Feature Article:

REFERENCE BASED PRICING…
THE KEY TO SOLVING THE HEALTH INSURANCE INDUSTRY'S COST ISSUES??

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The Problem

With our US Congress and Trump Administration still unable to solve issues on health care, and with California still facing the possibility of Single Payer ballot initiatives, it's time we started thinking of the root of the problem… The COST of health care. Everyone talks about the uninsured, the discontinuance of subsidies, but how about talking about the real problem? *We have the greatest health care system in the world!* We don't have to wait in line for important services, we can call and make an appointment and get in to see a doctor, or schedule an MRI or CT scan quickly… we don't have several months' wait for basic services. Medical miracles save millions of people a year and make people's lives better. *The problem is, the costs keep going up, and no one seems to care about doing anything to stop that.* Yes, insurance premiums keep rising, but why is that? Is it because the bad old insurance companies are the problem? *No, it's not!* The true cost of the problem, in my opinion, for whatever it's worth, is that the medical providers' costs keep going up, with facilities often marking up retail rates 300%, 500%, 600% or more... That's one heck of a mark-up….and no one is doing anything about it! *Facilities, particularly, can charge whatever they want, and it's all a mystery as to how that number for a particular service or stay is actually calculated*. And better yet, the exact same service at the exact same facility could be 5 different numbers, depending on who is paying for it! What's wrong with this picture?

What's wrong with this picture is that, as many of us in the industry have been saying for too many years to count, medical care is not transparent, and the prices charged are completely arbitrary. Does anyone *not* agree with that? Well, good, we have a common starting point… So why don't we take a look at that part of the puzzle, and try to come up with ways to make health care more cost effective and predictable? And by doing so, perhaps lower the cost significantly, so more people can afford it, and maybe then the subsidy problem wouldn't even be an issue, and the young, healthy population might actually want to sign up for coverage, making the pool larger, and bringing costs down further? But how do we do that?

There is a little known (in California, at least) solution that's been successful in other parts of the country, but for reasons sort of unknown, or just not talked about (more on that later), it's been slow to hit the west coast, particularly California. It's called Reference Based Pricing.

What is Reference Based Pricing?

Reference Based Pricing (RBP) is a health plan financing strategy leveraged by large, mostly self-funded employers that can result in significant reductions in claims cost, while providing freedom of choice of providers and complete transparency of the true costs of facilities/hospitals. Yes, I said it; you don't have to read it three times… ***Transparency…*** I'll talk more about that later. And I'll also talk about the idea of perhaps the fully insured market getting involved with reference based pricing… More to come on that as well.

A reference based pricing model replaces the traditional facility PPO contracts with a fully transparent and sustainable pricing mechanism, by using a percentage of Medicare Rates as the payment allowance benchmark. Compare this to the unknown "discount" of a PPO network, which is unpredictable and varies greatly by provider and service. PPO contracted rates are generally a hidden, arbitrary number. So, no transparency, no consistent

starting (or base) price. As Ryan Day, President of HST in Irvine, a reference based pricing vendor, says, it uses a "bottom up, rather than a top down" pricing model.

Reference Based Pricing reimburses hospitals and other facilities based on a multiple of Medicare rates, which is known, fair and acceptable to most providers. Because the rates are generally higher than Medicare rates (most commonly 140% to 150% of Medicare), most facilities accept this pricing structure. According to Dave Fear Sr, Principal of Shepler & Fear in Sacramento, 90% of facilities now accept Medicare rates. So, a higher RBP model should logically be acceptable.

So how does this work exactly? Prior to services being rendered, a fair price is established based on the Medicare rates. Both the provider and the patient can be advised up front of their costs, because they are known in advance. That means that the patients (and the employer, in a self-insured health plan) have transparency of their health care costs, up front, making them predictable and known. *No more guessing games from providers.* Providers are advised up front of the RBP plan, and they agree to those payment amounts before the service is provided. As a successful type of trade-off to providers, plans usually offer a "fast pay" protocol, usually in 7 to 10 days, to incentivize providers to accept this payment model.

RBP vs PPO

RPB plans can have "open access" to all facilities, or a self-funded employer could lower out-of-pocket costs for select facilities known to accept RPB without issue, by plan design. So, no more PPO network for hospitals and facilities… As a comfort level to employers, RBP plans can still use a PPO provider network for physicians. This is quite common. Honestly, I can't see not using a PPO provider network for doctors (at least in the short run), because I can't see small providers understanding the RBP model; at least not yet. Some popular PPO networks, however, won't allow plans to purchase the doctor only network currently, so changes in physician networks may be required. There is talk, however, that more networks may be working on adjusting to this new model by offering stand-alone physician networks in the future.

