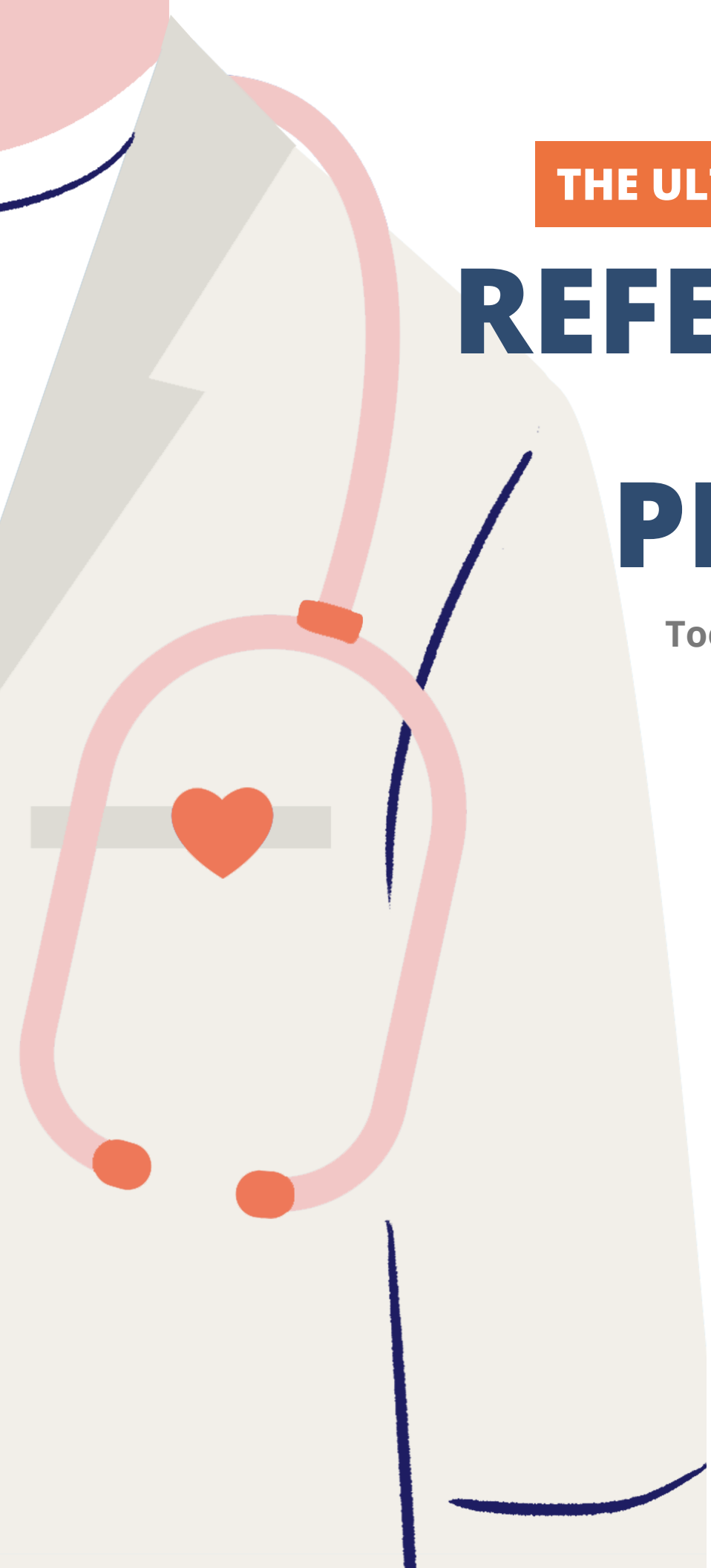

THE ULTIMATE GUIDE TO

REFERENCE BASED PRICING

Tool for Business Owners and HR Managers

RMC GROUP

INTRODUCTION

Most employers offer a healthcare plan as part of their employee benefit package. A strong employee benefit program helps an employer attract and retain quality employees.

In addition, a healthy workforce can help an employer's bottom line by reducing absenteeism and increasing productivity.

At the same time, however, any type of healthcare program can be a major expense for a business, and, unless it is well designed and administered, the associated costs can become a major obstacle to profitability.

With healthcare costs constantly rising, employers are always looking for ways to lower their costs. Some of the more common methods include increasing the share of insurance premiums paid by employees and increasing deductibles and co-pays. Of course, neither method is likely to be well received by employees.

