Top Ten Lessons of a Reference Based Pricer

Introduction

Where two gather to discuss reference-based pricing ("RBP"), you will have three opinions. Few would argue that the use of fixed fee schedules instead of traditional cost-containment methods (like preferred-provider organizations ["PPO"]) is not one of the (if not the) most hotly debated and misunderstood topic in our industry.

As someone that has made a career trying to help healthcare providers and health plans get on the same page as it relates to cost-containment initiatives, I have compiled my personal top ten lessons about RBP from 2015.[1]

10. The Status Quo Reigns but…

Though RBP as a PPO replacement is a popular topic, the actual market percentage involved in such a full PPO replacement plan is quite literally decimal dust. That said, we would be well served to remember the words of Bill Gates, "*We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten. Don't let yourself be lulled into inaction.*"[2] Perhaps for this reason, we are now seeing very large groups moving into this space or seriously considering this approach.

Say what you will about RBP (and many critics do) – but in many cases, it has (at least) been shown to actually save money – whereas complex, flashy and mainstream initiatives like Accountable Care Organizations ("ACO") are reportedly not faring well (overall).[3] As we migrate from volume to value-based models (away from fee-for-service), health systems with a 30-year dependency on volume are struggling to reduce utilization *and* the unit costs of care.

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[1] If RBP is a new concept for you, I refer you to an excellent primer by my colleague, "In Reference to Reference Based Pricing" by Ron E. Peck, Esq., Sr. Vice President & General Counsel, The Phia Group LLC, The Self-Insurer, May 2014

[2] Bill Gates, "The Road Ahead" published in 1996, quoted by Nancy Weil and IDG News Service http://abcnews.go.com/Technology/PCWorld/story?id=5214635 June 23, 2008,

[3] See, Are Medicare ACOs Working? Experts Disagree, KHN News as republished by http://www.medpagetoday.com/PublicHealthPolicy/Medicare/54215) October 21, 2015

9. RBP: Know Your Flavors

We are seeing the largest movement ever of health plans treating out out-of-network ("OON") claims to a percentage of Medicare calculation; using RBP solely as a U&C replacement rather than as a complete PPO replacement. Further, we are seeing an expansion of the definition of OON to include out-of-area ("OOA") wrap PPO networks. The variety of network arrangements and claim types (not to mention ways of using references for pricing and scope of RBP usage) has led to the need for categorizing RBP types:

- *Layered Reference Based Pricing ("LRBP")*
    - *Payer imposes fixed prices on certain high-cost services, even when provided by an in-network provider that, in effect, overrides the already-negotiated contractual rate / allowed amount*
- *Medicare Reference Based Pricing ("MRBP")*
    - *Application of Medicare pricing as the (primary) basis for determining plan indemnification for all claims*
    - *These plans offer this reference price to any willing provider*
- *Hybrid Reference Based Pricing ("HRBP")*
    - *Combination of a professional (physician) PPO network with reference pricing for institutional claims*[4]

At the Phia Group, we have not seen much in terms of LRBP usage despite the fact that it has certainly received the lion's share of media coverage (due to the performance of the CALPERS program).[5] The most common PPO-replacement model to date has in fact been HRBP. Admittedly, facilities see a PPO logo (regardless of sub-script text that says it is for professional services only) and tag the claim for the PPO discount. As expected, this causes disputes. Perhaps for this reason, and in partnership with specialty data vendors, we are seeing a recent surge in the market that uses only a percentage of the Medicare rate (or its equivalent) for *all* claims, shifting from HRBP to MRBP.

