broadly speaking, if you're a patient that gets hit with an unreasonable like overpriced out of network bill, just the mere threat of being able to call a hotline that is run by the federal government and file a complaint with the federal government gives you tremendous leverage to negotiate and encourage that hospital or whoever that doctor is to give you a fair deal for the services that were provided to you. And so I just wrote a newsletter today that came out today. And if people want to see my newsletter, it's at Marshallallen.substack.com. It's a free newsletter. And the story today was about a woman in Portland named Shellie Schrattenholzer, who went to a hospital for an ultrasound guided wrist injection, and her doctor referred her there saying this is the only place where I can perform this procedure. So she went to the hospital. This was on January 7, so that No Surprises Act just went into effect on January 1. She found out later when she got the bill that this was out of network. It was newly out of network just at the beginning of this year. So she gets hit with a bill for about $1,500 for a simple, short, quick procedure and she knew something wasn't right. And so she reached out to me. We talked through the No Surprises Act. I called the hotline myself to ask about her case. She called the hotline herself. And they said yeah, the No Surprise Act might apply here. This is a case where you could file a complaint. And honestly, I don't know for sure that the No Surprises Act does apply to that case. Again, that's not really my point.

My point is, I wrote a template for her to send to her hospital and her insurance company saying you're out of network bill, overpriced out of network bill, is a violation of the No Surprises Act or appears to be and so you need to not balance bill me for this -- one of the provisions in the No Surprise Act is that the hospital and the insurance company need to come together and negotiate a fair in network rate for that service. So in the letter I said look, here's what you say. This appears to be a violation of the No Surprises Act. You and the insurance company need to sort it out and leave me alone. If you don't, I already called the hotline. They said that my case might be one they could investigate and I will file a complaint against you and I'll do it in 48 hours unless you comply. So Shellie mustered up some courage. She adapted my template for her own use and sent it to the hospital CEO, CFO, General Counsel, billing department again, you got to send it to the higher ups. You need to create the incentive that they need to correct the problem. She got a call the next day with an apology from the manager in the billing department. And they knocked that $1,500 bill down to about $178 and she paid it on the spot.

JT

I think that they call back is a new paradigm. Yeah, right, that's new.

MA

So again, is the No Surprise Act limited? Yes. Does it only apply in certain situations? Yes. But if a patient knows how to use that, now, we have some leverage to incentivize the medical provider to treat us fairly, and be reasonable with their prices. And again, that template is available on my newsletter site. So people can go there and they can use that template themselves. I mean, that's why I wrote it.

That's why I'm sharing it. I want people to be empowered.

JT That's a great detail. There's another facet that I've seen related to reeling in the costs and this will be a little more technical for some viewers. There are different providers and billing entities associated with a service you get at a hospital, there's the facility, there's the physician, there's different supplies, et cetera. And then there's a specialist and or an anesthesiologist for surgeries, in particular. One promising sign that I saw was that it was a major hospital system that told the anesthesiologist in particular we have to comply with AEOB mandate.

Advanced EOB showing the member responsibility portion and you're always a variable cost. You must commit to a par amount of billing unless there's extenuating circumstances in this procedure.

You must commit to a par amount of billing unless there's extenuating circumstances in this procedure. Otherwise you cannot provide services at all at our facilities anymore because you're putting us in violation us the hospital in violation of our our estimate or advanced EOB. That's an unanticipated one, but it makes sense. They don't want to be exposed. It's a real threat to the the health system itself.

MA That's really significant. And again, I've done a lot of reporting on the quality of care. Probably I've done more on the quality of care and patient safety than I have on the cost of care. And it is possible to figure that out, right? It's not like every knee replacement, or all these other 80% of procedures that people just go into every day, they're scheduled. They understand what goes into these things. It's not impossible. Every patient isn't a snowflake, where you have to make it up as you go along. And so that's really great that you heard that. I think that's an important thing.

JT It's predatory. I've seen correlation between the the average income and zip codes and how aggressively they bill for the anesthesiology, incremental part. These are sort of their trade secrets and I'm not going to name names but there's there's patterns associated with where they think they can get the money.

MA I do not think that's ethical. I do not think that is a moral way. When we're talking about people's sickness, they don't have the ability to control whether or not they go to the doctor or whether they go to the hospital. So if you're applying shrewd possibly shady business principles to people's health, that's where it's unethical and immoral. And I think it's important for people to understand that because that then motivates them to say this is not right, this is wrong.

> **We need to stop accepting it. This is normalized deviance. We have come to accept wrongdoing as something that's common in healthcare.**

And now we need to stop accepting it. And so as these things become more exposed and known and out in the open, it becomes more obvious to people why are we tolerating this? And then hopefully, the employers and the employees will begin to do things differently and that's what I love about what you all are doing and others like you are saying "we're offering a better way forward here." Now people need to have the courage to take it.

JT

I appreciate it. We are on the same mission. It's a very, very large, complicated industry. We don't influence all users but we are on the same mission, which is to genuinely improve the access and understanding of care and transparency associated with cost and quality metrics so people can make reasonable decisions and they're really not faced with these, let's call them predatory billing practices. Because that's what they are.

MA

And that's how the disruption happens. You know, there's the early adopters. You see now that employers can save 10, 20, 30, 40% even more by changing the way they engage with the healthcare system, and employees can save hundreds or 1000s of dollars per encounter, if they just understand that they need to engage the system in a different way. You know, there's a lot of direct contracting going on now where employers are designing their health plans to direct contract for let's say it's the birth of a child or a joint replacement, where they will identify the medical providers will be fair and reasonable with their pricing and who are also high quality and the plans I've seen you know, the patient can still choose to go to a different hospital if they want with a different doctor, but then they're going to pay the cost sharing and the plan. Whereas if they want to go to say a knee replacement is $25,000 through direct contract versus $80,000 outside of the direct contract, which it could be a spread that great. Well, your cost sharing is going to be zero. If you go to the direct contracted provider. It's going to be whatever it would normally be with your deductible and coinsurance and copayments if you choose to go outside that direct contract. So that's that's how this change is happening. And the exciting thing is, is that it's happening right now, so people need to get on board with it.

JT

Before we break. I wanted to see what's your next speaking enagement? When will you be on the stage in front of the industry luminaries. Next you will be at SIIA for example?

MA

I'll be at the Texas Association of Health Plans which I'm really looking forward to that's coming up in November. I have some other events that are also coming up soon. So yeah, I love to do the speaking. It's really fun. I also do you know a fair number of webinars like this one. I just did one recently for Voya Fnancial, the big stop loss carrier. Yeah, it's fun for

me and if people want to find out more again, my newsletters the best place marshallallen.substack.com And then marshallallen.com. And my my videos that curriculums at allenhealthacademy.com

JT Fantastic. I appreciate it. We have some things to talk about. We launched a few large groups in Texas and perhaps you can help out with them. That's awesome. Love it, Marshall. Thank you. I appreciate your time and the mission that you're on. Keep fighting the good fight!

MA My pleasure. Thank you.

JT Folks. That's a wrap on podcast number two. Great time spent with Marshall Allen. If you have any questions related to helping with cost containment in the healthcare space, you're in the right hands contact Medxoom or Marshall, and we are happy to help. I'm very encouraged by the progress, rather prompt progress, this year related to the efficacy of the mandates and the legislation that's helping to pull this data out into the sun and to help create meaningful savings and improvements ever experienced in our health care ecosystem. Thanks again. Speak to you on the next one in the next few weeks. Thank you. Take care