REFERENCE-BASED PRICING

Risks and Rewards of Playing Health Care Hardball

catalyst
FOR PAYMENT REFORM

THANK YOU TO CPR'S CONTRIBUTORS WHOSE SUPPORT HELPED MAKE THIS REPORT POSSIBLE.

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INTRODUCTION

In 2003, *Health Affairs* published a landmark study explaining why health care spending in the United States was outpacing all other OECD countries. The answer is in the study's four-word title: "It's the Prices, Stupid." The study's authors found that Americans use health care services at approximately the same rate and same intensity as the 30 other OECD countries, which led the authors to conclude that health care *prices* in the United States – not utilization – are responsible for our ever-escalating health care costs. [1]

Nearly twenty years later, the story hasn't changed. Data from The Health Care Cost Institute confirm that increased prices accounted for 75 percent of per person health care cost inflation over the past five years.[2] Meanwhile, the most recent report from the RAND Corporation's Hospital Price Transparency study demonstrates that the gap between Medicare rates and Commercial payments continues to widen year over year: in 2018, hospitals' average commercial prices grew to 247 percent of Medicare, up 17 points from the previous year.[3]

Reference-based pricing (RBP) models appeal to a small but growing number of health care purchasers because they tie health care prices to a rationalized external benchmark – often Medicare. Traditionally, health plan negotiations with health care providers begin with a document called a "chargemaster" -- a book of prices that the provider would *like* to charge for services, but which do not tie to the cost of delivering care, and which vary wildly among providers, even within the same market.[4] Consequently, "discounts," which have become the currency of health plans' negotiation strategies, only refer to discounts off of the *chargemaster*, and thus are not actual savings. Medicare, on the other hand, is designed to cover hospitals' variable cost at a rate of 108 percent, with margin built in for overhead and other fixed expenses.

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[1] Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid," *Health Affairs,* May/June 2003. Accessed April 16, 2021 at https://www.kff.org/wp-content/uploads/sites/3/2015/01/89.full.pdf

[2] Niall Brennan, et al., "2018 Health Care Cost and Utilization Report, "*The Health Care Cost Institute,* https://healthcostinstitute.org/images/pdfs/HCCI_2018_Health_Care_Cost_and_Utilization_Report.pdf

[3] Christopher M. Whaley, et al., "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans," *The RAND Corporation,* September, 2020. https://employerptp.org/wp-content/uploads/2020/09/RAND-3.0-Report-9-18-20.pdf

[4] Steven Schramm, "Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan," *National Academy for State Health Policy,* April 6, 2021. https://www.nashp.org/wp-content/uploads/2021/04/MT-Eval-Analysis-Final-4-2-2021.pdf

"If I'm a traditional carrier and I'm renting my network out to employers, I don't have any financial interest in whether somebody pays $100 for a service or $200 for a service. It doesn't impact my revenue. Under the traditional model, the financial incentives are not aligned down to the people or employers that are paying for health care."

Scott Ray, CEO, 6Degrees Health

Tying the health care prices to Medicare is a surefire way to lower costs, but it is not without risk. Unlike PPO plans that have confirmed contractual price agreements with health care providers, RBP plans operate on a combination of one-off case rates (e.g. an agreed-upon rate for a single patient or single procedure), tacit and informal agreements with providers (hand-shake deals) and by asking for forgiveness rather than permission after care has been delivered. This leaves plan members – patients – exposed to balance billing. To that end, RBP vendors retain armies of patient advocates, litigators and other support resources to go toe-to-toe with providers, either fighting tooth and nail until the provider backs down, or negotiating into settlement, but at a rate much lower than the provider's contracted rate with health plans. In the rare circumstances when RBP disputes go to court, the justice system tends to rule in favor of patients and plan sponsors. But a strategy with high potential for conflict, disruption and ongoing dispute resolution puts off many purchasers – no matter how urgent their need for lower costs.

Catalyst for Payment Reform (CPR) is an independent, nonprofit organization on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. For over a decade, CPR has championed efforts to change how we pay health care providers, holding the health care delivery system accountable for health care outcomes, patient experience and affordability. Simultaneously, CPR contends that "It's not payment reform if it doesn't address prices." As such, CPR assiduously monitors new and emerging strategies designed to improve health care affordability, tracking the efforts of employers and other health care purchasers to take command of their health care spending and engineer solutions that drive greater value to their health plan members.

For over a decade, CPR has championed efforts to change how we pay health care providers. Simultaneously, CPR contends that "It's not payment reform if it doesn't address prices."

"Large organizations like state entities are starting to look at RBP and saying, 'We're not going to pay these PPO rates anymore; we're going to start taking our destiny into our own hands, because it's ridiculous to pay these amounts."

Tom Wittick, SVP Growth, ELAP Services

Reference pricing models first attracted CPR's attention in 2011, when the California Public Employees' Retirement System (CalPERS) launched its reference-based benefits pilot for hip and knee replacements. A new variation of the model captured national attention in 2016, when the Montana State Employee Health Plan renegotiated all of its hospital contracts to tie payment amounts to a multiple of Medicare. In the background, a growing cohort of independent vendors began offering RBP health plans that pay providers in Medicare multiples with or without establishing a contractual agreement.

