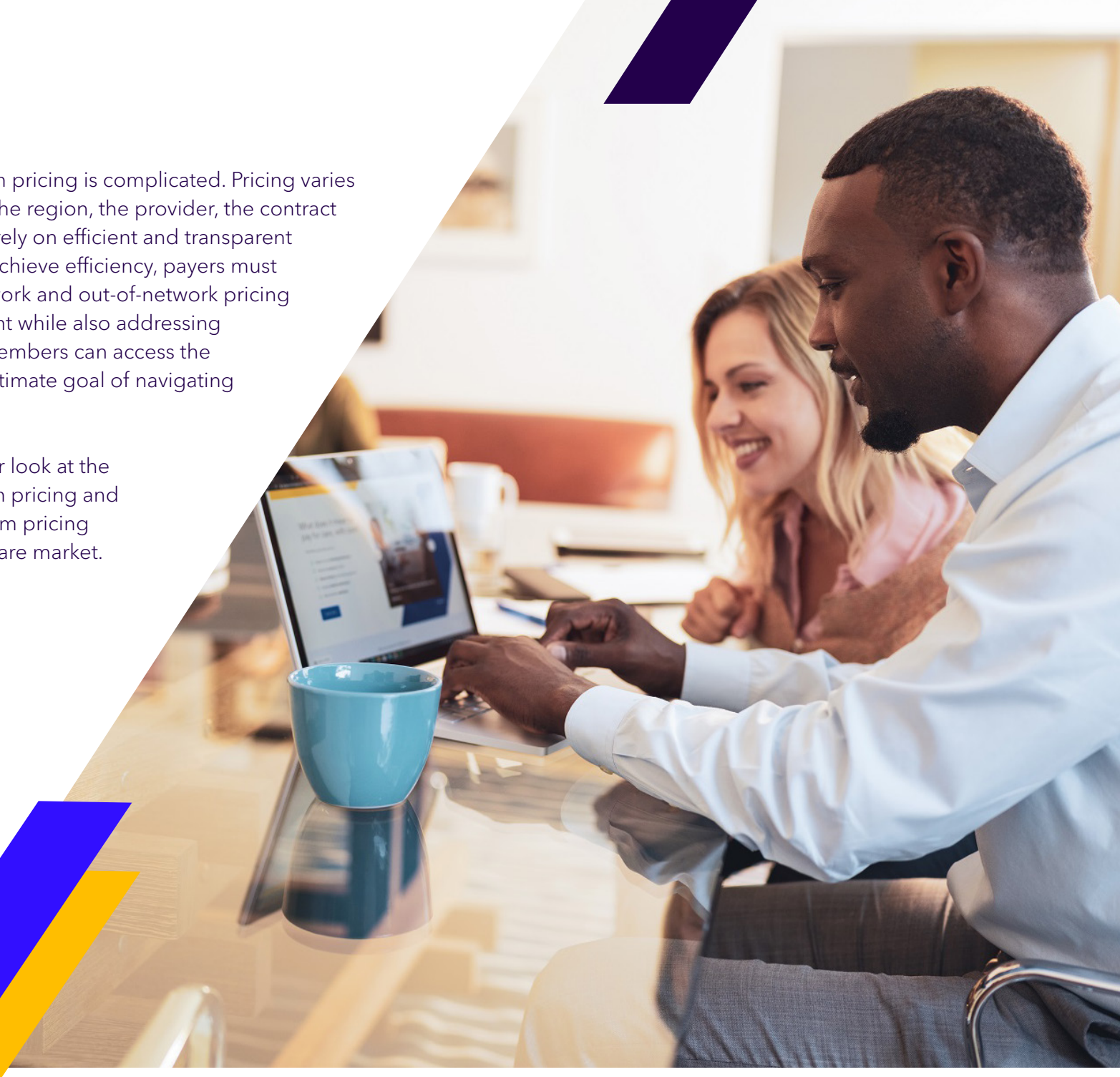
Balancing Rising Healthcare Costs with Complex Claims Pricing Considerations

zelis

Introduction

The landscape for healthcare claim pricing is complicated. Pricing varies widely depending on factors like the region, the provider, the contract and the network status. Providers rely on efficient and transparent claim pricing and processing. To achieve efficiency, payers must navigate the challenges of in-network and out-of-network pricing in a shifting regulatory environment while also addressing the rising cost of care. Ensuring members can access the affordable care they need is the ultimate goal of navigating these complications.

