

# Reference-Based Pricing **UNDER FIRE**

AMID CLOSELY WATCHED LITIGATION OVER FAIR MARKET HOSPITAL PRICING, ALTERNATIVE METHODS EMERGE AS A MORE PRECISE AND LESS ADVERSARIAL APPROACH FOR SELF-INSURED HEALTH PLANS

WRITTEN BY BRUCE SHUTAN

**W**

hat's a fair market price for various hospital services? Reference-based pricing (RBP) has long sought to answer that proverbial \$64,000 question – and seriously slash balance bills on behalf of self-insured health plan participants.

Legal battles have been intensifying, particularly within the past year. Critics charge that the strategy is too adversarial and a shakedown of the hospital chargemaster to procure below-market rates that appear to be both unreasonable and arbitrary. Proponents see it as a necessary tactic to wrest control of prices that vary widely from one market to the next and pad hospital coffers to a point where profit trumps patient outcomes.



Scott Bennett

“Some of the larger hospital systems in certain markets are getting much more sophisticated in their challenge to reference-based pricing,”

observes Scott Bennett, an attorney with Sixprints LLC who specializes in RBP cases.

That strategy includes rejecting some forms of RBP or requiring upfront payment of as much as 50% if a patient's insurance cannot be verified. These hospitals may balance bill immediately or refuse access to services. To combat these actions, he says many self-funded groups are considering ways they can be more

transparent and identify what the plan covers on the front end of the process.

### HIGH-PROFILE LITIGATION

During 2018, eight notable federal RBP lawsuits emerged in Oregon, California, Colorado, Nebraska, Utah and Florida involving a dozen significant challenges that included disputes over pricing methodologies, plan language, access to services and balance billing just to name a few of the key issues. Several of them were settled or remanded back to state court, while Bennett says the number of hospitals filing lawsuits has not increased within that timeframe.

Also, a recent Supreme Court case in Texas involving a hospital lien held that contract payments involving Medicare multipliers and other accepted payments could be evidence of reasonable, fair market value.

Cases often will start with a discovery battle that Bennett says the employer or patient gain significant leverage if the court rules that a hospital has to disclose contractual information and chargemaster details. This gives “an impression that the court is not interested in just applying the chargemaster rate as the benchmark,” he adds.

One common type of lawsuit involves an alleged breach of signed patient contracts stipulating payment terms on a hospital admission form, while another involves an action taken against the health plan under ERISA. Bennett says it could be argued that hospitals are receiving surprise reference payments “because they're expecting an out-of-network payment to be something they can negotiate.” But even if it's out of network, he notes that payers counter that it must be reasonable and consider balance billing the patient an abusive collection tactic.

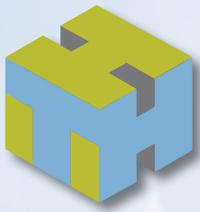
Mindful of the leverage fully-insured groups have in negotiating hospital prices, some self-funded groups enlist the services of RBP experts. These specialists can help draft a reasonable agreement, manage costly out-of-network billing, and provide patient advocacy or support. RBP litigation reflects the fact that “self-funded employers aren't willing to jump back into the fully-insured contracts,” Bennett explains.

### NEW RBP CLEARINGHOUSE

It's difficult to estimate the number of self-insured employers nationwide that have adopted RBP or track its growth in the absence of a trade organization that deals exclusively with this topic, according to Steve Kelly, co-founder and CEO of ELAP Services, which has been embroiled in RBP lawsuits during the past 11 years. His firm's RBP expertise business typically grows about 20% to 30% year-over-year as the number of ELAP competitors also has swelled.

A new website seeks to measure and examine the RBP phenomenon by acting as an information clearinghouse. RBPricing.com's mission is to educate the marketplace on this increasingly popular strategy, reports Lester J. Morales, CEO of Next Impact, LLC, an HR and benefits marketing and consulting firm, who was instrumental in its launch.

One motivation was the industry's lack of understanding about the subject matter as the self-insured community transitions from a tire-kicking stage to more sophisticated and widespread use of



# hi-tech health

Solutions as Individual as You.

Whether you're looking at a claims administration system for the first time or are tired of navigating the complicated maze of your current system, Hi-Tech Health can provide a customized software solution which will eliminate your frustration and put you on the right path to success.