Another method to control costs, which has become more popular in recent years, is Reference Based Pricing or RBP. RBP controls costs by limiting the amount that a plan is willing pay to a provider for medical care. An RBP plan can be complicated to implement and is not for every employer.

This article will discuss how RBP differs from a more traditional health insurance plan and identify the circumstances in which an RBP plan might make sense.

WHAT ARE THE DIFFERENCES BETWEEN FULLY-INSURED AND SELF-FUNDED HEALTH PLANS?

Typically, there are 2 types of employer-sponsored health plans:

1 Fully-Insured Plan

In a fully-insured plan, an employer pays premiums to an insurance company in exchange for the insurance company's promise to pay medical expenses incurred by the employer's employees. Premiums can be a substantial expense for the employer because the aggregate premiums paid to the insurance company by all employers must exceed the aggregate claims paid by the insurance company.

A fully-insured plan generally makes a Service Provider Network available to the plan's members. A Service Provider Network is a collection of medical service providers, assembled by the insurance company, who agree to provide their services to network members at pre-negotiated discounted rates, rather than their standard billing rates. This arrangement works to the benefit of all parties. The insurance company is able to reduce the cost of claims. The employer's premiums are presumably lower if the claims costs paid by the insurance company are lower. The plan's members gain access to quality medical care at discounted rates. And medical service providers benefit through the volume of patients driven to them by plans adopting the network.

2 Self-Funded Plan

In a self-funded health plan, the employer does not transfer its responsibility to pay medical claims to an insurance company but retains that obligation and pays claims out of its general assets. Often, an employer will purchase what is called "stop-loss insurance" to protect itself against catastrophic claims.

An employer adopting a self-funded health plan is betting that the cost of claims, plus any stop-loss insurance premiums, will be less than the health insurance premiums that it would otherwise pay in a fully-insured plan. In addition, an employer will usually engage a Third-Party Administrator or TPA to adjudicate and pay claims on behalf of the employer. Often the TPA will arrange for a Service Provider Network for the employer's plan. In that respect, a self-funded plan is the same as a fully-insured plan.

However, unlike a fully-insured plan, a self-funded plan can use Referenced Based Pricing, instead of a traditional Service Provider Network. An RBP plan provides an alternative pricing structure, along with the opportunity to use any service provider who accepts the plan's terms.

Reference Based Pricing is a *strategy* to *contain costs*

An employer adopting an RBP plan is betting that it can pay less for certain medical care than the discounted rates that are available through a Service Provider Network.

In an RBP plan, there is no Service Provider Network in the traditional sense. Instead of accessing care through a Service Provider Network, an employee can obtain medical care from any service provider who agrees to accept the rates that the employer is willing to pay.

In that respect, an RBP plan does not have in-network and out-of-network providers. The rates paid by an RBP plan are based on a reference amount, often the amount that Medicare would pay for comparable care.

HOW IT WORKS

Most Common Reference Amount is Medicare

In an RBP plan, the employer determines the amount that it is willing to pay for medical care. The employer can set this amount arbitrarily, but, most often, the employer sets the amount based on a reference amount. The most common reference is the amount that Medicare pays.

For example, an employer may determine that it is willing to pay a provider 150% of the Medicare rates. The employer can establish prices for all medical care or only for certain procedures, such as hip or knee replacements, which tend to be very expensive and where the cost varies greatly from provider to provider.

Pre-Negotiated Rates Unavailable

A medical service provider's standard billing rates, before network discounts, are essentially an arbitrary starting point for negotiation. When a health plan uses a Service Provider Network, medical service providers are paid based on pre-negotiated discounted rates.

However, in an RBP plan, there is no pre-negotiated rate. The employer sets the rates that it is willing to pay, and each medical service provider has the option to accept or reject the payment terms of the RBP plan. The rates paid by an RBP plan generally fall in the range of 120 – 300% of Medicare rates, depending upon location and other market factors. The employer realizes a savings if its RBP rates are less than the pre-negotiated discounted rates that it would otherwise have paid using a Service Provider Network.

HOW IT WORKS

Cost Savings in RBP Plan

It does not make financial sense for most medical providers to accept Medicare rates for all services. They are simply too low. That is why a provider's standard billing rates, as well as the discounted rates that it offers to Service Provider Networks, exceed the Medicare rates, often by a significant amount.

As a result, it is vital that, when an employer adopts an RBP plan, the reference rate should be set at a level high enough to attract service providers to accept the coverage, but low enough to produce savings when compared against the rates the employer would pay using an established Service Provider Network. Cost savings of up to 20 – 30% are possible, as compared with a fully-insured plan or a self-funded plan renting an established Service Provider Network.