In this whitepaper, we take a closer look at the ways regulations are shaping claim pricing and how stakeholders can address claim pricing challenges in the evolving healthcare market.



Regulatory impact on pricing

The No Surprises Act (NSA) went into effect at the beginning of 2022, creating waves in the claim pricing space. "The NSA is currently the most influential legislation shaping the market," says Maisie Weir, vice president of sales at Zelis.

The NSA was enacted to protect consumers from unexpected bills stemming from out-of-network emergency care. Thus far, the NSA seems to be delivering on that promise of consumer protection. In the first nine months of 2023, consumers were shielded from more than 10 million surprise medical bills, according to a survey conducted by AHIP and the Blue Cross Blue Shield Association (BCBSA).

While the NSA has benefited consumers, its enactment has led to an increase in disputes between providers and payers through independent dispute resolution. "The concept of the No Surprises Act was that providers would join in-network agreements to increase patient access to affordable care. However, what we're seeing are providers opting out in favor of engaging IDR processes," explains Weir.

Federal agencies estimated approximately 17,000 claims would go through the federal IDR process each year. However, the number of disputes exceeded those estimates, reaching 334,828 from April 15, 2022, to March 31, 2023, according to AHIP and BCBSA. The Brookings Institution dug into CMS data on IDR disputes and found that the median decision across three service categories is at least 3.7 times Medicare reimbursement.

In the first nine months of 2023, consumers were shielded from more than 10 million surprise medical bills.

Estimated IDR claims:
17,000

Actual IDR claims:
334,828

Median IDR decision:
3.7 x Medicare reimbursement

Payers are now in a challenging environment where contracted rates are often escalating.

In addition to the NSA, payers must contend with the nuances of state-level requirements that address healthcare coverage, pricing and payment in different ways. Texas introduced a law addressing ground ambulance services, banning surprise bills for consumers with state-regulated insurance plans -- just one example of the many state-level laws payers must comply with when managing claims pricing.

For payers serving multiple markets, this can swiftly become a complicated matter.