Unlock  
**YOUR**  
Claims Administration  
Puzzle



## Your Business. Your Time. Your Way.

Whether your goal is to grow faster while competing with larger Third Party Administrators, streamline your paperwork, or simplify your billing services, we'll work with you, one-on-one, in a fraction of the time it takes other software companies to get you started!

1500 Route 517 Suite 200  
Hackettstown, NJ 07840  
908.813.3440  
[hi-techhealth.com](http://hi-techhealth.com)  
[sales@hi-techhealth.com](mailto:sales@hi-techhealth.com)





Lester Morales

RBP. There also was nowhere to consume agnostic information about the topic, he adds.

“We wanted

to make a ‘safe’ forum for people, employers and advisers to gather intelligence, resources, etc., around RBP,” Morales says, noting that the approach can save self-funded plans an estimated more than 15% on their health care spend.

The reason RBP has become more widespread is because self-insured employers “don’t understand what they’re paying” for hospital services, according to Kelly, whose company started a website called the Employer Bill of Rights. “If there can be a dialogue between the employer community and provider community, good things will happen,” he explains.

RBP strategies have surpassed first-mover status, but are still well short of reaching critical mass in movement, observes Ray West, chief growth officer of Maestro Health. Roughly 85% of the new groups his firm has sold have adopted a full RBR strategy that doesn’t include a PPO network or defined discounted network layer. He says PPOs have “put hospitals and providers in a position where the only way they can give you a discount is if they increase the prices.”

RBP has gained considerable traction in recent years because it’s straightforward, simple and provides cost savings at upwards of 30%, observes Merrit Quarum, M.D., CEO of WellRithms. He says another reason is preferred provider networks are failing to provide enough savings or guard against high costs and don’t have the same leverage they once did 10 to 15 years ago. There also are significant regional differences between networks, providers and payers.

His colleague, John Hennessy, SVP of business development for WellRithms, believes a pure Medicare multiple can be arbitrary and not necessarily a fair market price. “Facilities are pushing back because it doesn’t meet that definition of reasonable and customary” pricing, he reports.

The best possible solution, of course, is for payers and providers to avoid a lengthy dispute or costly jury trial. One way to find a reasonable middle ground is through rapid dispute resolution, according to Hennessy. He cites as an example the use of arbitration in New Jersey and Texas in “allowing self-insurance to opt into that system” as an early first step to quickly resolving disagreements.

Apart from the obvious need for more transparency, Hennessy says stop-loss carriers that are “getting clobbered in the network deals” recognize that RBP is an alternative and are starting to price these services.



John Hennessy



Merrit Quarum

### ALTERNATIVE APPROACHES

When used across the board, a simple multiplier can be very useful for underwriting, Quarum adds, but it’s not a good reference for a reasonable or expected price, nor is it defensible. Rather than using a Medicare multiplier, his company employs methodologies associated with the legal principle of quantum meruit to reasonable costs based on what providers generally receive for their services. After pursuing this approach in the workers’ comp area for 20 years, he recently began applying it to the group health side for self-insured employer customers.

Moving to dispute resolution and arbitration worked wonders in work comp, Quarum notes, adding that “the evidentiary standards are already in place with respect to what that would look like, so the groundwork has already been laid” for applying it to RBP.

WellRhythms recently consulted for *National Public Radio* and *Kaiser Health News* on a collaborative “Bill of The Month” series, opining on a reasonable price for medical services the father of a young family in Austin, Texas would be expected to pay. The hospital involved decided to drastically reduce his balance bill to only about \$300 from nearly \$109,000.

“We don’t believe we made this happen,” Hennessy admits, “but we believe our collaborative approach, working with others to shed some light on the inequities in the original bill, was a part of the change that took place.”

There are a number of factors that determine fair payments, the largest actuarial base being Medicare reimbursements, according to West. With the Centers for Medicare and Medicaid Services last year reporting a number of hospitals and facilities having profitable operations from Medicare payments, he says “it’s becoming increasingly difficult for them to say they can’t make a profit, especially when they have to report to Medicare every year their cost-to-charge ratios.”

