REFERENCE-BASED PRICING: PITFALLS FOR A NEW ERA

Written by Jon Jablon

How many times have you read an article or listened to a sales pitch about how great reference-based pricing is? RBP can add a lot of value, and many of us have seen that first-hand. But that is not the purpose of this article. As a consultant in the self-funded industry, The Phia Group has lots of opportunities to review and assess reference-based pricing plans and various claims situations. We have seen plans experience a great deal of RBP success – but we have also seen many RBP failures.

As many of you reading this have found out the hard way, and often unexpectedly, there are certain ways that RBP can go poorly and cause harm to an employer's health plan, employee base, or even business reputation.

RBP is a powerful payment methodology used by thousands of health plans around the country, but like so many cost-containment tools, a full understanding of the entire process and a strong implementation of the key elements are absolutely crucial to its success – and even seemingly inconsequential flaws in the process can prove to be problematic down the road. Let's go through some of the biggest pitfalls.

LACK OF PREPARATION: POOR SUPPORTING SPD LANGUAGE

Like so many things in the self-funded industry, a health plan's rights with respect to RBP pricing are only as good as the plan's language. A plan document should contain language to both allow the plan to pay claims as it sees fit, and to create arguments against balance-billing. A lack of adequate plan language makes the health plan especially vulnerable to appeals and lawsuits.

To provide a practical example, I was recently presented with a case where a health plan had neglected its Plan Document through the years. It was last restated in the late '90s, it had over 30 amendments, and it was just plain old confusing to read. That group utilized an RBP methodology, and yet there was a complete lack of payment limitation language, except for one sentence: "Expenses allowed at an amount the Supervisor deems reasonable."

There are two main problems there: one is that the Supervisor was the TPA (so the first moral of this story is that TPAs should be wary of that type of unexpected liability), and the other is that this does not reference the 155% of Medicare at which rate the group's RBP vendor had been pricing claims for six months.

What happened next? A large hospital system decided that it wanted to appeal, rather than jumping straight to balance-billing, and in the course of the appeal, the Plan Document was produced. I can just imagine the hospital's attorney's eyes filling with gigantic dollar signs when it saw that non-existent RBP language; the result is that while the vendor was repricing claims and raking in its fee, the Plan Document had not supported the program, and the Plan had not limited its exposure.

Rather than face a lawsuit, the Plan had no choice but to pay the hospital's demand in full… and ***hopefully*** amend its Plan Document language as soon as possible.

The seldom-referenced section 402(b)(4) of ERISA requires a health plan to "specify the basis on which payments are made to and from the plan." There is precious little law to interpret exactly what that means, but it is the backbone of the sentiment that "your rights are only as good as your language," and it seems safe to say that the particular provision within this health plan does not meet the relatively low standard of specifying how payments are made.

POOR EXPLANATIONS: INACCURATE EOBS

There are two extremely common mistakes that health plans make when generating Explanations of Benefits with respect to RBP claims: (1) providing inaccurate or nonspecific remark codes, and (2) calling the amount over the Plan's allowable amount a "discount."

The former is a compliance problem; ERISA requires that EOBs contain not only an explanation of why the claim was priced as it was (according to the regulations at 29 CFR 2560-503.1, "The specific reason or reasons for the adverse determination"), but also a reference to the specific provision in the Plan Document that allows the denial ("Reference to the specific plan provisions on which the determination is based").

The latter is a business issue; a "discount" is something that is allowed by the provider (typically in the contractual sense), whereas the excess or disallowed amount is, by definition, not agreed-upon in advance by the provider. Incorrectly using the term "discount" is problematic because not only is it incorrect, but it starts all parties out on the wrong foot – and working with a hospital to write off a bill is much more difficult when the provider goes into the conversation already thinking that the payor has tried to take advantage.

INCORRECT IMPLEMENTATION: APPLYING RBP PAYMENTS TO CONTRACTED CLAIMS

RBP results can be so good that some employers are tempted to apply RBP to contracted claims as well, the theory being that the contracted rate is still higher than what the plan deems reasonable, so the RBP savings are desirable for ***all*** claims, even contracted ones. While the contracted rate may well be just as arbitrary and overbilled as the original billed charges, it's important to remember that contracts are legally-binding instruments, and contracted providers sometimes have powerful legal backing.

This is perhaps another topic for another article – suffice it to say that unless the applicable fee agreement allows it, the health plan's chosen pricing cannot be applied to contracted claims without violating that agreement. It is a frighteningly-popular misconception within the self-funded industry that network or other fee agreements generally allow health plans to apply the contractual discount *on top of* the plan's chosen edits or reductions (including Medicare rates).

Consider the example of a $50,000 claim subject to a mandatory contractual 10% discount, yielding a contractual payment rate of $45,000. The payor priced the claim at 150% of Medicare based on the Plan Document, which totaled $10,000. While the contractual rate would require that this claim be paid at $45,000, an alarming number of health plans and TPAs will apply that contractual 10% discount on top of the Medicare-based $10,000 (yielding payment of $9,000). Given the large discrepancy between payment of $9,000 and payment of $45,000, it is not difficult to assume that a contracted medical provider will push back, and *hard*.

BAD NEGOTIATION TACTICS: NOT HAVING AN END-GAME

One of the hallmarks of a successful RBP program is patient protection, which can come in many forms – including direct contracts, case-by-case settlements, balance-bill indemnification, attorney representation, and other options, depending on the particular program used.