But why would you want to get rid of the PPO contract? Many PPO contracts have shown consistent decreases in claim cost, there is no question there. Some of the largest PPO networks tout 40% to 65% off of the rates. But that's where the waters get murky…. *Forty to sixty-five percent off of what rate?* What is the base rate that the provider charges? That is a mystery to us all. And it changes based on whose PPO contract it is that the patient is covered under. A hospital doesn't tell us up front what the cost of the charges will be when someone calls in for insurance verification. Yes, the patient and the carrier or administrator can know what their co-pay is, or if there is coinsurance involved, but no one knows the cost until the bill arrives… and then we see this PPO write-off number, so we can see the tremendous "savings" to the self-funded health plan. But if five people with different health plans had the same service at the same hospital, I can pretty much guarantee that you would see 5 different facility charges (base rate), before the "discount" was subtracted. In some hospital PPO contracts, the "discount" is taken off of a contracted rate, some have per diem rates, or sometimes, it's taken off the billed rate, which, again, varies GREATLY depending on who is providing the health coverage.

Buyers Beware?

According to Ryan Day, President of HST, it's a "Buyers Beware" market. "Here we are; we've purchased something [and] we have no idea what the cost is.. We're just supposed to trust people that give us discounts… What they're off of NOBODY KNOWS, but hey, I negotiated with the hospital, I'm your carrier but don't worry… I negotiated a good deal but, by the way, you can't see it…" Does this sound at all like our current health care model?

Under the buyers beware market, according to Ryan, " You have no recourse, and we can't really tell you what the price is... and it's like *we don't buy anything else that way… We would never buy a car that way, we would never buy a mortgage that way, but when it comes to medical it's like, here I go!* I don't know how everybody got trained to just operate that way. And I think, data wasn't there before previously, and now data is there. In the sense that, WOW, I can know what Medicare's paying for that because Medicare releases all their information, and then I can see exactly what the cost is for that hospital too." Reference based pricing, according to Ryan, is a way to keep those costs in line, and make that buyer indeed, more aware.

Cost Examples

Let's take a look at a few examples. In the first example, provided by HST, a hospital charges $75,000 for a procedure and offers a 40% discount off of the billed rate, allowing $45,000, or a PPO contract rate of $45,000. This is traditional PPO discounting, or top-down pricing. In contrast, the **RBP plan pays 140% of Medicare**, or $22,250. This results in a savings of $22,750 (PPO cost of $45,000-RBP amount of $22,250) for this procedure. This is "bottom-up" pricing. That's real savings. No arbitrary starting point. We start at a known price.. the Medicare allowed price, and the plan offers payment at 140% of Medicare. Most providers already accept Medicare pricing, so this should be a relatively easy sell, since this is offering a fair price, and a higher price than they are currently getting for Medicare patients.

In another example, provided by Shepler & Fear, a General Agency that offers reference based pricing in some of their self-funded plan quotes, let's take a base rate of a service of $150. This is the rate reported to Medicare as the actual cost of the service. The provider's billed charge for that service is $900, or a 600% mark-up for that service. In this RBP example, the Medicare allowed charge for that service is $225, or a 50% mark-up (i.e. 150% of Medicare). The Medicare allowance is based at 125% of the cost (paid at $187.50). Comparatively, the PPO network allowance for that same charge is $420, or a 280% mark-up. *So if you're the self-funded employer footing the bill, would you rather pay the $225 or the $420?* If that's my company's money that's being spent, I would obviously rather pay the $225. So, yes, the PPO network price is less than the provider's billed charge, but it's still more than the RBP rate for that same service. That's the difference with reference based pricing.

Consumer Fear of Medicare Acceptance

There is a wide-spread consumer fear of providers not accepting Medicare rates and being turned down for care. I think a lot of this is confusion between the difference of Medicare payments and Medicaid (MediCal in California) payments. According to the American Hospital Association, hospitals received only 89 cents for every dollar spent by hospitals caring for Medicaid patients in 2008, and 91 cents for every dollar spent on Medicare patients in 2008.[1] This underpayment is then offset by charging much higher rates for other patients. According to that same report, 53% of hospitals received Medicare payments less than cost, while 56% of hospitals received Medicaid payments less than cost. There are arguments, however, to these numbers, as that report was created in 2009, and things have changed since then. *Even if this were the case, if RBP payments are based at an amount of 140% to 150% of Medicare rates, the hospitals are still making a profit on those services being provided.*

According to Dave Fear, Sr of Shepler & Fear, the Medicare system now pays Medicare providers in a more equitable manner (125% of the cost, or a 25% markup above cost).

Another consumer fear is that most hospitals don't accept Medicare patients, so perhaps they wouldn't accept my plan with reference based pricing, since it's based off of Medicare rates.

