3 ways businesses can cut waste, fraud, and cost in health care plans

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Employers, health care providers, and insurers may see employee health care from very different perspectives. But there's one thing they can agree on: health care costs are too high.

Studies by health care organizations point to waste and fraud as key drivers of those costs.

Employers in the U.S. pay up to 25% of their health care spend on waste and fraud, according to a study in the Journal of the American Medical Association. That's money they could have spent to grow the organization and employee wages.

The National Health Care Anti-Fraud Association estimates financial losses from health care fraud amount to tens of billions of dollars each year. The Journal of the American Medical Association estimated in 2019 that waste in U.S. health care ranges from $760 billion to $935 billion annually.

There are countless ways fraud and waste can manifest in the health care industry, but here's a list of several of the worst offenders.

Key sources of health care waste and fraud

Lack of coordinated care. Examples include physicians ordering duplicate tests and multiple diagnostics, largely because patient information is not efficiently shared or transferred. Effectively the left hand doesn't know what the right hand is doing.

Brand-name prescriptions. Using high-cost, brand-name prescription drugs is an unnecessary extra spend when generic, lower-cost, equally effective alternatives are available.

Unnecessary treatments that offer little or no benefit. An example cited in Harvard Men's Health Watch is spinal fusion. This is a costly procedure that, in many cases, is ineffective and may cause more harm than good in the long term.

Inappropriate level of care. One example is when a patient seeks care for a minor ailment in an emergency room. Another is when a surgeon performs a procedure in a hospital setting rather than in an outpatient setting. Shoulder and knee surgeries and kidney stone treatments are often performed at a higher-than-needed level of care.

Fraudulent billing practices. The Centers for Medicare and Medicaid Services lists among common fraudulent billing practices: billing for no-show appointments, claims for more complex services than those rendered, or claims for services not performed.

The good news is that much of this unnecessary cost is avoidable. More importantly, businesses can take steps to help reduce waste

and fraud.

What businesses can do to reduce waste, fraud, and cost

Select an intrinsically monitored network. Medical groups that monitor and take responsibility for medical costs while focusing on evidence-based care will always deliver better care and value for an organization's health care plan.

Select an accountable care organization (ACO) that's not owned by a hospital. Providers in an ACO that's not owned by a hospital prioritize keeping patients healthy and out of the hospital, rendering outpatient treatment whenever it's clinically appropriate. In health care, the "setting of care" has a huge impact on cost. Outpatient settings, when determined by the treating physician to be clinically appropriate, offer significant savings. Keeping your employees out of the hospital when appropriate can mean huge cost savings for both employers and employees.

Focus on quality, not quantity. In health care networks, bigger isn't always better. When you consider the impact that fraud and waste can have on your organization's costs, it makes sense to select a smaller, more cohesive network. A medical group network practicing evidence-based medicine can go a long way in controlling the waste — and the cost.

By taking these steps, employers can play a big part in controlling their organization's health care costs while ensuring their employees get access to high-quality care. That's a win-win formula. When employees stay healthy and happy, they help drive operational consistency. Lower total health care cost saves money to reinvest in the organization's growth.

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