8. Charges Under Attack from Within…

Moody's Investor Service recently reported that, on average, contracts result in collection of nearly one-fifth of what providers bill.[6] In response to this reality, and some scathing critiques

[4] Timothy D. Martin. Cost-Sharing, Maximum Out of Pocket Limits, and Balance Billing: An Analysis of Regulatory Guidance for Reference-Pricing Plans Under the Affordable Care Act.
[5] David Frankford and Sara Rosenbaum, Go Slow On Reference Pricing: Not Ready for Prime Time, http://healthaffairs.org/blog/2015/03/09/go-slow-on-reference-pricing-not-ready-for-prime-time/ March 9, 2015.
[6] Melanie Evans, Hospitals Rethink prices as patients grow more cost-conscious,

(think TIME Magazine's "*Bitter Pill*"[7]), we are starting to see providers willingly looking at their pricing because consumers are shouldering greater shares of the cost of care.[8] Here is a sampling of provider comments that speak for themselves:

- *"Charges are meaningless data – virtually no one pays charges"*[9]
- *"(the chargemaster) Those are not our real rates. I am not sure why you care."*[10]
- *"We acknowledge that we have had a historically high charge structure. It does not mean however that we are receiving high or unreasonable payments from insurers. The CMS report focuses on charges, not the more meaningful payment data."*[11]
- *"The biggest misconception is that hospitals are charging too much to rip off consumers. I can't think of anyone that is happy with the current pricing mechanism. We'd like it to be simpler and more transparent."*[12]

7. Charges Under Attack from Without…

California's Fifth District Court of Appeals ruled that hospitals cannot seek reimbursement in amounts exceeding the "actual" (fair market) value of the services rendered. In the case of *Children's Hosp. Cent. Cal. v. Blue Cross of Cal.* (226 Cal. App. 4th 1260)[13], the court overturned a lower court's ruling that would allow a hospital to argue that what is reasonable and customary – and payable – to a hospital is not limited to the facility's billed charges, and rather,

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http://www.modernhealthcare.com/article/20151205/MAGAZINE/312059981?utm_source=modernhealthcare&utm_medium=email&utm_content=20151205-MAGAZINE-312059981&utm_campaign=am December 5th, 2015

[7] See: http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/; "Bitter Pill: Why Medical Bills Are Killing Us" By Steven Brill, Feb. 20, 2013

[8] Melanie Evans, Hospitals rethink prices as patients grow more cost-conscious, http://www.modernhealthcare.com/article/20151205/MAGAZINE/312059981?utm_source=modernhealthcare&utm_medium=email&utm_content=20151205-MAGAZINE-312059981&utm_campaign=am December 5th, 2015

[9] Jan Emerson-Shea, Vice-President for External Affairs for the California Hospital Association, quoted by Roni Caryn Rabin, Wide Range of Hospital Charges for Blood Tests Called Irrational, http://www.npr.org/sections/health-shots/2014/08/15/340637076/wide-range-of-hospital-charges-for-blood-tests-called-irrational August 14 2014.

[10] Statement from an unnamed Hospital spokesperson as reported by Stephen Brill, Bitter Pill – Why Medical Bills are Killing Us, Time Magazine, April 4 2013

[11] Grant Gegwich, vice president of public relations and marketing for the Crozer-Keystone Health System, as quoted by Patti Mengers, Study: Crozer is #12 in U.S for high patient mark-ups, Delaware County Daily Times, http://www.delcotimes.com/article/DC/20150610/NEWS/150619980 June 10th 2015

[12] James Wentz, CFO of University of Mississippi Medical as quoted in Emily Le Coz, The Big Shell Game: What you need to know about your hospital bills, http://archive.clarionledger.com/article/20131006/NEWS01/310060034/The-Big-Shell-Game-What-you-need-know-about-your-hospital-bills October 13, 2014

[13] Children's Hospital Central Cal. v. Blue Cross of Cal. 72 Cal. Rptr. 3d 861, 876, Cal. App. 2014), review denied, http://law.justia.com/cases/california/court-of-appeal/2014/f065603.html

the "value" of the service is determined by examining all rates that are the result of contract or negotiation, including rates paid by government payors.