In-network pricing challenges

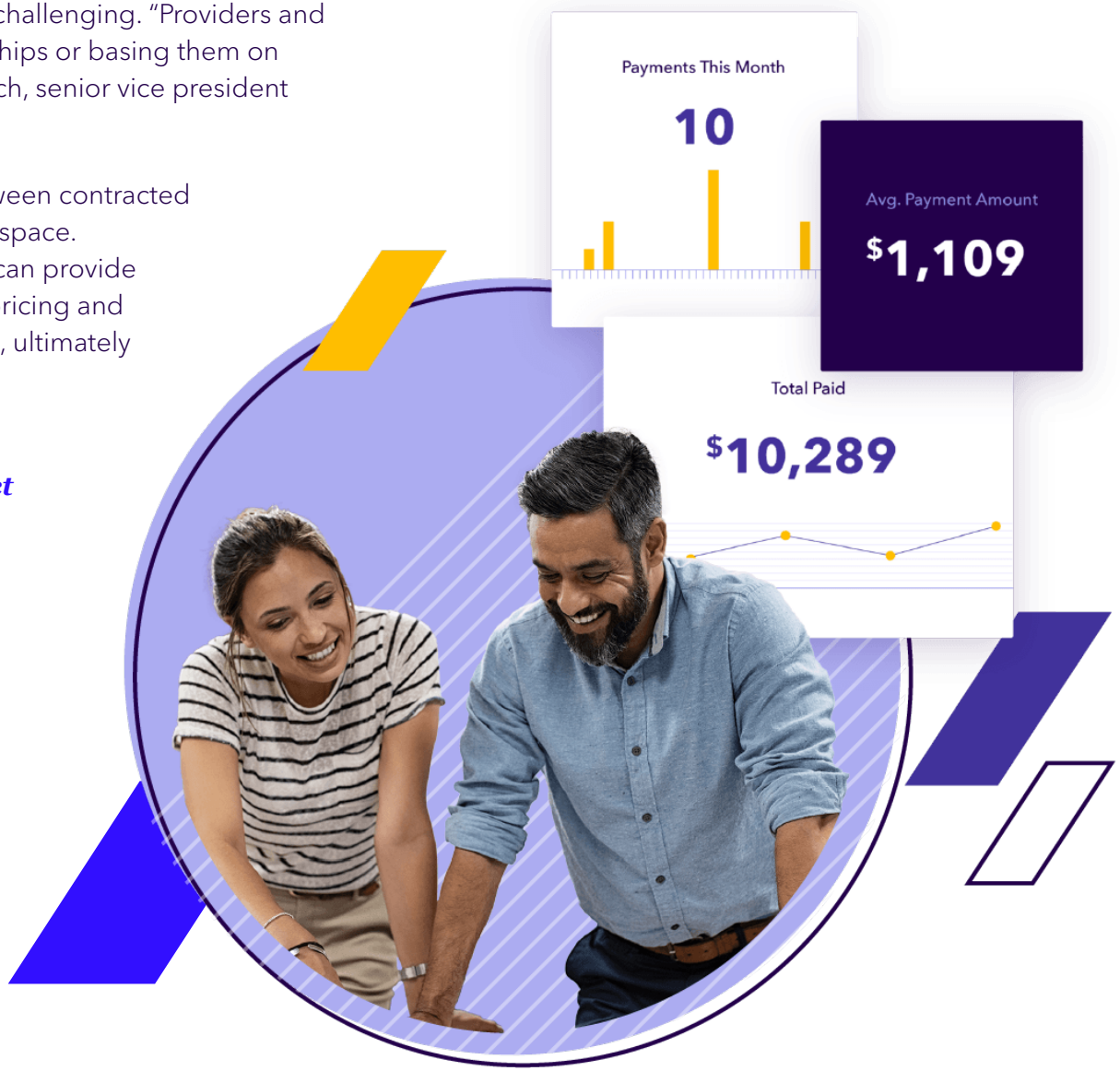
Contracts dictate in-network relationships between payers and providers, but contracting and billing in these relationships are still challenging. “Providers and payers are now entering unique contracting relationships or basing them on Medicare to establish a benchmark,” says Mary Piecuch, senior vice president of product strategy at Zelis.

Without transparency, reconciling the difference between contracted rates and billed amounts complicates the in-network space. “A strategic claim pricing partner with the right tools can provide that transparency,” Piecuch adds. “Automated claim pricing and adjudication can improve efficiency and reduce costs, ultimately improving how payers manage their networks.”

Data transparency remains vital as payers manage their networks and negotiate contract rates with providers.

“Everyone is disclosing their availability and contracted rates, but the question is how we can use this now publicly available information to empower payers to improve their contracting and reimbursement strategies in the marketplace,” Weir notes.

A strategic partner can take a holistic view of a market, mine the relevant data and build a plan for claim pricing that addresses the general and unique challenges a payer faces.



Out-of-network pricing challenges

Historically, the out-of-network space has not been tightly regulated.

"Out-of-network claims force payers to operate outside of their standard reimbursement models," explains Carrie Gardner, vice president of product, out-of-network, at Zelis. "Unfortunately, the result is often patients being balanced billed for services."

However, the NSA has introduced regulation in the out-of-network space. Payers must consider the impact of this regulation while they manage the cost and complexity of out-of-network claims. Negotiation and compromise are essential elements in addressing out-of-network pricing challenges, and they require both the ability to leverage data and strong relationships with providers.