This vendor-convened model of reference pricing has grown – not dramatically, but steadily – over the past decade, to the point where an estimated 2-3 percent of employee benefit plans use a Medicare multiple to pay providers for health care services.[5] In the fourth quarter of 2020, health care costs increased by over 10 percent compared to the same period in the year prior – the largest increase since 2003 - and survey research indicates that 87 percent of CFOs rank controlling health care costs as a top priority for their organization. [6,7] Vendor-convened RBP plans offer can offer immediate savings, averaging about 20 percent less than traditional health plans.[8]

Seeing the tangible impact of RBP health plans and the unrelenting inflation of health care prices, CPR set out to determine *how* and *why* RBP can work, the risks and trade-offs it poses, and explore strategies for merging RBP with more traditional value-oriented health care strategies. To this end, we developed a request for information (RFI), which we distributed to eight RBP vendors and one third-party administrator (TPA) who partners with multiple RBP plans. Through the course of reviewing responses, consulting with experts, stakeholders and RBP clients, we developed an RBP Evaluation Toolkit, comprising standardized questions, response specifications, and an evaluation tool to measure program outcomes.

[5] Alliant Employee Benefits
[6] Willis Towers Watson, "U.S. commercial insurance prices see biggest increase since 2003 in Q4 2020," March 2021, https://www.willistowerswatson.com/en-US/Insights/2021/03/survey-shows-that-q4-2020-us-commercial-insurance-prices-achieved-the-highest-increase-since-2003
[7] Willis Towers Watson, "2020 CFO Survey – Health Care Costs," November 2020, https://www.willistowerswatson.com/en-US/Insights/2021/01/2020-cfo-survey-health-care-costs
[8] Edward Day, "How reference-based pricing is recalibrating buying benefits," *Benefits Pro,* September 2020. https://www-benefitspro-com.cdn.ampproject.org/c/s/www.benefitspro.com/2020/09/07/how-reference-based-pricing-is-recalibrating-buying-benefits/?amp=1

This report is intended to share our most salient findings, and answer the following questions:

- What is RBP and how has is evolved?
- Why would providers accept drastically lower prices under RBP plans compared to the rates they receive from traditional health plan?
- What are the risks of RBP and how do RBP vendors attempt to mitigate them?
- What should health care purchasers look for in an RBP vendor?
- Where is RBP headed in the future? Is this trend likely to catch on?

THE EVOLUTION OF REFERENCE PRICING MODELS

Like so many health care innovations, reference pricing strategies have grown into multiple branches; consequently, the term "RBP" has come to mean different things to different stakeholders.

In this section, we explore the three different branches of reference-based models:

- Reference-based **Benefits** – which sets a maximum allowed benefit for elective procedures
- Reference-based **Contracting** – which anchors provider contracts to Medicare rates
- Reference-based **Pricing** – a vendor-convened model that also anchors provider prices to Medicare, with or without a formal contract in place

REFERENCE-BASED BENEFITS (RBB)

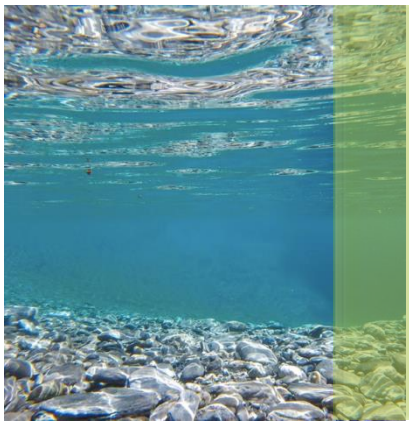
Setting a Benefit Maximum for Elective Procedures

In 2011, the California Public Employees' Retirement System (CalPERS) surveyed prices for joint replacement surgery across the California marketplace. It found a 7-fold difference in prices for the procedure without any correlation to the quality of care. To reduce spending,

CalPERS set a threshold benefit level of $30,000, and identified 46 hospitals state-wide willing to accept this *reference price* (or less) for joint replacement. If a CalPERS health plan member selected a higher-cost hospital, CalPERS paid the first $30,000, but required the plan member to cover the difference out-of-pocket. After the first year, CalPERS achieved program savings of $2.8M, an average savings of $7,000 per patient, without any detriment to clinical outcomes.[9] Moreover, the program spurred hospital competition: several hospitals whose prices were above the $30,000 reference price voluntarily renegotiated their contracts so that they could meet the threshold and continue to care for CalPERS plan members.

The CalPERS RBB model offers tremendous promise, but it is complex to administer and requires members to act as *informed and engaged health care consumers*. And the complexity multiplies as purchasers add additional elective procedures that are subject to a reference price. If members don't research provider prices in advance, the results could be financially devastating.