Further, there is IRC § 501(r)[14]: when Section 501(c)(3) applies to a facility, upon billing self-pay patients directly, the law requires providers to not "engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for . . . financial assistance . . . ." The law explicitly prohibits the use of gross charges. Providers may only bill the qualified self-pay patient at the "best" (meaning lowest) negotiated commercial rate, average of the three "best" (lowest) negotiated commercial rates, or the applicable Medicare payable rate.

The subtleties of Section 501(r) cannot be overlooked. If a patient has insurance, the patient's liability is the billed charges and whatever "discount contract" the insurer may have; if a patient does not have insurance, the patient's liability is a reduced or fair market value-based rate, but only via the financial assistance policy. When will this bubble pop?

6. Medicare is a Good Benchmark but Providers Do Not Like It

Providers that do not want to explore RBP opportunities will not appreciate any metric (Medicare, "Costs," etc.), aside from the very narrow scope of what they are willing to accept (*e.g.*, charges or a meaningless discount off random charges). If you ever speak or have ever spoken to providers about Medicare rates, you know that they will be quick to tell you that Medicare "does not cover costs." This is supported by the American Hospital Association (AHA) "Underpayment By Medicare and Medicaid Fact Sheet":

- *Medicare and Medicaid account for 58% of all call offered by hospitals;*
- *85% of Hospitals participate despite the fact that doing so is voluntary (i.e., non-obligatory);*
- *Medicare pays for only 88 percent of costs;*
- *Medicaid pays for only 90 percent of costs;*
- *65 percent of hospitals reported that Medicare payments were less than cost (the other 35% of hospitals reported that Medicare covered their costs); and,*
- *62 percent of hospitals reported that Medicaid payment were less than cost (in other words, 38% of hospitals reported that Medicaid covered their costs).* [15]

To be clear, 35-38% of hospitals have their costs covered by Medicare and Medicaid; the rest do not at varying levels. On that point, I would like to remind people that nearly one-third of

[14] 26 U.S. Code § 501 - Exemption from tax on corporations, certain trusts, etc https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act
[15] ibid.

healthcare is waste,[16] so one could argue that if hospitals removed their share of the waste; Medicare would likely cover more reported costs and then some, wouldn't it? Either way, MRBP plans pay Medicare **plus a percentage**. Though RBP payments may represent a shortfall from typical reimbursements; the payment is meant to pay a reasonable profit above *responsible* use of resources.

5. MOOP, the Willing Provider, and You!

The Department of Labor ("DOL") has explained (see FAQ XXI)[17] that amounts applied to an individual's out-of-pocket maximum do not (but may, at the plan's option) include "premiums, balance billing amounts for non-network providers, or spending for non-covered services." Confusion has since arisen regarding the FAQ, which presented "parameters" (like network adequacy) that must be met by "RBP" plans before this can apply. In other words, charges not covered by the RBP plan will not apply to the patient's maximum out of pockets ("MOOP"), if the qualifications are met. It seems obvious that only LRBP plans were considered. Some read the FAQ as requiring plans to have (adequate) networks in place, while others read it to mean that only if you have a network, must it be adequate. According to some, plans with no network whatsoever are immune to the adequacy rules.

It appears we have lived with networks for so long that this market, and the Department of Labor, cannot conceive an environment where payer simply does not use network.

Healthcare providers all want volume; they want "steerage." In contrast, payers want to encourage members to obtain the necessary services from a low-cost, high-quality facility – and hospitals have been known to sue if they are excluded from a network under "any willing provider" laws.[18] In this context, providers want the patients to have the right to choose, and choose *them* (and providers spend a fortune in direct to consumer marketing). "Any willing provider" laws allow any provider that meets a plan's standards and agrees to the plan's terms to become one of the Plan's preferred providers. RBP plans address "any willing provider" concerns by nullifying them, and the plan can actually save money in the process. It's a beautiful thing.

