



## In Reference to Reference Based Pricing

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If you've been listening to webinars, attending meetings or pretty much been doing anything other than living under a rock, you know that many self-funded plans and their claims administrators are contemplating utilization of a fixed "fee schedule" for pricing purposes, in lieu of the currently predominant network-discount-off-of-billed-charges approach.

More often than not, this fixed "fee schedule" approach utilizes references such as Medicare rates, MSRP, AWP and the like. Everyone agrees that this approach – utilization of a fair market price for services rendered – makes sense from a common sense perspective. Indeed, almost all other consumer goods are bought and sold utilizing this method; we set a fair price for a good or service, adjust the price to take "special considerations" into account, reduce the price to draw attention and lock in the sale, and make the exchange. Comparison shopping and the competition it inspires is as American as apple pie and baseball! Thus, it's worrisome for many that our health plans currently pay whatever the provider of medical services charges, without any fixed "fair market value" to compare the price to. Further, this results in a lack of price-controlling competition between providers. Providers in turn differentiate themselves from each other based on their services, facilities, accolades, and the like – not on value. We meanwhile, as payers, secure a discount; but is a discount worth

the paper it's written on, if the rate is excessively inflated many times beyond the value of the discount?

This all seems like a great argument to drop your network and utilize reference based pricing. The problem, however, is that many fail to recognize the many benefits and services we secure utilizing networks, above and beyond discounts. While discounts may be the first thing payers think of when PPOs are mentioned, few if any give full credit to the network for other benefits they provide, until the network is gone. Addressing the vacuum left behind when a network is abandoned is therefore a key requirement for a successful plan.

To address the problem, we must first stop acting like health insurance is the same as auto or home-owner's insurance. Unlike a car or house, we can't shop around, stick a price tag on a replacement, and cut a check to the insured. First; there is assignment of benefits. Unlike auto-insurance, where your carrier issues you (the insured) a check; and you have to make the purchase with this "allowance" in mind, with health plans – the consumer doesn't look at the bill, because the consumer never deals with payment. By receiving an assignment of benefits, the provider becomes the consumer as well; insofar as they have stepped into the shoes of the insured. They hold the services in one hand, and the purse strings in the other.

Second; there is no transparency. Unlike other scenarios, where the insurance carrier issues the insured an "allowance" and the insured must behave as an educated consumer (to ensure they get everything they need with the money they have), in healthcare, there is neither a need nor incentive for consumers (patients) to pick and choose which services to pay for; and which to forego. The services received dictate the funds available; the opposite of all other economic exchanges (where the funds in hand dictate the services purchased).

So... Can we eliminate assignment? Just hand cold, hard cash over to the insured, and let them decide what to do with it? Not likely. Unlike cars and contractors, health care is often needed on an emergency basis and people don't have access to information needed to make informed decisions. Furthermore, our society views medical care as a human right, rather than a consumable good.

Perhaps this is why, regarding "assignment of benefits" and our chest-thumping idealistic view that patients

should be consumers, when push comes to shove many plan sponsors agree that patients should not have to deal with the actual billing and payment for their care. Unlike a car or home, they should be focused entirely on getting well. Health, unlike "possessions" is a sensitive subject, and one about which consumers cannot possibly make rational decisions. Someone may choose a \$15,000.00 compact car over a \$30,000.00 sedan, but no one is willing to be frugal when it comes to their health.

With this in mind, then, it's easy to forget that healthcare is an industry, and hospitals are businesses. If we get trapped in ideological debates over morality and values, we miss the plain truth – you can't force anyone to take less than they are willing to accept as payment in full. You either give them what they want, identify alternative forms of payment, or go elsewhere. As one hospital attorney once said to me, "slavery was abolished many years ago."

With this in mind, try to put yourself in the shoes of the provider; and appreciate the knee-jerk emotional reaction many providers have had to reference based fee schedule payments. Despite the fact that millions of lines of data prove that the provider should make a hefty profit off the reference based payment offered by the plan, the mere suggestion that the provider's services "aren't worth what the provider thinks the services are worth" is an affront.

I often remark that the difference between a reference based "fair market value" fee schedule and a discount is that, with the fee schedule I don't need to know what the provider is charging. I only need to know what service the provider provided. With a discount, you need to know what the provider is charging. The problem with discounts is that by increasing the amount charged, the discount can always be nullified.

A 20% discount can be voided by an increase in the actual fee. Without a market-wide fixed price, from which discounts can be taken, there is no way to truly apply a value to said discount.

Why then, do payers still cling to network arrangements? For the "other" unsung consideration referenced above. Networks represent more than a discount. They represent an understanding. They secure a pathway for plan participants to receive care without fear of balance billing. The payer, payee, and patient all know that – if and when care is needed – they know how the process will roll out. Security is the greatest benefit of all in a game based on shifting risk.