According to Medicare specialist Ryan Dorigan, Regional Sales Manager, AGA, " [Only] the VA (government-funded care for veterans) and Shriners (free orthopedic and burn care for children) are pretty much the only two [that do

not accept Medicare]. Other military hospitals for active-duty soldiers probably don't either. A quick Google [search] also points to facilities run by Indian Health Services as nonparticipating hospitals. There are likely some other odd exceptions, *but the vast majority of hospitals in the US participate in Medicare Part A for inpatient services*. More clinics, physicians, and providers, such as the Mayo Clinic, do not participate in Part B, which covers physician fees and outpatient services." But for facility care, consumer fear of not being able to receive care at hospitals and facilities is no longer true.

According to Ryan, it's pretty simple to see if your local hospital accepts Medicare patients. You need only logon at Medicare.Gov and use the hospital locator to find hospitals anywhere in country that accepts Medicare.

Dave Fear Sr, from Shepler & Fear, stated that in many of the "sunbelt states," you will see hospitals advertising to seniors to use their hospitals. If the hospitals were losing money on Medicare payments, according to Dave, they certainly would not advertise to get more of them…

Another fear may be the facility provider over-billing in other areas if they are locked into a RBP payment model. If they are, for example, limited to 140% of Medicare, and receiving only $22,500 from the example above, we would want to be sure they are not adding additional charges for fraudulent services, or overcharging on complications that would generate new items to bill on. So perhaps the old fashioned hospital bill audit program would be something to consider if using a RBP model.

Implementation & Education

It's important to note, however, that education of the employees and HR department of the employer is key here. *What we need to prevent is the provider push-back, or their desire to try to balance bill the patient.* For this to work most effectively, covered employees and dependents should be given advance education of RBP. " I recently attended the SIIA conference in Phoenix where they put on several panels by employers who talked about their experiences with RBP," commented Dave Fear Sr. " The learning curve is somewhat steep because there are a lot of things that must happen for RBP to be successful. It's not just the money savings, but it is the way that people obtain their health care and interface with their providers. Thus employees and employers must invest some time to implement RBP carefully. Agents need to work with RBP vendors who can help develop employee education programs, communicate the issues and then provide follow up customer service to both employees and local health care providers so that all parties are on the same page. This is not an easy task nor is it inexpensive. Brokers need to work with TPA's who have RBP service staffs and with RBP administrators who have strong back room service – including a legal team that can work with providers who are resistant to non-balance billing provisions of RBP programs." But, if done properly, it can and has been successful.

In a small amount of cases, these employers need to know that provider push-back can occur. In those situations, anyone interested in in RBP model needs to know how to handle those situations. "You want employer groups, before they even make their decisions, to know all the ins-and-outs," said Ryan Day. " I'm not trying to sell you a bag of goods, saying like 'Hey everything's roses over here; don't worry about balance billing… its never going to happen.' That's not it. You're *going* to get balance billing. It's going to happen 2% of the time,[but] when it happens, here's what we're going to do." So, for most self-funded employers using RBP, it's 98% effective without balance billing, but you have to be prepared to handle that 2%. In HST's RBP product, they offer a patient advocacy team to handle those situations.

What are the Savings?

What types of savings are self-funded health plans that have implemented RBP seen? Most RBP vendors estimate about 20% overall claims savings (the highest cost of any self-funded health plan) when you use reference based

pricing. In addition, there are premium savings of 8 to 20% on excess loss premiums, reductions on aggregate factors, and in some cases, savings on RBP administration fees vs. network access fees. So, overall, in a million dollar health plan, that can be substantial.

I asked Dave Fear Sr. what types of savings he's seeing in the RBP plans he's sold. "That really depends on the carriers and we are seeing changes constantly as those carriers learn about RBP and how it works. Currently we are seeing products with RBP programs come in 10% to 30% [overall] less than those with traditional PPO's. A lot depends on geographic areas (as is true with Medicare reimbursement payments too) and the underlying plan design. I'm not seeing huge discounts on the specific and aggregate premium rates yet, but am seeing aggregate attachment points lower when RBP is used compared to a PPO plan. So far the claim savings I'm seeing are strong for facilities and not as strong for physicians. But then again, the facility costs have always been the higher cost of the two anyway."

MaryAnn Wessel, Vice President at EBA&M, a Costa Mesa- based TPA, reported that they are seeing approximately 9.6% off specific rates and 8.5% off aggregate factors for RBP plans.

US Benefits, an excess loss carrier in Irvine California, is quoting a range between 9 to 20% off specific rates and 8 to 13% off aggregate factors for RBP plans, depending on the percentage of Medicare being used. They report that it's "still relatively new but there has been quite a bit of interest in seeing this as an option in comparison to traditional PPO's."