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[16] Health Policy Brief, Reducing Waste in Health Care. A third or more of what the US spends annually may be wasteful. How much could be pared back – and how- is a key question http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_82.pdf December 13, 2012

[17] U.S. Department of Labor, FAQs Aboout Affordable Care Act Implementation (Part XXI) http://www.dol.gov/ebsa/faqs/faq-aca21.html October 10, 2014.

[18] **Susan K. Livio 17 N.J. hospitals sue state for approving Horizon's new health plans** http://www.nj.com/politics/index.ssf/2015/11/11_nj_hospitals_challenge_state_approval_of_horizo.html November 19th 2015.

4. C'mon! Really?

RBP programs (whatever the flavor) require proper plan language to be compliant and user-friendly, as it relates to other stakeholders in the self-funded community. I have personally seen RBP plans that had . . . drum roll please . . . no plan document at all! More common, however, are poorly drafted documents. I am all for moving at the speed of business, but you absolutely cannot compromise when it comes to actually granting the plan rights (in writing) that it later exercises.

Also, let's face it – RBP is en vogue; nearly every industry vendor either offers some RBP product, wants to, or at least says that it *can* if clients need it. All plan sponsors, TPAs, and brokers should view those options with caution and concern. Fear the potential that you may be sold on a vendor that has only just started to deal with RBP, because you, the client, asked for it. Also, many vendors, through active sales, may actually be growing beyond their ability to scale operations, the result being poor service or no service at all – yet charging top-dollar for it.

Finally, I have lost count of the number of people in the industry that are somehow equating the term "fiduciary" with protection of patients from balance billing. In response to that let me summon my inner Bob Newhart in emphatically saying "STOP IT!" In the RBP context, fiduciary responsibility means paying claims according to the fixed fee schedule explicitly stated in the plan document. If Plan Administrators do that, they have fulfilled their fiduciary duty and can defend themselves from those who would challenge this. Balance billing is the responsibility of the member. While the plan may choose to step in and help protect the member by settling claims (and I think they should), strictly speaking, the plan has no fiduciary or equitable obligation to do so.

3. You've Got to Know When to Hold 'em; Know When to Fold 'em

Oddly, we have seen many RBP plans absolutely refuse to negotiate claims with providers and openly opine that all claims need to go to collections before settlement can ensue. In general, I disagree with that approach.

External collections can add a difficult layer of liability: additional cost. Once external collections are in play, providers net less money on any settlement. They now want more to cover those costs; more than they may have previously been inclined to offer a payer, because they now need to pay the collector (typically 20-35%). Plus, outside parties have their own interests, which therefore look to compromise budding positive conversations between payers

and providers. Remember, collectors (and RBP vendors too to a large extent) make money from disagreement in this market.

In many instances, a complete lack of flexibility in strategic settlements can galvanize a regional provider community to "gang up" and reject an RBP Plan. We have witnessed state hospital associations actively campaign against certain vendors, educating their membership on how to fight or even eliminate RBP plans. This can involve *en masse* pursuing the patient for payment or even pushing away patients for non-emergent care (aka "black balling"), which can damage the viability of an RBP program (and potentially *all* RBP programs).

That is not to say that being inflexible cannot work at times; in some cases, rigidity has value, and the trick is to be watchful and thoughtful about what is happening in the provider community context. For this reason, we recommend open strategy discussions between all parties involved in the RBP program, which typically involves input from TPAs, vendors, and the plan sponsor. A mere subtlety in market dynamics or a key relationship can make all the difference between success and failure. In other words, the ideal RBP program is a customized one, tailored to the needs of a given client in a given situation. This is where many vendors show their true colors – whether in a positive or negative light.