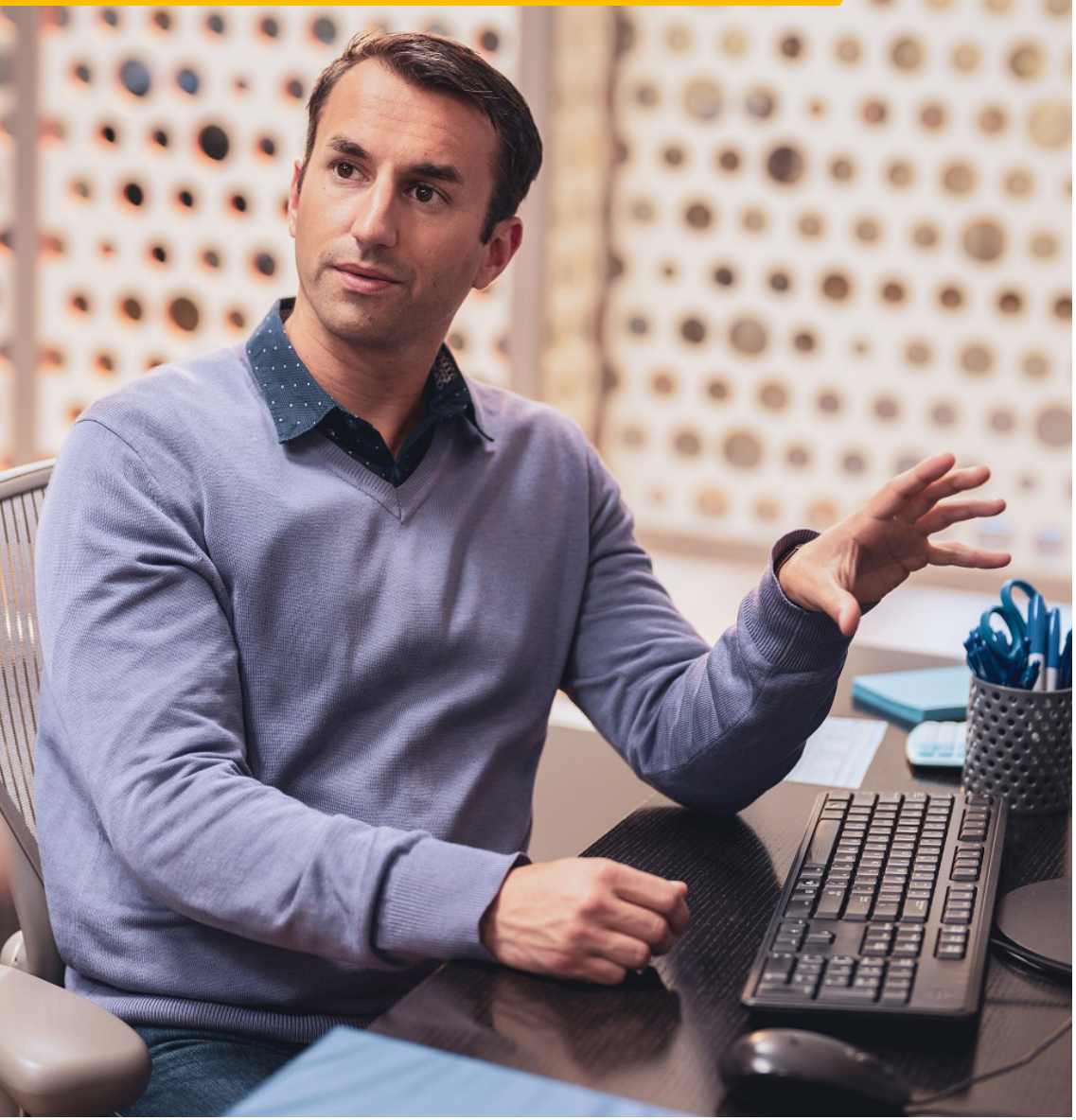
"The right partner takes a more hands-on approach, focusing on building relationships to achieve valued savings, rather than merely consistent discounts that may not be optimal for everyone involved," says Gardner.