As previously mentioned, the only way to prevent a provider from balance billing a patient for the difference between an amount charged and an amount paid is: (1) pay the remainder; (2) identify other consideration the provider will accept as payment in full, or (3) agree via contract – prior to payment – on a reduced amount the provider will accept as payment in full.

Absent a contract, payers can attempt to disincentivize providers from balance billing (by revoking assignment of benefits and paying patients directly, steering patients to other facilities, and leaking stories of the facility's abuses to the press), but when push comes to shove, disincentives are not prohibitions. Because there is no guaranteed way to prevent balance billing, many payers are loathe to implement such a reference based pricing methodology, and resort to the network contracts that – albeit perhaps more expensive – also provide comfort and security.

For this reason, we are now seeing many benefit plans consider implementation of a reference based price fee schedule for all claims, however, they also explicitly state that the plan will pay "negotiated rates" above all else.

They subsequently create a narrow network including only a few providers willing to accept payments only slightly greater than that allowed by the fee schedule, in exchange for prompt payment, steerage, and other non-monetary consideration from the plan. A number of firms are popping up who specialize in negotiations with providers, whose services are now being deemed to be valuable additions to reference based pricing programs, securing deals with providers before treatment is sought. Employers, administrators, and carriers can then instruct participants regarding which providers accept their plan's payment in full, and what the repercussions are for visiting another provider instead.

A final important thing to consider is how this all impacts stop-loss. Stop-loss carriers are thrilled to witness efforts on the part of payers to reduce their expenditures. Innovative cost

containment efforts benefit stop-loss just as it benefits the plans. Unfortunately, due to the uncertainties described here and elsewhere, and a lack of historical data, stop-loss carriers are having a hard time determining the true savings plans will enjoy using such methodologies, and in turn, are having a tough time calculating discounts they can offer when underwriting coverage for such benefit plans.

Stop-loss carriers appear to be dealing with these issues in two ways. Some carriers will assess a plan document that generally limits coverage to – as an example only, 140% of Medicare rates – but assume that the plan will actually pay an average of 180% Medicare (or some other inflated amount); quoting a fee based on this assessment. Other carriers underwrite based strictly on the plan terms – in our example, 140% Medicare – but also provide such a competitively low rate, the plan sponsor is willing to sign on, knowing that additional negotiated amounts are entirely on them to pay. In the first instance, the carrier will accept submissions for reimbursement that include additional negotiated payments (meant to stop balance billing), whereas the second carrier will deny all payments made in excess of the amount set forth in the plan or policy. In these instances, the hope is that the savings from the bargain stop-loss fee is enough to make up for the occasional negotiated amount paid outside the terms of the plan document.

For the reasons shared above, the rationale behind industry efforts to define fair market values, set fixed prices, and work with reference based fee schedules is in many ways responsible and common sensical. Unfortunately, we cannot force the providers to accept these payments as payment in full. As businesses, providers have a right to charge whatever they want. Perhaps this experience, more than anything else, is forcing payers to appreciate anew what PPOs bring to the table. While efforts



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to disincentivize balance billing are ongoing and legal arguments have been made to suggest that providers should not be able to demand more than a reasonable profit, there has been no universally shared concrete nationwide example of case law or regulation that protects patients – absolutely – from balance billing after their plan pays less than the provider's billed amount.

This is what we're seeing in the industry today; and this is why providers will continue to balance bill. Providers do not balance bill to obtain additional funds from the patient. Providers balance bill to disincentivize plans from screwing around with the status quo. To date, it is a winning strategy. It has become increasingly clear, therefore, that the only reference based price fee schedule programs left standing are those that belong to sponsors that are either willing to have their participants be balance billed, are willing to pay fees to organizations that will "deal" with the balance billing, pre-negotiate with individual providers and/or narrow networks, or are willing to negotiate and pay additional amounts to providers – on a case by case basis. In all four instances, some benefit plans are seeing savings over their past network dependent structures; while others have been disappointed by the results. The bottom line? There is no universal answer. The question for most, then, is whether the savings are enough to counter the headaches suffered along the way. Let's hope those headaches go away... I don't feel like paying \$75 for an aspirin. ■

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*Ron is also frequently called upon to educate plan administrators and stop-loss carriers regarding changing laws and strategies. Ron's theories regarding benefit plan administration and healthcare have been published in many industry periodicals, and have received much acclaim. Prior to joining The Phia Group, Ron was a member of a major pharmaceutical company's in-house legal team, a general practitioner's law office, and served as a judicial clerk. Ron is also currently of-counsel with The Law Offices of Russo & Minchoff.*

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