2. Contract-o-Phobia

The contracting process is not simple. The following is a redacted excerpt from an actual communication we have received:

> *I'm still unclear as to why a smaller TPA such as you would not contract with a network such as [regional networks] for a statewide provider network. Even if we could come up with a reasonable reimbursement rate, I am reluctant to set a precedent with one TPA. I think I mentioned before that there is not enough volume of covered lives in our service to negotiate a significant discount with you. We might be more open to the idea of a small discount if we were the only providers in a narrow network of choice.*

Regardless, it is imperative that plans who choose not to use a network at all must still work toward contracting with (or at least identifying) "safe harbor" providers that have agreed to refrain from balance billing in exchange for the plan's maximum payable amount. The primary challenge is to avoid creating networks. In many ways, RBP expands the leverage with the provider as you now can combine both the claims incurred to date, and future claims. We have seen some RBP plans able to get providers to compete for their business and would highly recommend pursuing these options when it makes sense.

From a contracting perspective, stop-loss coverage should be taken into consideration as well. If an RBP plan pays an amount rigidly defined in the plan document, then the carrier will be satisfied with that payment since it was what the carrier has underwritten. If, however, the RBP plan pays extra to settle the claim, various carriers will react to that expense in different ways. The best-case scenario is a plan document that supports payment of contracted or settlement amounts; if the carrier has indicated that it will honor negotiated rates as the plan's proper payment, then a negotiated agreement may not only safeguard the patient, but also can help safeguard stop-loss reimbursement.

1. Balance Billing; It's About Punishing Non-Par Plans

The first thing I do when I call on an account undergoing balance billing is to ask the provider if it knows that it is billing a patient the balance up to 100% of its charges. I usually get a response in the affirmative and something like "well, the Plan is non-par, and so charges are due." I go on to explain that the Plan is not "non-par" in the traditional sense. In other words, this Plan has not rejected the provider as part of a network, but rather, the plan defined its benefits to be a percentage of Medicare, and that it was the member who chose to seek care at the provider's facility. In this context, the consumer has actively chosen that provider – over all other options – for services, and the provider is billing the patient at its highest rate possible. I am pleased to report that many providers, when they truly understand this dynamic, write off the balance.

That having been said, there are, and likely will always be, providers that are aggressive and will balance bill the member in every case. By acting in this manner, providers are effectively punishing patients who do have insurance. The purpose of this practice is to reiterate their expectation of greater payment from insured patients; even if the patient's insurance does not cover the full balance, which self-funded plans very rarely do. This is a way to try and force insurers to pay more by holding the patients' credit as ransom; and we are back to the status quo…

Conclusion

RBP simply reduces the unit cost or price of what is (one way or another) being consumed. Is this too simple or blunt an approach? At the end of the day, we are well served to recall the 2003 article from Gerard Anderson, Professor at Johns Hopkins Bloomberg School of Public Health, about the real problem in US healthcare: "It's the Prices, Stupid: Why the United States is so different from other countries."

Whether I'm purchasing a home (shelter) or a cheeseburger (sustenance), there is a general range of prices. Those prices are set by the seller taking various real elements into account, such as location, quality, supply and demand. Cost to the seller, necessary profit margins, and other factors impacting the seller, as well as need, ability to pay, and other options available to the buyer, are hallmarks of a free market, capitalistic, healthy economy. This is how we establish fair value, drive (healthy) competition, and make sense of things. What we pay; what we charge; and why. Yet, for some reason, common sense economic concepts are moot when applied to healthcare. Without the shelter and sustenance referenced above, I'd perish – yet – we allow these concepts to apply to the obtainment of such goods. Healthcare does matter – of course – but it is not so unique that it should be treated like some invaluable, priceless commodity for which providers can charge whatever they wants, at will, randomly, without any controls or rationale.

Jason C. Davis is Business and Product Development Consultant at The Phia Group. He specializes in medical claim review/negotiations and cost-containment program development including vendor, network, and provider contracting. With the goal of combating the steadily increasing costs, Jason routinely consults The Phia Group's industry-leading attorneys on complex claims provider negotiations, payment disputes, and balance billing management. Before joining The Phia Group, Jason was a key member of another cost-containment firm, holding positions in claim negotiations, cost-containment R&D, business development, and upper management.