The advent of the NSA regulation in a previously unregulated space leaves many payers facing a gap. How can they handle this new market dynamic that is anything but stable as legal challenges to the NSA continue?

The right strategic partner has the technology and service model offerings to keep payers up-to-date and compliant in a changing landscape. "A true partner maintains diligent oversight, keeping stakeholders informed and responding to legislative changes on behalf of clients," says Gardner.

Claim negotiations require the ability to leverage data and strong provider relationships for success.

Regulatory changes introduced by the NSA and at the state level are shaping how payers approach claim pricing.



Market dynamics and strategic responses

As market dynamics continue to shift, payers are under increasing pressure to manage the complexities of both in-network and out-of-network claim pricing.

Regulatory changes introduced by the NSA and at the state level are shaping how payers approach claim pricing. Changing dynamics among their member populations are also at play. In the wake of the pandemic, more people are working remotely, oftentimes for employers far beyond their geographic areas. Supplemental networks can help address this challenge, providing additional coverage for those located out of network.

Payers need a partner capable of helping them build a strategy that provides the best in-network coverage possible and achieves savings for the out-of-network space that will always exist.

Out-of-network costs continue to rise, leaving payers to ask questions: How can we balance these rising costs while limiting the impact they have on providers and members? How do we be an effective partner and reduce the friction they are experiencing?

Some large payers with dominant positions in a specific market can successfully create a cohesive approach to claim pricing. But achieving that becomes much harder in highly competitive and out-of-network markets.

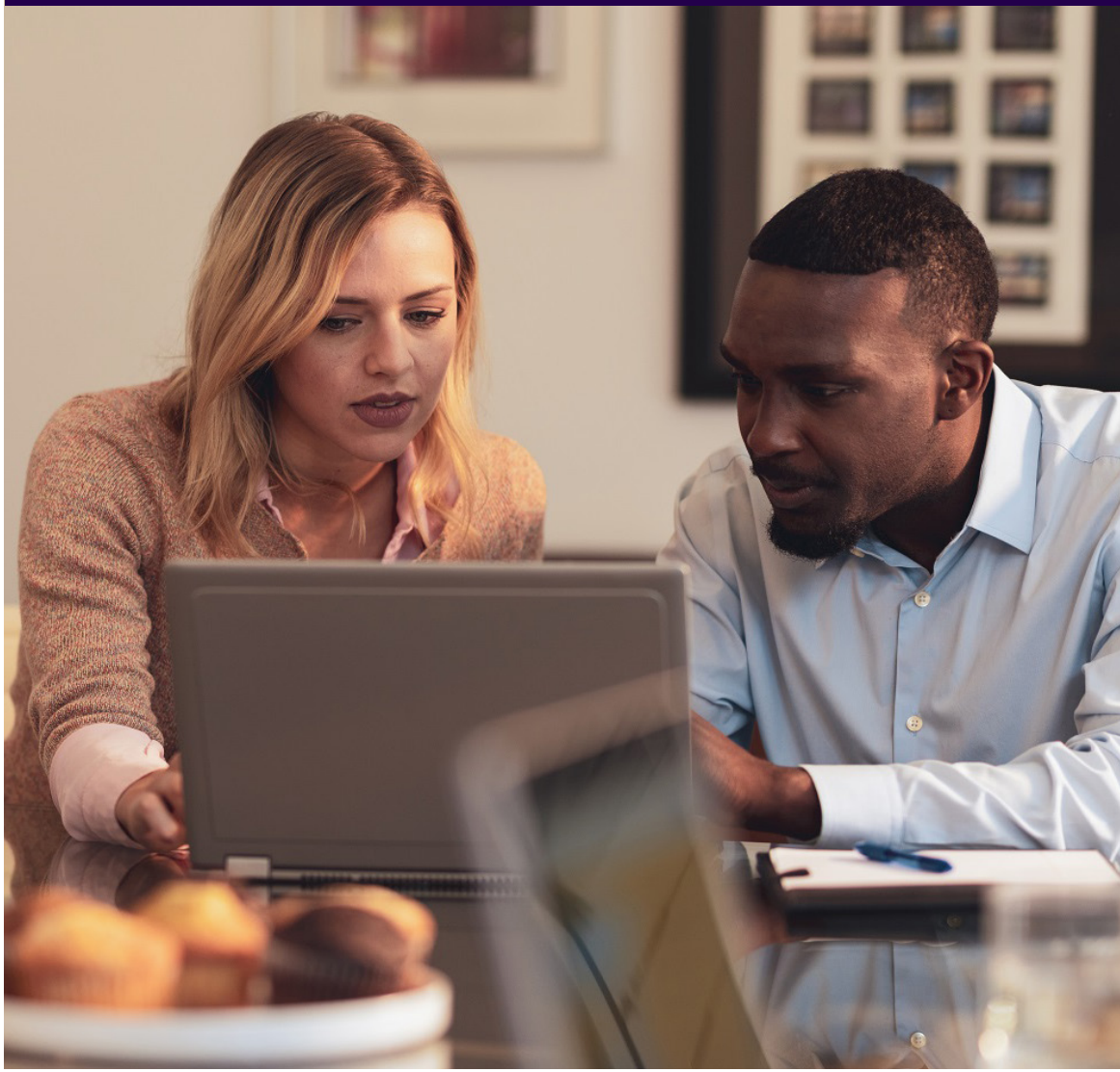
"Outside their service area, health plans find operating effectively without a partner challenging. It's rare to encounter a health plan or large payer that doesn't engage a partner to support their strategic efforts," Weir pointed out. "In competitive situations, health plans certainly need a partner equipped with the insights, data and experience to empower their strategic initiatives."