The Role of the TPA

A service provider is under no obligation to accept an employer's RBP rates. The employer simply determines the amount that it is willing to pay, and the provider accepts or rejects. As a result, an employee may find that his or her doctor is not willing to accept the employer's RBP rates.

In this situation, an employee may either pay the difference between the plan's RBP rate and the minimum that the provider will accept, or find a new provider who is willing to accept the plan's RBP rates. Often, an RBP plan allows some flexibility for the TPA to negotiate payment terms with individual service providers, within reasonable limits.

REFERENCE BASES

What Reference Bases are Available?

Medicare's rate structure is by far the most common reference used in RBP. Medicare can be thought of as a large volume and low paying national network (so low paying that it does not always cover provider costs). It provides a basement benchmark for medical service rates in any geographical area of the US.

Other methods are available that take into account known facility pricing information and estimate professional service costs using value units and geographic rate index adjustments. These appear to be much less common and require much more effort to produce a similar result.

BALANCE BILLING

What is Balance Billing?

Balance billing occurs when a service provider is paid the RBP rate by the plan, but then bills the member for the difference between the provider's standard billing rates and the RBP rate.

The employer's TPA will generally intervene with the provider on behalf of the member to attempt to negotiate the elimination of the balance billing.

In addition, an employer can purchase products to insure the plan and its members against balance billing. However, as noted above, a provider is under no obligation to accept an employer's RBP rate and under no obligation to waive the balance billing amount.

OTHER FACTORS?

Here are 3 other factors that employers should consider when evaluating Reference Based Pricing

1 Member Education & Engagement

When an employer adopts an RBP plan, the education of its workforce must be a top priority. Many perceived problems with RBP programs are simply the result of miscommunication between the plan's members and the service provider's front office staff. Members may be required to explain that they are covered by a self-funded plan and give the provider specific instructions on how to contact the TPA regarding benefit confirmation and invoicing. Most TPAs have member service resources dedicated to assisting members when they have issues with providers accepting coverage or submitting claims.

2 Potential for Disruption to Members

This is, in part, related to member education and engagement. Members need to understand the benefits provided by the plan and be prepared to spot common issues. These include providers claiming that a member is not insured because the provider failed to contact the TPA to confirm benefits, as well as providers invoicing members directly, instead of submitting invoices to the plan's TPA. When this happens a member's claim may initially be denied because the provider did not submit the claim to the TPA as directed.This can often be resolved easily with a little bit of communication between the member, provider and TPA.

3 Perceived Complexity

Medical billing is complicated, and there is often more than one way that a service provider can bill for a specific procedure or package of procedures. A TPA knowledgeable in medical billing best practices should be employed to process provider bills and determine plan and patient payments in accordance with the plan document. A good TPA can also identify and address billing irregularities and predatory billing practices (i.e., service unbundling, surprise billing far in excess of usual and customary rates, adding bills for specialist services that were not disclosed to the patient in advance).

HOW RMC CAN HELP

MyHR: An Extension of your HR Team

Plans that implement an RBP strategy may experience increased employee confusion. Some HR teams, especially those without RBP experience, may find it difficult to assist their employees. Many insurance brokers and HR consultants offer a program to engage employees and help answer their benefit-related questions. For example, RMC offers MyHR, a free service that takes the strain off an employer's HR team. MyHR acts as an extension of an employer's HR team by providing fast and consistent answers to employee questions by trained benefit specialists. Having a resource like this is vital to making the transition to, and the administration of, an RBP a seamless experience for an employer and its employees.

An employer should check with its insurance broker or HR consultant to see whether they offer this type of service, both during and after open enrollment.

Large Claims / Catastrophic Claims Management

A major threat to any healthcare program is large claims; especially claims that are unexpected. It is vital that an employer work with an HR consultant that can strategically develop cost-saving programs for expensive medical claims, including kidney disease requiring dialysis, cancer, hemophilia, hepatitis C, Crohn's disease, colitis and transplants. An employer should make sure that its HR consultant offers a free review of large claims to determine whether an employee is eligible for government assistance programs, such as Medicare, MedicaidRx or a number of other federal and state subsidy programs. This will help reduce the employer's overall cost. This type of service is important to any group health plan, whether level-funded, self-funded or self-funded with a captive.

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PLAN DESIGN MATTERS.

Health insurance can be challenging for employers, but it doesn't need to be.

For help with your benefits contact us.

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