What is “RBP?”

In the context of health care, it can be any one of a number of methodologies for establishing a maximum amount to pay providers for specified goods or services at a commonly known rate that is calculated to provide a reasonable reimbursement for quality goods or services.

a. The rates can be specific to a procedure like appendectomy or hip replacement surgery also known as “bundled” rates;

b. Are based on some framework established by a third party to the health plan and provider (Independent studies, Medicare (CMS), Ingenex/Fair health, the Red Book, etc.); or

c. Are developed by the plan itself, based on historical charges for those healthcare goods and services.
**Shift to Cost Based Reimbursement**

- Most network agreements are based on a discount off of billed charges

- Billed charges bear little relationship to actual costs

- Employers looking to identify and pay for true value of healthcare services are seeking cost based reimbursements rather than “discounts”

**Shift to Cost Based Reimbursement**

- Provides transparency into the cost and profits built into healthcare services pricing
  - Allows employers to identify lower cost care locations
  - Provides some predictability in healthcare spending trends

- Generally based on self reported published costs
  - Via CMS or commercial directories that report CMS data

- Requires plan design modifications to include reimbursement metrics
Shift to Cost Based Reimbursement

- Plan pays the reported “cost” of a service plus a profit margin specified by the plan
- Works best with PPO for physician / professional services and facility only cost based auditing
- May raise contracting issues for providers and health plans:
  - Exclusivity and non compete clauses is certain agreements
  - “Best pricing” obligations or thresholds
- May create balance bill issues for members

Commonly Cited Benefits

- Cost savings – in actual payments and administrative costs
- Predictability - because the plan sets the rates upfront, it can better anticipate what it will spend on common services
- Rationality – employers/plan sponsors can feel good about the reimbursement levels because they are set based on research or analysis performed by some third party. Providers are better able to understand the pricing and more likely to accept the payment resulting in fewer appeals, or may even adjust their pricing down to be more competitive.
- Flexibility/Convenience – still allows plan participants ability to select from approved providers without compromising quality of care but limits plan liability for very high priced providers with no apparent added value.
Changing Market Forces

“For 2014, PwC’s Health Research Institute (HRI) projects a medical cost trend of 6.5%. Taking into account likely adjustments to benefits design such as higher deductibles, HRI projects a net growth rate of 4.5%.”

“Medical Cost Trends: Behind the Numbers 2014” PwC, HRI Whitepaper

How Did We Get Here?

Why Have PPOs Failed?

• The PPO That Was

• The PPO That Is

• Between a Rock & a Hard Place
Success Stories

Safeway Supermarkets:
- A national grocery chain with 40,000 EE’s (both union and nonunion)
- First used RBP on pharmacy charges in 2008 (started with nonunion)
- Set the reference at the cost of the generic drug; participants paid any costs above that OOP
- Expanded to labs and diagnostic colonoscopies in 2009
- Set the prices and provided participants with a list of the locations & facilities that accept the rate
- Saved millions of dollars in first 2 years
- Have since expanded RBP to other diagnostic tests and labs and are reviewing other procedures

Success Stories

CalPERS (California Public Employees’ Retirement System)

Over 1.3 million public employees, retirees and their dependents

Joint venture between Anthem Blue Cross of California and CalPERS in 2011 reviewed the spend, identified high frequency high cost procedures and focused in on standard hip & knee replacements

Identified a bundled rate of $30,000 (actual bills ranged from $15,000 - $110,000) as adequate to allow choice of provider and reasonable compensation based on area hospitals.
Success Stories

• Identified 41 hospitals in the plan footprint that provided the service at or below the reference price without variation in quality (complications, infections, need for revisions in first year etc.)

• Eliminated co pays for patients who selected a facility from the approved list. Co pay went up (20%) for providers not on the list, any amount above $30,000 becomes patient responsibility

• CalPERS saved $2.6M in the first year and $5.5 M in the first two years without impacting quality of care.

• Created a “halo effect”- When CalPERS rates became known during 2012, several other hospitals approached Anthem Blue Cross to reduce their contracted rates to $30K or very close to it. The approved list expanded the following year to 54 facilities

Success Stories

Why so Fortunate?