In self-funded plans, the specific and aggregate premium are small portions of the total cost of the plan. Aggregate factors represent the worst case scenario for claims. It's the claims savings themselves that are the largest portion of the savings.

Why is California Lagging Behind?

So why haven't we seen this type of pricing model much in California to date? After all, California is often looked at as a pioneer in health care concepts. "I agree that California is a pioneer in new concepts, but unlike other states," commented Dave Fear Sr., "it is also dominated by powerful health care systems which are tough to regulate and control. These systems have great power in their ability to demand higher payments from payers (health plans, insurers, self-funded employers). Without naming names, I think that some health care systems border on anti-trust activities with their domination of the health care marketplace."

I asked Dave Fear Sr. if he could offer a few simple recommendations to those considering RBP. "Find a good broker/consultant to work with and then work with a TPA who has relationships with RBP vendors who can provide proof of savings through detailed claim reports. Some brokers will ID RBP vendors first, then the TPA second and that is ok too. But many TPA's have developed good relationships with RBP vendors so you can work through them too."

Should We Be Looking at RBP in Fully Insured and Other Scenarios?

Personally, I believe we should be looking at reference based pricing throughout the marketplace. We are facing the high likelihood of a strong pro-single payer campaign in 2018, when single payer will be on the ballot. Why not stop the in-fighting in Washington and the states and instead look at ways to actually lower the cost of health plan coverage? If RBP is a viable option, which is certainly looks like it is, then we should encourage our fully insured health insurance carriers to embrace this model, rather than fight it. ***I would like to challenge the health insurance carriers in California to start offering at least one plan in their product portfolios that use reference based pricing. Let the carriers get good cost-savings data on those plans. Use that data to offer long-term reductions in the cost of those health plans. By doing that, we could all win.*** If people could afford these plans,

as an alternative, more individuals and employers would likely choose to purchase coverage, lowering the number of uninsured, and perhaps even get the young, healthy ones to want to buy coverage, because suddenly, it would be affordable to them…even without a subsidy. And maybe, just maybe, we'd have the kind of ammunition we need to show the people of California, as well as throughout the nation, that single payer won't bring down health costs, and that the market itself is offering ways to solve this problem on its own.

Are Politicians in California Now Clinging to the Medicare Concept to Push Single Payer Through?

Another thing to consider is that California's politicians are now starting to grab onto the Medicare model as a way to bring Single Payer to the voters in a ballot measure, and write legislation to pay all providers at the Medicare rates. There is talk that by doing that, they could possibly get people on board with Single Payer. But is that realistic? Is it fiscally responsible?

According to Senior Care expert Harry Thal, "The payment for Medicare is lower than commercial plans which negates the rational of using Medicare rates for a single payer system. The commercial rates hospitals are paid offset the lower Medicare (and still lower Medi-Cal) reimbursements. If single payer were to be adopted using Medicare rates, the hospitals would all close down."

So what are the possibilities? Can the Medicare model help Single Payer? "I think it's important to note that with Medicare and the volume of patients, most hospitals will continue to accept Medicare payment rates but they do have a choice," commented Ryan Dorigan. "Medicare beneficiaries can still enroll on to private managed care plans and the hospitals are free to work out their own contracting arrangements with each private plan. This blend of the government setting rates but allowing a private market place to improve those rates and provide more comprehensive coverage is the way that true Medicare works every day. I think the closer we get to crafting a bill which combines the Federal government setting prices and creating transparency but still allowing a free market to reduce costs and waste in the system then the closer we will be to a true solution. True Medicare is not a single payer mandate which would prohibit any type of a private plan option and that is why I think an extension of Medicare as it exists today is the best option that we have right now."

Is Reference Based Pricing the Solution; The Middle Ground?

I think we're all in agreement that something has to be done to control costs, and something should also be done to help fight the Single Payer threat in California. Is Reference Based Pricing the solution? Is it the middle-of-the road pricing model that could bring down costs and help to solve the health care crisis? Is this something CAHU should consider supporting, and perhaps suggesting in future state legislation?

It may not be 100% the answer, but I believe looking further into reference based pricing is a good start. **I encourage the carriers to give this some thought and perhaps work with the industry to see RBP as a possible way to bring down costs, and not see it strictly as competition. *Then maybe we all can win.*** ##

Editor's Note: The opinions in this article are those of the author and those of the contributing experts. They are not necessarily the opinions of the Orange County Association of Health Underwriters, the California Association of Health Underwriters, or the National Association of Health Underwriters.

1) American Hospital Association, *Underpayment By Medicare and Medicaid, Fact Sheet, 2009*