



The Next Evolution of Referenced Based Reimbursement (RBR) Programs

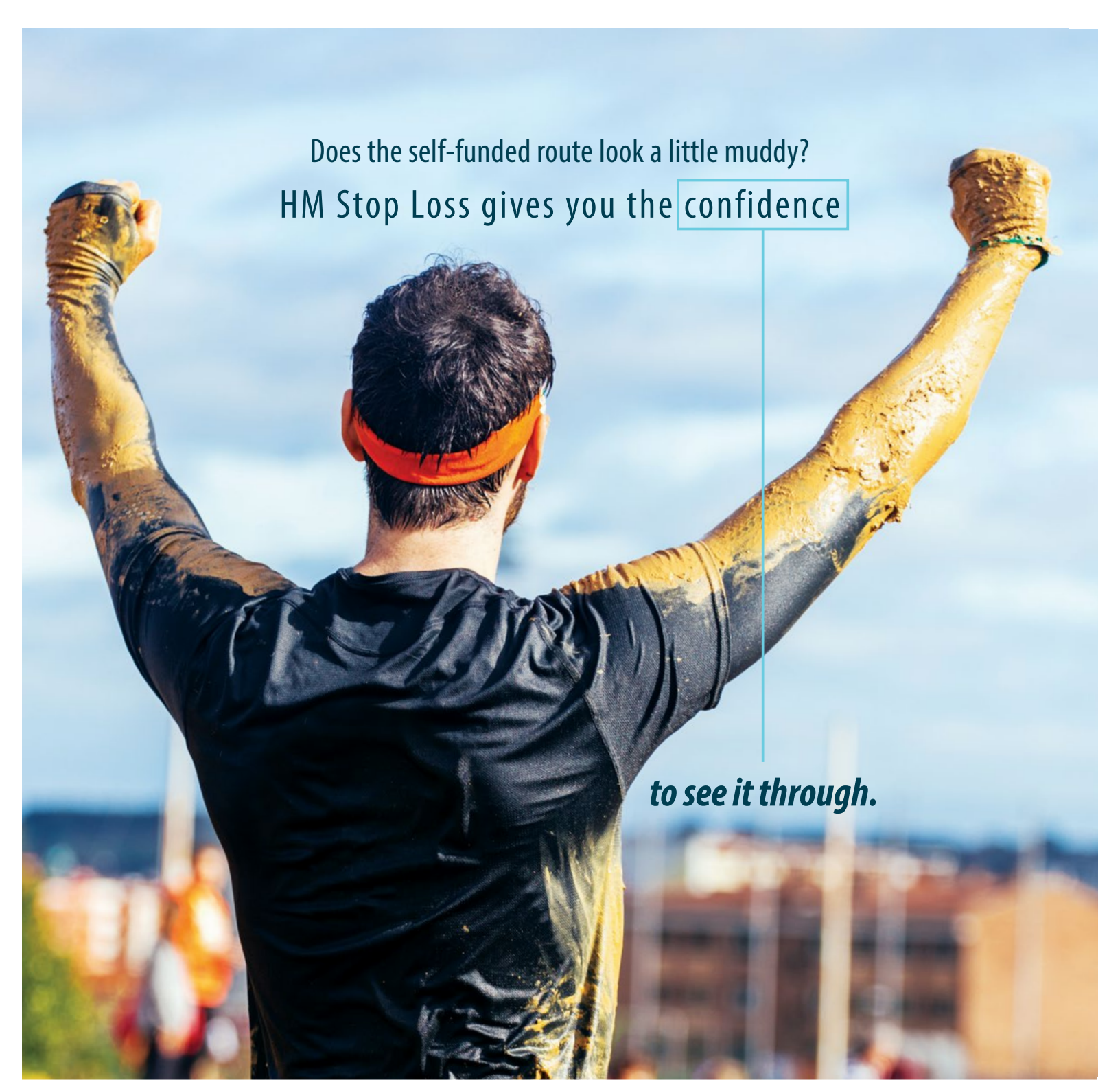
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QUICK OVERVIEW

Over the past several years, the group health insurance and cost-containment markets have seen interest and growth in Reference Based Reimbursement (RBR) solutions. Options range from repricing out-of-network (OON) medical bills at a percentage of Medicare or other reference based reimbursement model like “cost plus”, to a complete replacement of the PPO or managed care network.

The latter approach has gained traction with small to medium sized self-funded employers (typically 50-500), though larger employers, especially companies with lower wage and/or transient employees have also considered this solution to battle increasing medical Plan costs.

Likewise, many Brokers and TPAs have promoted these options as tools to reduce Plan medical spend, as well as being a differentiator for them in the market. There are now multiple organizations offering this type of program nationwide. In this article, we will focus specifically on the use of RBR as a partial or total replacement of a PPO as part of the medical benefits Plan.



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THE BASICS OF RBR

The concept is to eliminate reliance on network discounts in favor of savings obtained through the application of a percentage of Medicare, “cost plus”, or other reference based repricing mechanism. The most common method appears to be using Medicare as a benchmark for recommending provider payment since that is the most recognized and used reference based repricing tool.

Most RBR vendors set a standard percentage of Medicare in recommending a payment. For services where no Medicare reimbursement is available or applicable, other pricing mechanisms are used including cost-plus and usual, customary and reasonable (UCR). The vendors then support their recommendation through a combination of telephonic interface with the providers and members, along with varying levels of legal assistance.

Several organizations will even take on the “fiduciary” responsibility of the Plan, protecting it from legal action by providers. This may include paying attorney’s fees, court costs and even additional payments to the provider. Fees for these services may be based on a percentage of savings, a percentage of billed charges, or a per employee per month (PEPM) fee.