Settling claims is perhaps the simplest way of protecting patients; by eliminating balances via settlements, balance-billing is extinguished. Likewise, if a third party offers to indemnify the patient, then the patient is protected in that manner as well – and hiring litigation counsel on behalf of the patient can be an effective tool in combatting balance-billing or spurring settlement negotiations where a provider was otherwise hesitant to negotiate.

As has been proven time and time again, the state of the industry is such that medical providers are generally permitted to charge any amounts they choose. Charge masters are arbitrary yet still enforced by many courts, and providers are free to send patients to collections or file lawsuits when they have not received their full

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billed charges – and some providers feel even more inclined to do that if the provider has been paid at a percentage of the Medicare rate.

Many medical providers treat a Medicare-based payment as a personal assault on the value of their treatment and seek to abuse health plans even more because of that!

Some consider there to be two "separate" responsibilities to settle RBP claims or otherwise provide patients an avenue of protection from balance-billing – a social responsibility, and a legal responsibility.

The social responsibility can be thought of in terms of the employer's desire to provide its employees with sufficient coverage and a desirable program of health insurance; even though reference-based pricing and balance-billing are permitted by law, most employers utilizing this type of model are typically loathe to allow patients to be balance-billed, and desire to settle claims as part of the normal RBP process.

For many employers, seeing a valued employee be sent to collections or become the defendant in a hospital's lawsuit is the worst-case scenario.

There is, despite popular misconception, a legal responsibility to settle claims as well. A few years ago, the Department of Labor came out with set 31 of its series on Frequently Asked Questions on the Affordable Care Act.

While previous guidance provides that balance-billed amounts do not count toward the patient's out-of-pocket limit, this FAQ indicates that that rule applies only when there is an "adequate network of providers" who will refrain from balance-billing. When there is no adequate network of providers, however, the guidance suggests that health plans must in fact pay for balance-billed amounts that exceed the patient's out-of-pocket max.

Although the Department of Labor has neglected to provide additional guidance and make sure people understand what the FAQ guidance really means, the general opinion is that health plans must have a systematic program of settling balance-bills one way or another – and in fact most health plans utilizing RBP *do* have some system, whether direct contracts, a narrow network, or simply making sure they settle claims on the back-end.

There's no simple way to overcome the rising claims trend in today's market. But we know that incorporating smart practices into our business model is helping us to gain more control of the situation. We're making informed decisions based on data analytics and industry knowledge; using the insight of in-house experts to create thoughtful solutions; and choosing our cost containment partners wisely as we work to protect our clients' financial well-being.

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This is certainly a relevant factor for reference-based pricing, but not necessarily one that is prohibitive. This is an indication that RBP must evolve in order to remain compliant – and evidence that the threat of walking away the negotiation table may not be an option for many health plans.

THINKING THAT RBP IS "ALL OR NOTHING"

When employers are sold on RBP by TPAs, brokers, or vendors, often those entities fall into the common sales trap of promoting only the positive aspects of RBP, without painting a full picture of some of the potential snares as well. As a result, since RBP results do tend to add value, many employers immediately jump to leaving their respective PPO networks and applying the RBP methodology to all claims. After all, more claims subject to RBP theoretically means more added value, right?

In practice, however, it often proves extremely beneficial to utilize some system of agreements as part of the overall RBP process. This ensures that employees have "safe harbors" to visit, promoting employee security, ease of use, and even compliance (see above!).

There are no pre-set requirements for what RBP is or is not; though many enter into it with a set of preconceived notions of how it ***should*** work, an RBP program can be tailored to suit a given health plan's needs (subject to the vendor's and TPA's standard practices and capabilities, of course). Many health plans using RBP combine it with narrow networks, direct provider contracts, physician-only networks, or even primary networks (using RBP only for out-of-network claims).

Since RBP is meant only for non-contracted claims (see above, again!), RBP can in theory be used for ***any*** claims that the health plan has not previously agreed to pay at a certain rate.

On that note, the last point:

NOT REALIZING THAT RBP IS JUST U&C FOR THE MODERN ERA!

When providers say "we expect payment at U&C" or similar things, it can be useful to take a step back and think about what RBP really is. At its core, RBP is just a way of pricing claims. It's not a unique type of health plan, nor is it a way of changing the claims processes. It's simply a way to determine how much money to pay on a given claim.

"Hang on," you may be saying, "but isn't that what Usual and Customary is?" Yes, it is! RBP can be conceptualized in many ways, but one of the most familiar is as a way of determining U&C. Just like RBP, "Usual and Customary" is not necessarily a pre-set term with a well-defined meaning; it is the way that a health plan determines what is payable. Interestingly, hospitals tend to suggest that "U&C" has to be defined as what other area providers charge for the same service, yet there is no support for that requirement. In fact, many health plans define "usual and customary" as an amount that hospitals commonly ***accept*** as payment for a given code. That can take into account private payors and even – gasp! – ***Medicare.***

The employer determines the definitions within the Plan Document. If your plan defines its payable amount as U&C, and bases that amount on Medicare rates, then you can honestly say that your plan does pay U&C.

In conclusion: take care to ask your vendor – or ***potential*** vendor – lots of questions about their processes and how they manage these and other elements of their respective programs. With so many vendors in the industry, there can be lots of conflicting information, so make sure you've got your facts straight prior to signing on the dotted line. ■

As Director of The Phia Group's Provider Relations department, Jon Jablon routinely advises health plans, TPAs, brokers, various industry vendors, and stop-loss carriers regarding balance-billing, claims negotiation, provider and network contracting, and much more.