Insights and data specific to a payer's market empower them on both the in-network and out-of-network sides of the business. Harnessing that data creates more transparency in the claim pricing process, ultimately helping to develop stronger relationships between payers and providers.

The right strategic partner can also leverage that data to make the entire process around claims, from pricing to processing and payment, more efficient. "Our ability to achieve 99% auto adjudication on in-network claims brings down the cost of those claims and pushes it through for accuracy," says Piecuch.

While data and technology are critical components in solving the challenges of claim pricing, they are not the whole answer. Payers also need a service-oriented partner that recognizes their unique needs and their members' unique needs. Does a partner have the resources to build relationships with providers and lay the groundwork for effective negotiation? Does a partner have the right combination of people and technology to reduce post-payment disputes? Does a partner have the right support in place to educate, empower and assist members with balance-billing situations?

Our ability to achieve 99% auto adjudication on in-network claims brings down the cost of those claims



The role of data and technology

Claim pricing in both the in-network and out-of-network spaces requires strategic decision-making backed by data. “Having source data is a challenge in the industry,” says Piecuch.

Accessing essential data and finding the actionable insights necessary to power claim pricing decisions can be costly. For many payers, the technology required for data analysis rests outside their organizations.

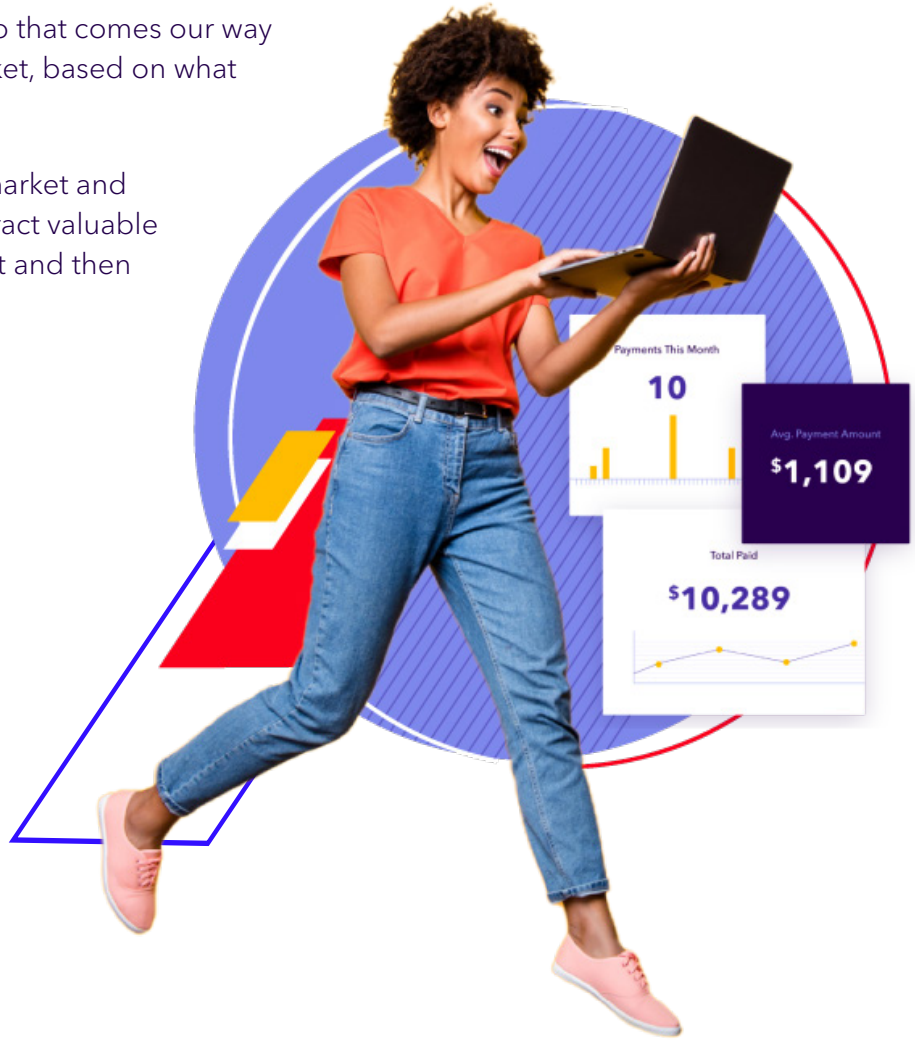
“At Zelis, we’re prepared to partner with our clients to handle any type of scenario that comes our way based on what we’re seeing in the data, based on what we’re hearing in the market, based on what we’re hearing from our clients,” says Weir.