RBR Options:

There are several options for employers to consider when discussing RBR as a network replacement solution:

- **Partial PPO Replacement:**

This service offers a physician only network and applies the RBR solution to all facility charges. This enables the employer to take a smaller step into the RBR world by offering standard PPO access for physician and professional services, while also impacting approximately 50% of the total medical costs represented by inpatient and outpatient facility services (1). This approach can be used as a transition product to full PPO replacement.

- **Complete PPO Replacement:**

With this option the employer eliminates the PPO and replaces it with RBR based payments to all providers, including services for urgent and emergent care.



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THE UPSIDE

For employers, the Plan savings can be dramatic, especially if a total replacement strategy is implemented. Instead of network savings ranging from 20% to mid-40% (depending on if accessing a rental PPO vs. a carrier network), they can achieve savings of 50% to over 70%, depending on the baseline percentage of Medicare used for payment recommendations. Additionally, the member can see significant out-of-pocket savings since these reductions can impact applicable deductibles, coinsurance and copays.

The number of employers implementing RBR plans is increasing, especially in markets where providers have shown a willingness to accept "reasonable" reimbursement. For many, 150% of Medicare has been acceptable as payment in full, especially for physician services. In fact, many physicians are accepting fees at or below 120% of Medicare. Even some facilities have been willing to accept 150% to 180% of Medicare in lieu of balance billing members. In addition, these solutions provide members open access to any provider regardless of location.

THE CATCH

There always seems to be a catch with solutions promoting Plan savings that seem too good to be true, and the RBR product is no different. With the elimination of the PPO network there's no longer an out-of-pocket cost safety net for members, putting them potentially at risk for significant fees above their Plan deductibles, coinsurance and copays. In some cases, depending on the service and the percentage of Medicare applied, they could be balanced billed for tens of thousands of dollars, or more.

Though most of the organizations providing this service offer aggressive "patient advocacy" services to assist in reducing or eliminating balance billing, there are no guarantees.

When the vendor takes on "fiduciary" responsibility for the Plan, it does NOT usually apply to the individual members.

This fact can cause significant concern and potential employee dissatisfaction with the Plan and the employer. And because interaction with the provider on behalf of the member can take months, even up to a year, there may be a risk to the financial well-being of the member, including impacting their credit worthiness. However, considering the lack of contractual leverage with providers, the incidence of cases resulting in legal action directly against members appear to be relatively small. For some employers, the risk is worth the reward of the medical savings to the Plan.

THE EVOLUTION

Despite the significant savings that can be generated through these programs, many employers are still reticent to offer them due to the concern it could create employee dissatisfaction, and potentially lead to the loss of high value employees. Consequently, some RBR vendors are now offering services to help mitigate or eliminate provider push back on payments, and member balance billing.

- **Concierge Services:** Several vendors now offer a range of concierge services, including "pre-negotiation" of elective facility and high cost services. The goal is to encourage members to notify the vendor when high cost services are needed so they can identify providers willing to accept a set percentage of Medicare or other fee in return for having care directed to the them. Typically, the vendor will contract with the appropriate provider(s), which may even include making payment prior to the delivery of care to secure the savings. The concierge services will often include coordinating and contracting

for all care for the member; scheduling pre-testing as well as post treatment to enhance the level of service. The result is significantly reduced costs for the Plan and the member; eliminating balance billing, and providing a positive member experience. Some vendors have gone as far as identifying highly utilized providers for the employer with the goal of contracting prior to the need for services.

- **Medical Tourism:** Another tool being used to limit the impact on members while also generating impressive savings is directing care to providers outside of the Plan's geographic market, including internationally. Again, the goal is to obtain an aggressive contracted rate in return for directing care to the provider(s). Many times, the employer will cover the travel costs for the patient and a family member because the savings are so significant to the Plan. This may be included as part of the concierge service offering, or as a standalone product.
- **Specialty PPO Access:** Some vendors have taken a further step to help eliminate provider balance billing and increase employee satisfaction by including specialty network access, including, but not limited to diagnostic and radiological services, Centers of Excellence and transplant.

It is important to note that the member may still have the option to waive these options and select any provider with the understanding that there may be significant additional out-of-pocket costs.

FULL CIRCLE

What is most interesting about the next iteration of RBR products is the focus on developing solutions that can limit or even eliminate provider balance billing. This can be done through a combination of services as mentioned above. If enough providers are contracted, we have what can loosely be defined as a "narrow network". In some markets, vendors that have a significant volume of business are proactively contracting with highly utilized physicians and hospitals. In other cases, they may contract on a client specific basis. Consequently, RBR products could become a stepping stone for groups to move to formal narrow/high value networks.

The more these solutions add direct negotiated provider agreements, including other contracted specialty networks, the more employers may gravitate toward PPOs offering limited provider access with agreements based on a percentage of Medicare similar to, or even less than that used by RBR replacement solutions. We are already seeing an increase in narrow/high value network offerings and anticipate that over the next several of years RBR replacement and narrow networks will vie for many small to medium sized employers. Some vendors may offer both options recognizing that one size doesn't fit all. Only time will tell which product may gain significant traction in the market. Certainly, with the change in our governmental leadership and the potential of repealing or modifying the Affordable Care Act, we may see an environment that is conducive to accelerated growth of one or both options. ■

ABOUT THE AUTHOR

Corte B. Larossi has over 25 years' success in the group health, cost-containment, PPO and managed care markets. He's led sales, marketing, and product development teams for large managed care organizations including Prudential, BCBS, and the George Washington University Health Plan, and fast moving entrepreneurial businesses including United Claim Solutions, Coalition America (now Zelis Healthcare), and Memorial Health Services. He can be reached at cortearossi@outlook.com, and 423-505-9128.

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