• Well documented efforts to support the selected rates (rational rates)

• Significant member education and communication; all provided members with information about the facilities that provided services at or under the reference price and the relative quality of each facility, resulting in a substantial increase in steerage to those providers (CalPERS jumped @ 10% in first year)
Success Stories

• Modification of the plan document:
  – to reflect reduced or eliminated co pays and /or deductibles (creating a financial incentive to the member)
  – modified definitions to accurately identify the referenced basis for reimbursement
• Collaboration with their claim adjudicator to gather and analyze the data and then to process the claims correctly under the proper reference
• Communication with local providers about exactly how they selected the RBP

Can Reference Based Pricing Be A Minus? (Is + a -?)

a. These are large employers with lots of market power, not every employer can impact market pricing the way CalPERS and Safeway did.

b. Not all services can be distilled to a single reference source – Each of the “pioneer plans” carefully analyzed their data and selected a limited number of procedures and services. This works well for high frequency and primarily routine or scheduled services, less likely to have costly variables - They did not create references for all services and the process was data intensive.
Can Reference Based Pricing Be A Minus?

c. Access to plan and or provider specific pricing data is limited for most employers
d. High potential for cost shifting to members for outliers and balance billing
e. Added cost of member education and ongoing support
f. Provider charges may have no relationship with the costs of providing services thus using a community rating or “usual and customary” from a specific resource may not result is a truly fair and reasonable cap

FYI – It’s NOT Medicare-Plus!

• No option for covered benefits that Medicare excludes
• No option for unusual circumstances
• Violation of the “Ingenix” issue?
Can Reference Based Pricing Be A Minus?

FYI – It’s **NOT** Medicare-Plus!

- Plan (in writing) caps payment at “Medicare+ 40%”
- Decides to negotiate a particular claim (to avoid balance billing) and pay “Medicare+ 60%”
- Has there been a breach of the administrator’s fiduciary duty to administer the plan “as written?”
- Will Stop-Loss refuse reimbursement, due to payment in excess of plan terms?

The Solution:

- a better definition is required than “Reasonable & Appropriate”
  - Standard becomes “fair, reasonable & appropriate pricing” including “consideration of Medicare pricing…”
  - Use of discretionary authority rather than requirement to pay a fixed amount
  - Allows plan flexibility to adjust on case by case basis without running afoul of fiduciary duty or breach of plan terms
- Keeps plan away from “Ingenix” issue
Can Reference Based Pricing Be A Minus?

Stop The Stop-Loss Confusion!

• Make sure the stop-loss carrier understands the intricacies of the program; (not an auto-adjudication program based on a fixed Medicare rate)

• Obtain written commitment that they will work with you by:
  • Keeping claims open past policy expiration if case negotiation is necessary to resolve balance billing; as long as it still results in savings compared to in-network rate
  • Agreeing to recognize the plan administrator’s determination of fair, reasonable, and appropriate payable amount – before as well as after balance billing and negotiation; as long as it still results in savings compared to in-network rate

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Everyone Has a Role to Play

Third Party Administrator (TPA)

• Full disclosure prior to implementation
• Provide employers / plans with teaching Tools
• Materials must be ready to be customized for the plan’s metrics;
  • Cookie Cutters Belong in the Kitchen!
• Have a step by step program ready for implementation; education program, provider outreach (pre-treatment), prepare an internal balance billing and conflict resolution team, identify patient advocate(s) for Participants if needed
Everyone Has a Role to Play

Employer

• Explain program to employees – early and often!
• Ensure they know which – if any – providers are “in” and which – if any – are “out”
• Explain pros and cons; [savings and freedom to choose vs. balance billing and responsibility for excess amounts]
• Be very clear about any personal financial obligations
• Understand Assignment of Benefits (“AOB”)
• Keep EEs Advised as Program Evolves

Everyone Has a Role to Play

Employee

• Study the plan and plan benefits
• Speak to providers about AOB and balance billing
• Seek only medically necessary care
• “Shop Around” and do your part to create steerage for providers willing to “Play the Game”
• Communicate with the TPA
• Stand up for your rights rather than take the easy route; (Attack the Plan)
Conflict & Compromise

