Secrets to Making Reference-based Pricing Work
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In order for reference-based pricing (RBP) to work, health plan sponsors should do it in a way that involves implementing best practices for cost analysis, claim repricing, plan design, patient advocacy (including balance billing protection when necessary), and member education.

Ways to Make RBP Succeed

Employers, administrators, brokers and courts have begun to realize that determining the value of a health care service must involve something more than considering only a provider's billed charges. More and more courts are accepting evidence based on the reasonable and customary value of the claims and not what the facility actually billed.

A health care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value. The reasonable value of services (to be used to set the RBP payment your plan will pay) must consider evidence of the full range of fees that hospitals charge and actually accept as payment from private payers, Medicare or patients themselves.

Since Medicare reimbursement is almost universally accepted in the market, paying any willing provider the Medicare rate plus a percentage is an objectively reasonable approach to providing the broadest possible provider access for RBP plan participants. The problem is that these same facilities have been getting so much more than this from large insurers and networks for so long.

Toss Out the Red Herring

Since U.S. Department of Labor issued frequently asked questions on RBP in 2014, the argument was made that RBP must be illegal since the Affordable Care Act limits the out-of-pocket maximum that a patient can have. But the issue is that the agency wrote the ACA rule with in-network claims in mind.

Part of this confusion stems from the reality that networks have been so pervasive for so long that people cannot conceive of a world without them.

It is important to understand that a claim subject to RBP in many cases has no network and would be viewed under a typical network scenario as an out-of-network claim. Thus, according to DOL, balance billed amounts resulting from non-network claims are not included in the individual's out-of-pocket cost limitations.

Protect Members from Balance Billing

This doesn't make balance billing the patient desirable. The plan doesn't want to be price gouged by facilities but also doesn't want its patients to be balance billed. Plans have to play a balancing act, which is not easy to do.

If you are the patient, you start thinking that you are a pawn in a chess match when it comes to RBP. We repeatedly hear patients say they thought they had insurance and that getting balance billed must be a mistake. The upset patient runs to his or her HR department demanding answers, and in the end doesn't care what the plan pays as long as he or she doesn't get his or her credit scores ruined.

Employers typically do care about the employees' well-being but also care about the plan's finances. They realize that the more the plan has to pay, the pricier health insurance becomes. However, they have to balance this with understanding that balance billing is bad for business and for public relations.

Patient Advocacy Advised

The best RBP programs should have a patient advocacy process. The process should involve providers of all types. Any such negotiation would still require the plan administrator to determine any maximum payable amount within the parameters the plan defines for reasonable and appropriate reimbursement. Also, the plan administrator should be able to offer to cover any patient deductible.

Also, a comprehensive patient advocacy program will have information on providers in many service areas across the country and will help RBP plan members find providers that are unlikely to balance bill for their services.

Medical tourism is a favored aspect of RBP plans for the same reason that RBP plans are better for members who travel outside their normal service area. An RBP plan member who seeks care outside his or her regular service area is more likely to be able to find a provider that will accept RBP as payment in full.

Plan sponsors don't want to pay beyond their RBP payment, especially if their stop-loss carrier limits its reimbursement to RBP levels. Under that circumstance, payments beyond RBP would sap the plan and not the stop-loss insurer.

Bring Providers Along

Good RBP programs have direct contracts with out-of-network facilities, and plan documents that give the plan administrator leeway to negotiate with providers.

Specifically, successful RBP plans have contracts in which out-of-network facilities agree to accept the plan's RBP rates. At the same time, however, a readiness to negotiate claims when needed can prevent balance billing and collections. Facilities accepting the plan's RBP rate sets off a virtuous chain of consequences: no balance, no patients being balance billed, no complaints and no scrutiny.

Further, plan language must:
1. allow for the use of RBP;
2. describe the sources of pricing data to be used by the plan; and
3. address assignment and appeals.

If those and related questions are not answered, third parties will be able to find ways to refute the plan's payment methods. In order to do this correctly, you need to have great plan drafters, as well as experts at facilitating provider contracting and claim negotiations.

Patients must be educated about the process and understand the type of RBP practices involved. They must know whether the plan has a physician-only network or a narrow network, and what direct provider contracts exist. The plan should teach them what to do if they are balance billed, including: (1) who pays the balance and (2) what the worst case scenarios are.

Percentage of Medicare

Traditional networks have failed to stem the rising costs of health care. This has the overall effect of reducing access to health care. Further, networks have encouraged a pricing system where providers charge one thing for their services but accept an entirely different payment from plans with which they contract.

More and more plans are amending their plan language to Medicare-plus pricing if the patient goes out of network. This benefits the plan because it pays less per claim, and it does not pay the balance, because the patient chose to go outside of the network. It also doesn't have to pay a vendor to negotiate these claims with the providers.

A typical RBP plan offers reimbursement at rates between 120 percent and 180 percent of Medicare. According to the American Hospital Association, Medicare payment, on average, covers only 86 percent of actual costs in treating Medicare patients. This means that to cover costs, providers need to receive, on average, 116 percent of Medicare payment or more.

Leverage Facilities' Collections Issues

Last, but not least, we have to take a look at the provider's mindset. Hospital billing departments are extremely busy these days. The problem is that they aren't collecting a whole bunch of money. Collection of amounts that patients owe is large problem for many providers. Easing cost-sharing requirements offers a powerful incentive to providers to accept RBP, especially pricing that is well in excess of what many of those same providers receive from the Medicare and Medicaid programs.

Some hospitals and health systems are starting to review and revise their prices to make themselves more attractive to individual consumers, who increasingly experience sticker shock when they pay for services out of pocket under certain high-deductible health plans. The reality is that many hospital leaders are publicly admitting to scrutinizing their own charge masters. The master price list often just serves as the basis for rate negotiations with insurers in order to see how prices compare against the actual cost of delivering services.

As more consumers have to pay more things out of pocket, these pricing issues are gaining an increasing share of health systems' attention. The reality is that patients are starting to buy into

transparency of pricing. If you're a patient at one facility and you go to four different hospitals and you get the same service and the bill is different, you begin to wonder why. Hospital charge masters have been widely criticized for irrational pricing. Yet hospitals and insurance companies continue to use those master price lists in some negotiations.

For many years, providers have relied on a PPO's logo on a patient's insurance identification card to determine a network plan's reimbursement terms. Identification cards created for RBP plans have no PPO logo but they do contain detailed notice of the reimbursement terms stating that the payment will be based on a certain percentage above Medicare.

In Conclusion

Unlike network discounting from unrealistic gross charges, RBP plans use bottom-up pricing based on costs. Plan sponsors and drafters have a fiduciary duty to be prudent with plan assets. As more and more patients begin to look at the overall cost of care and the actual billed charges, it is getting harder for plan administrators to preach the benefits of network discounts since the bottom line is that most plan funds are coming from the contributions of members' paychecks.

About the Author

Adam V. Russo, Esq. is the Co-Founder and Chief Executive Officer of The Phia Group LLC; an experienced provider of health care cost containment techniques offering comprehensive claims recovery, plan document and consulting services designed to control health care costs and protect plan assets. The Phia Group's overall mission is to reduce the cost of plans through its recovery strategies, innovative technologies, legal expertise, and focused, flexible customer service.