Maestro’s RBP approach includes a strong dose of preventive medicine that it considers less adversarial and more collaborative. This fair-market reimbursement model pre-negotiates with hospitals, audits medical bills, increases plan transparency and empowers employees with the resources needed to better understand their cost and quality option tools, as well as access telemedicine advice and decision support. It also paves the way for direct contracting and bundled pricing for employers with promises of a 20% to 30% drop in overall costs on average.

The aim is to help consumers understand hospital charges as well as how to access care, communicate with their doctor and deal with balance bills. As part of their education, employees enjoy freedom of choice without narrow networks.

“It’s not just about post-bill,” West says. It’s about pre-education and interaction with the doctor upfront to make sure that they have an exposure to the way that the plan works.”

ELAP uses a Medicare-plus reimbursement multiplier, which Kelly considers a good starting point, as well as a cost-plus approach and line-by-line analysis of itemized bills – ultimately paying the higher of those two. Kelly describes it as an “evenhanded methodology” that’s friendlier to providers.

But occasionally there’s a legal challenge. Hospitals have accused ELAP of designing plans for underpayment and misrepresenting its strategies to employers, which stand accused of violating their fiduciary duty under ERISA. These lawsuits are often dismissed at summary judgment or settled out of court because hospitals are reluctant to endure the painful and revealing legal discovery process.

The company faced, and won, its first jury trial about midway through 2018 in Colorado. Jurors were sympathetic to ELAP’s argument on the relative value of medical services and validity of an admissions agreement, slashing a \$230,000 hospital bill down to about \$700.

“We think that employers have a right to their day in court,” Kelly opines. “If we think they’re being charged unfairly, we will stand shoulder-to-shoulder with them and take it to court.”

In the closely watched case of Centura Health in Colorado, a jury found that hospital charges were ambiguous. Bennett, who describes getting a jury trial as “a great strategic move on ELAP’s part,” predicts that it will lead to changes in documentation, with more transparent chargemaster rates referenced on hospital admission forms.

### NEFARIOUS PATTERN

Since RBP nearly always applies only to out-of-network providers, “the plan has to take into consideration whether or not they’re imposing an undue burden on the member,” explains Mark Flores, an ERISA claim appeal and compliance specialist who co-founded Avym Corp.