Balance Billing Happens

• The only way to stop it is a contract
• Plan Document applies to beneficiaries only
  • Participants and their Assignees

Black Balling Happens

• Identify Alternatives
• Notify the Media
• Direct Billing of Patients

Large employers directly contracting for specialty care:
- Seeking out “Centers of Clinical Excellence” for complex procedures like Cardiac, Neurological and Orthopedic procedures and surgeries
- Ex: Wal-Mart, Pepsico, Lowes
- Bundled rates = “all in”, facility, anesthesia & physician in one flat rate
- Ex: Dr Keith Smith - Surgery Center of Oklahoma

• May violate state healthcare contracting laws
  - Is the Employer or health plan now a “network contracting entity” that requires a license?
• May violate exclusivity and/or “most favored” pricing clauses in contracted arrangements for health plans and providers
• Does “Destination medicine” for specialty diagnosis amount to discrimination under ERISA – has yet to be tested.
Conflict & Compromise

A PPO State of Mind

• “We didn’t agree to this discount!”

• “You’re breaching the contract!”

• “We provided services in good faith; detrimental reliance!”

Conflict & Compromise

The War for Participants’ Hearts

• “We’re going to have to balance bill the patient…”

• Because?
  
  » According to the provider, “... the plan doesn’t offer coverage.”
  
  » According to the plan, “... the provider is charging more than the fair market value.”

• See how the media has already reacted! The patient is “holding the bag” ... AGREED! So? Direct the conversation regarding “WHY?!?!?”
Conflict & Compromise

Assignment of Benefits (“AOB”)

• In Exchange for Services, the Provider has Two Options:

  • Provider accepts from the participant – as consideration in full for the medical services provided – an assignment of benefits

  • Provider is only entitled to what the benefit plan determines is the fair market value of the loss, exactly as the participant was only entitled to what the plan determined was the fair market value of the loss

Conflict & Compromise

Assignment of Benefits (“AOB”)

• Option #1 is Getting Much Less Sexy – In accordance with Internal Revenue Code 26 U.S.C. § 501(c)(3), and PPACA revisions to the Code, 501(c)(3) providers are required by § 501(r) to:

  • Not “engage in extraordinary collection actions before [making] reasonable efforts to determine whether the individual is eligible for ... financial assistance ...”

  • Refrain from engaging in extraordinary billing and collection actions until after reasonable efforts have been made to determine whether a patient is eligible for financial assistance.
Assignment of Benefits ("AOB")

• Option #1 is Getting Much Less Sexy – In accordance with Internal Revenue Code 26 U.S.C. § 501(c)(3), and PPACA revisions to the Code, 501(c)(3) providers are required by § 501(r) to:
  • Limit the amounts charged for both emergency and non-emergency medically necessary care to patients, eligible for financial assistance, to not more than the amount generally billed.
  • Prohibit the use of gross charges; providers may only bill patients at a rate equal to the average of commercial and Medicare or, the applicable Medicare rate.

Conflict & Compromise

• Determine what providers value, and negotiate prior to treatment; (what PPOs once were, and are meant to be)...
  • Reduced or Eliminated Deductibles, Co-Pays, and/or Co-Insurance
  • True Steerage
  • Prompt Payment
  • Electronic Claim Submission and Payment
  • Promotional Activities
  • Positive Media Attention
  • A Fee Schedule that is Fair; [this is where discretionary authority versus "Medicare+" comes into play]

Experience Thus Far... And Solutions Emerging
Experience Thus Far... And Solutions Emerging

- Participants are still having trouble wrapping their heads around balance billing
- Employers need to decide whether to negotiate, or, stick to their guns
- Make providers understand – the old ways are gone... In today’s “pay or play” environment, the alternative is NO plan, and patients on the “exchange”
  - Not Beneficial to Anyone – Massachusetts as the Lesson

REFERENCED BASED PRICING: THE GOOD THE BAD AND THE UGLY

Best Practices and Cautionary Tales of Reference-Based Pricing for TPAs and Employers

-OPEN FORUM-