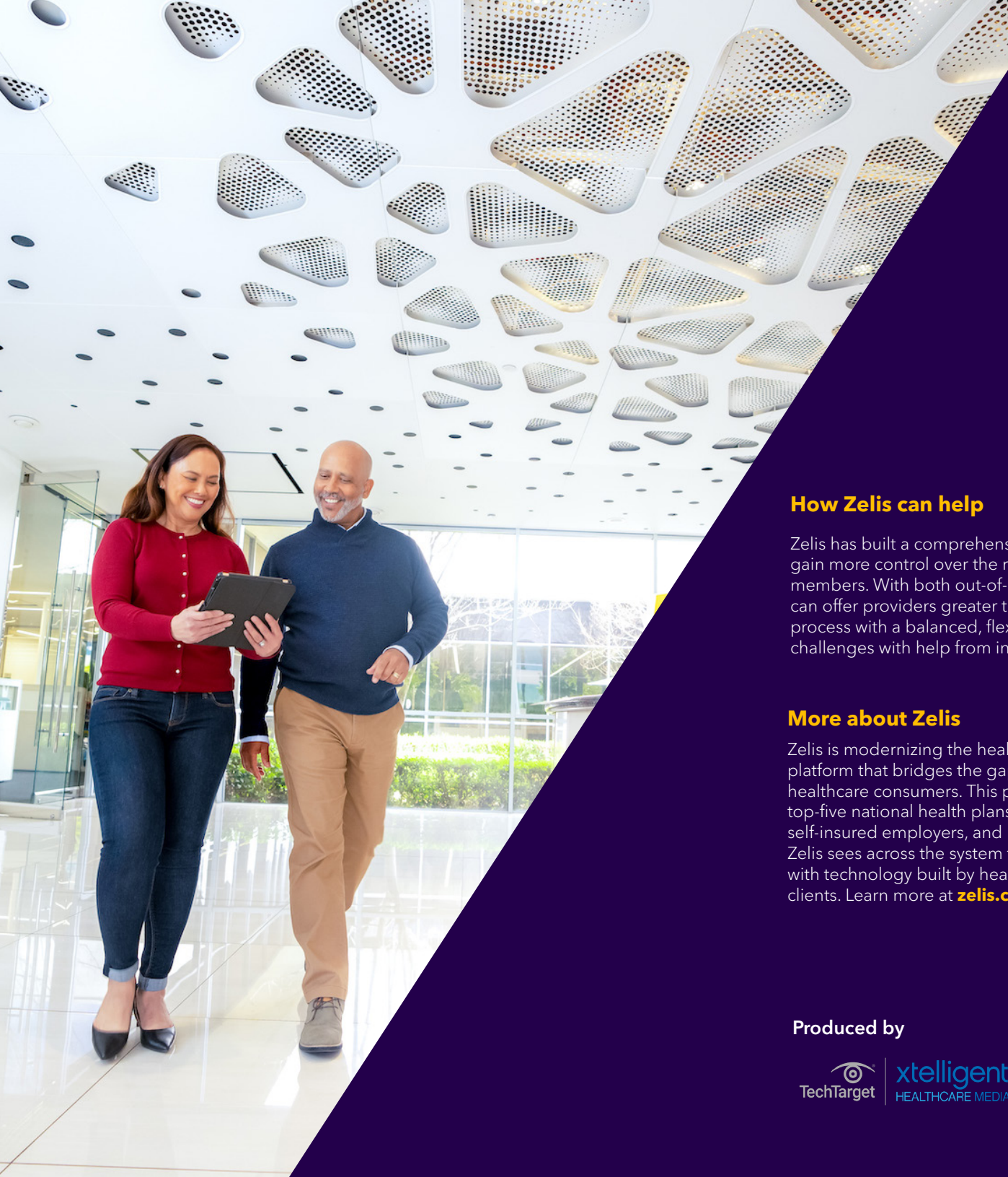
“It’s crucial for health plans to partner with a vendor who can analyze the entire market and determine the best approach,” explains Weir. “This partner should be able to extract valuable insights from data, identify what is most relevant to a payer in their current market and then collaborate closely on strategic planning.”

Out of necessity, payers are very focused on the needs of their members today. The demands of claim pricing and processing on a day-to-day basis can make planning for the future challenging. How could potential regulatory changes at the federal and state levels impact a payer's claim pricing strategy?

“Having access to data and support is crucial for developing strategies and processes that keep the payer, provider and member needs in mind for next year and beyond,” Weir stresses.

The outlook for healthcare claim pricing is difficult to predict, but the complexity of the space ensures challenges, old and new, will continue for payers. Instead of trying to find a path forward alone, payers can work with a partner that understands the nuances of their market and has the data, technology and people to tackle those challenges on their behalf.





How Zelis can help

Zelis has built a comprehensive suite of claims pricing solutions that help payers gain more control over the rising costs of healthcare to better support providers and members. With both out-of-network and in-network claims pricing solutions, payers can offer providers greater transparency into how claims are priced, strengthen process with a balanced, flexible approach to claims pricing and reduce compliance challenges with help from in-house experts. Learn about Zelis solutions **here**.

More about Zelis

Zelis is modernizing the healthcare financial experience by providing a connected platform that bridges the gaps and aligns interests across payers, providers and healthcare consumers. This platform serves more than 750 payers, including the top-five national health plans, BCBS insurers, regional health plans, TPAs and self-insured employers, and millions of healthcare providers and consumers. Zelis sees across the system to identify, optimize and solve problems holistically with technology built by healthcare experts -- driving real, measurable results for clients. Learn more at **zelis.com**.

Produced by

TechTarget | xtelligent HEALTHCARE MEDIA

zelis