The Evolution of the REVOLUTION of Referenced Based Pricing for Medical Benefits by Dennis Casey
As the name implies, under a Reference Based Pricing (RBP) strategy a benefit plan defines a fixed dollar amount (the reference point) that is the maximum allowed for reimbursement by that plan for a service or procedure. Plan Participants would absorb charges, if any, that are “balanced billed” beyond the reference point and subsequent benefit plan payments.

There has been an increasing interest over the past couple of years in the concepts surrounding RBP of the services and supplies for delivery of healthcare. Specific programs have been developed using RBP techniques for prescription drugs, colonoscopies, and joint replacement procedures, for example. WellPoint and Blue Cross and Blue Shield of Minnesota have programs in place that are broader in scope but do not attempt to pay all plan benefits subject to a reference price. AON Consulting has noted that over 60% of employers surveyed are strongly considering using RBP techniques for paying plan benefits in the near future (up from 8% currently using such programs). A growing number of Third Party Administrators (TPAs), most notably in Texas, Ohio, Minnesota, and North Carolina are abandoning traditional PPOs and using Medicare DRG Prospective Payment levels as the initial reference point and reimbursing providers at some point above that Medicare allowed amount, i.e. 130% to 170% of Medicare.

This new and somewhat revolutionary approach has been precipitated by a natural reaction to the current marketplace and political climate. RBP also anticipates the need for Plan Sponsors and providers to recognize that an alignment of their incentives in a fair and transparent manner is a logical way for all parties to meet their objectives going into the future.

RBP was created to deal with a problem – the uncontrolled cost, and the rate of growth of such cost, of healthcare in The United States of America. The first step toward solving a problem is to recognize or acknowledge that such a problem exists. The United States, by any reasonable measure, has the most expensive healthcare delivery system on the planet. The US spends over $8,000 per capita and over 18% of its GDP on healthcare annually. The next highest amounts for developed nations are $5,400 per capita for Norway and 12% GDP for The Netherlands. The median levels among developed nations are $3,200 per capita and 9.5% GDP.

One could argue that the above noted cost would be “worth it” if the outcomes were perceptibly better under the US model but that is not the case. There is simply no detectible ultimate health difference among the populations under review. Five year survival rates for cancers, asthma mortality rates, infant mortality rates, diabetes amputation rates, in-hospital fatality rates, longevity rates etc. do not show discernable differences in managing the ultimate health of the various populations.

By almost every standard of measure it should be likely that healthcare delivery would be cheaper in the United States than in other developed nations. Our overall population demographics are significantly better; our rate of population aging is lower; our percentage of population that are smokers is significantly less; our access to doctor and hospital care is lower; our hospital discharge rates per 1000 are lower than median levels for other developed nations; the cost of generic drugs is significantly lower; and the availability of diagnostic imaging (MRI, CT, PET, Mammography etc.) is two to three times above the developed nation median (in a normal economic model the over-abundance of a service typically means that the price for such a service is low). The only measure that is detectable that adversely affects healthcare costs between the United States and other developed nations is our national obesity levels which are currently around 34% of the population versus a developed nation mean of about 16%. It should be noted that the much publicized cost of litigation and mal-practice insurance in this country, while not insignificant, doesn’t really move the needle very much in terms of population expenditures, about 1% of total healthcare spend annually or less than 2 billion dollars. By way of contrast, if we were able to restrict the use of anesthesiologists for healthy colonoscopy patients (a practice no other developed country condones) that alone would save 1.1 billion annually in this country.

So why does healthcare cost so much more in this country? Simple – it’s the price we are charged for the services being delivered. Please note that we use the word price. In many cases the cost of particular goods and services are no different in the USA than elsewhere. Relative costs for training, relative costs for nursing care, the cost of supplies, the relative cost of support staff, and many more factors are the same or lower in the US versus other developed nations.

It is unfortunately true that our system creates markets where we can be overcharged for some items such as brand name prescription drugs and implantable devices, for example. Lipitor costs, on average, $124 a month in the US and $6 in the New Zealand, Advair inhalers cost $300 in America and $45 in France and Nasonex is $108 here versus $21 in Spain (maybe that’s why I’m irritated...
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that their “spokes-bee” on TV has a Spanish accent. Implantable joints made by the same US manufacturer are sold to hospitals in Belgium for $4,000 and to United States facilities for $8,000. But what happens after that joint has been acquired? In Belgium the average hospital markup is $180. In the United States the hospital markup is commonly over $20,000. The price being charged ends up having little or no relationship to the underlying costs and traditional market forces are unable to control ultimate expenditures.

This has been going on for a long time and benefit plans have employed a variety of tools to mitigate these costs over the last 35 years. A chronological summary of those efforts might include:

• Late 1970s through early 1990 the proliferation of Self-Funded Benefit Plans. The benefit plan will take on risk in order to manage final expenses. What will be the reaction of my plan members?

• Late 1980s the advent of Utilization Review and Large Case Management programs. The benefit plan will initiate controls over how long or where a member can stay hospital confined. What will be the reaction of my plan members?

• Mid 1990s the beginning of Managed Care and PPOs. The benefit plan will influence what providers the members will use. What will be the reaction of my plan members?

• Mid 2000s the utilization of Disease Management initiatives. The benefit plan will involve itself with treatment plans for specific members. What will be the reaction of my plan members?

• Mid 2000s the wide use of combined Consumer Directed and Defined Compensation models (FSA/HRA/HSA) for paying claims under the benefit plan. The benefit plan transfers significant risk on a tax preferred basis to members. What will be the reaction of my plan members?

• Early 2010s increased proliferation of Wellness and Population Health Management techniques to control costs. The benefit plan inserts itself into the lifestyles of its participants. What will be the reaction of my plan members?

• Mid 2010s the inauguration of Reference Based Pricing (RBP) models to limit plan payments on either a procedure or overall basis. The benefit plan puts a defined limit on payments, based on reviewable data, which it is willing to pay for services provided. What will be the reaction of my plan members?
It is notable that of all the strategies described above only the RBP strategy gets to the heart of the real issue – the price charged. The benefit plan will employ a variety of educational, proactive and reactive support services for the members who may or may not end up with “balance bill” issues as mentioned above. Ultimately by moving the risk of unsupportable charges to members the plan is creating a new universe of consumers who will be engaged as never before with their providers and requiring such providers to defend their charged price in an open market.

Dr. Harold D. Miller argues persuasively (www.paymentreform.org) for a significant reconsideration of the provider payment methodology used in this country. Fee for service payments, episode payments, comprehensive care payments, value based payments, and shared savings programs should all be carefully evaluated. Accountable Care Organizations (ACOs) hold promise in a laboratory but 93% of providers in an Opinion Leaders Survey by Modern Healthcare see the current financial interests of healthcare providers as either an “Extremely Significant” or “Very Significant” barrier to the ultimate success of ACOs. Until political will and market demand ultimately force some major reformation of our pricing systems, a process that is likely to take a considerable amount of time, RBP provides serious tools that benefit plans must consider carefully.

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