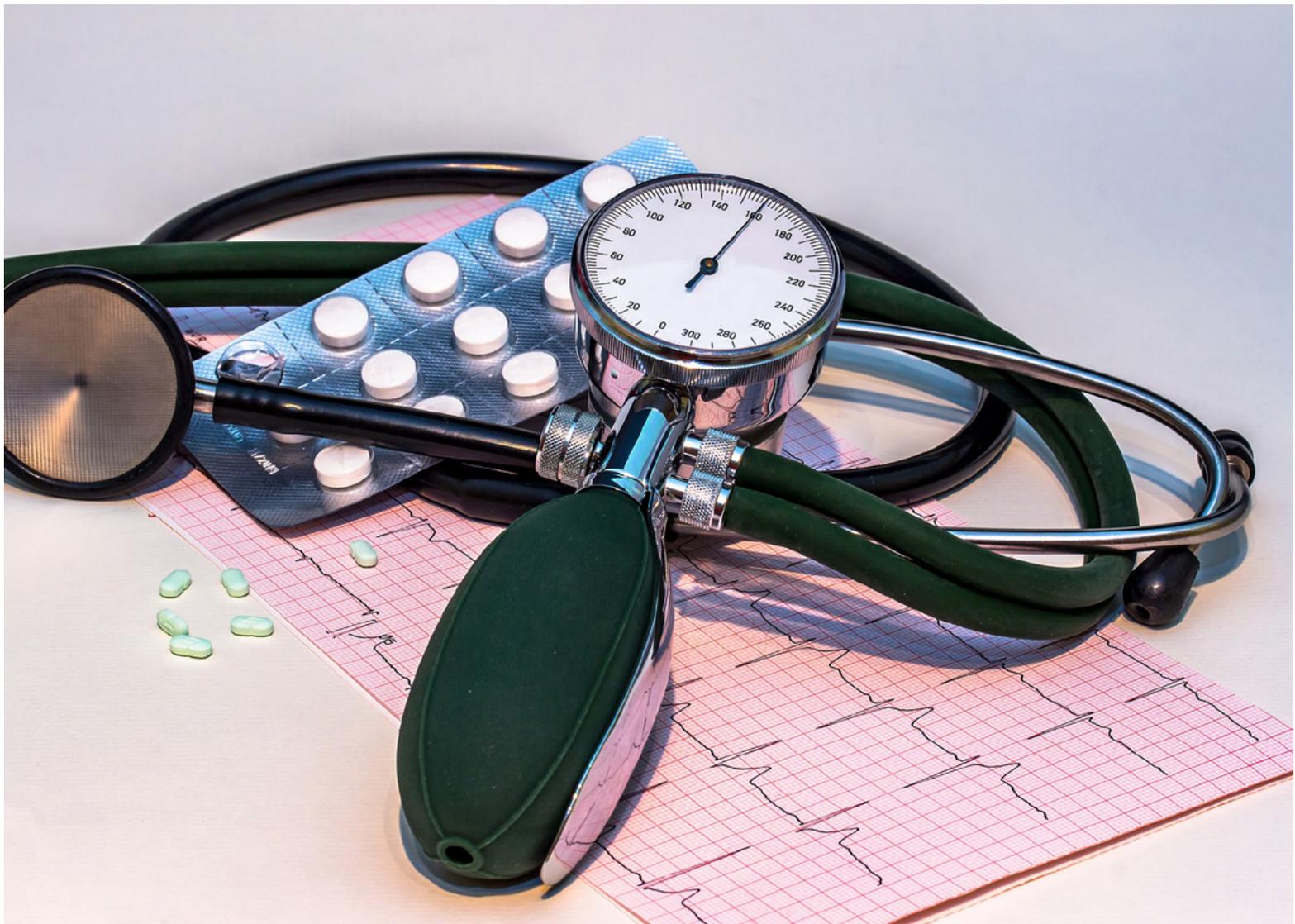


Ray West

He says self-insured employers have a fiduciary duty to disclose ahead of time to their health plan members any limited fee schedule for certain procedures or services. That arrangement also must be evenly integrated across the board without discriminating against any members, while provisions that changed have to be properly ratified and executed into the plan documents. He cites a Department of Labor action against Macy's for failing to do just that with RBP provisions in the department store's health benefits plan.

His firm, which ensures that doctors, hospitals and employer plan claims are properly adjudicated and paid when claims are filed to self-insured plans, has seen a nefarious pattern in the marketplace. A payer, for example, might agree to only half of an out-of-network doctor bill for \$200, citing RBP as the reason. The third-party administrator then would inform the self-insured employer that they saved them \$100, then "invoice the plan for 30% of \$100 savings on that balance between the \$100 payment and \$200 bill charge," according to Flores.

"Guess how many TPAs or consultants are willing to implement reference-based pricing on a flat fee structure?" he asks rhetorically. "Very few, if any. Why are they going to bother doing it? It's not their money. It's the plan's money."



They're telling the plan we're saving you money, but the 'savings' is being shifted to the patient responsibility. They have an inherent conflict of interest to try and generate as much savings fees as possible, even if it means saddling the patient with improper liabilities or exposing the plan to costly litigation."

It behooves these assorted vendors and/or TPAs to have out-of-network doctors charging \$300 or \$400 per procedure "because they're now going to charge a savings fee based on that billed charge," Flores says. He predicts a "tsunami, of lawsuits" against plan administrators for allowing TPAs to inflate claims and misrepresent facts in breach of their fiduciary duties.

West offers another prediction: greater movement toward value-based care and direct contracting. He lauds the Oklahoma Surgery Center's bundled-facilities model for guaranteeing quality, removing multiple bills and tackling recidivism. Such arrangements are "best deployed for highly definable engagements like knee-replacement surgeries," he says. ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for 30 years.

**Koehler  
Fitzgerald**  
LLC

Protecting Patients and  
Plans Across the U.S.

**Our team of attorneys and paralegals:**

- Defends out-of-network balance bills in all 50 states
- Utilizes a proprietary and fully relational database to manage claims and provide customizable reports
- Has a record of savings of up to 70% of billed charges

1111 Superior Ave. E, Suite 2500  
Cleveland, OH 44114

Office: (216) 538-9370  
Fax: (216) 916-4369

[www.koehler.law](http://www.koehler.law)