That is why Self-Insured Schools of California implemented a newer rendition of reference-based benefits, as profiled in a CPR case study, which focuses on *site of service* instead of *specific providers*. SISC identified five elective procedures (arthroscopy, cataract surgery, colonoscopy, upper GI endoscopy with or without biopsy) to which they apply a reference pricing benefit design *only if plan members receive these procedures in a hospital setting* rather than a lower cost outpatient facility. Because the benefit design applies to site of service rather than procedure price, it is likely easier for plan members to navigate. As of July 2020, the program has saved over $3M, with less than 0.2 percent of members incurring additional charges for using hospital facilities.[10]



Reference-based benefits set a threshold benefit level (the "reference price") for an elective service or procedure. Newer RBB models focus on site of service instead of specific providers.

[9] Amanda E, Lechner, Rebecca Grourevitch and Paul B. Ginsberg, "The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer," *Center for Studying Health System Change,* December 2013. https://www.nihcr.org/wp-content/uploads/2015/03/HSC_Research_Brief_No._30.pdf

[10] Catalyst for Payment Reform, "Guiding Members to High-Value Choices through Reference Pricing: Self-Insured Schools of California (SISC)," July 2020, https://www.catalyze.org/product/sisc-reference-pricing-case-study/

REFERENCE-BASED CONTRACTING (RBC)

Anchoring Hospital Contracts to Medicare Rates

In Montana in 2016, Marilyn Bartlett, as administrator of the Health Care and Benefits Division for Montana's state employee health plan, informed hospitals that the state's plan would pay a maximum of 230 percent of Medicare rates, and that any hospital unwilling to accept these rates would be excluded from the state employee health plan network. With its 33,000 covered members, the State of Montana's employee health plan represented business hospitals couldn't afford to lose.[11] Eventually, every hospital in the state signed on. As a result, the health plan saved an estimated $47.8 million in inpatient and outpatient costs from 2017 through 2019.[12]

Reference-based contracting found success in Montana, but the strategy has faltered in other parts of the country. In 2019, the North Carolina State Treasurer's efforts to recapitulate Montana's strategy fell apart when the majority of hospitals refused to accept the planned contract rate of 196 percent of Medicare. Even with over 700,000 plan members in its ranks, the North Carolina hospitals' response to the ultimatum of take it or leave it was: leave it. As such, the health plan had no choice but to revert to the PPO rates from its existing carrier.[13]

REFERENCE-BASED PRICES (RBP)

Like Reference-Based Contracting, Minus the Contract

The third model – and the focus of CPR's research - is reference-based *pricing* (RBP). Under a reference-based pricing model, vendors re-price claims at a multiple of Medicare's rates (usually somewhere in the ballpark of 140-180 percent). The vendors pay providers at this rate with or without a contract. Providers will either accept the payment, which is usually much lower than what they would receive from a commercial health plan, or they won't, in which case the provider will balance bill the patient for the remainder. If a patient is balance billed, the RBP vendor's reserve army of advocates and legal representatives fights the provider or negotiates on the patient's behalf until they reach a settlement.

On its surface, RBP may seem like a dangerous game of brinksmanship between vendors and providers, using the patient in the middle as a pawn. But CPR's research shows that the reality is more complicated and the risks more nuanced. The reasons why a reference-

[11] https://benefits.mt.gov/Resources/About-HCBD/

[12] Steven Schramm, "Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan," *National Academy for State Health Policy*, April 6, 2021. https://www.nashp.org/wp-content/uploads/2021/04/MT-Eval-Analysis-Final-4-2-2021.pdf

[13] Shelby Livingston, "N.C. walks back reference-based pricing plan for state workers," *Modern Healthcare*, August 2019.

based pricing model can work expose just how strange and impractical our system of paying for health care has become. The proceeding sections explore the Reference-Based Pricing model in greater detail.

UNPACKING THE RBP MODEL: KEY FINDINGS

As noted, RBP plans operate by setting a payment amount for a specific service by multiplying Medicare's baseline rate by some factor or multiple. RBP vendors pay providers at this rate with or without a contract – and sometimes even without knowledge of whether the provider will consent to accept the payment. Sometimes providers will bill patients for the difference between the Medicare multiple and the rate in their chargemaster (their billed rate). This is called *balance billing.* When a provider balance bills a patient, the RBP vendor either negotiates on the purchaser's/patient's behalf, or fights with the provider until the provider ultimately (almost always, according to those we interviewed) relents.

Here are a few basic insights that explain how RBP plans operate:

1. RBP Vendors assume some – but not all – of a TPA's services

RBP vendors are not insurance companies, nor are they third-party administrators (TPAs) – although some have a short-list of preferred TPA partners. Rather, RBP vendors take over a subset of TPA functions, which include the following:

PROVIDER NEGOTIATION: Although RBP is sometimes called "the network-less network," most RBP vendors *do* have tacit agreements with providers; in some cases, they even hold formalized contracts. The important thing to understand is that the parts of the network that are governed by RBP operate under the RBP vendor's rates, not the TPAs. Thus, although RBP vendors do not own or operate networks, they appropriate network functions from their TPA partners.

CLAIMS ADJUDICATION: Under an RBP plan, when a provider issues a claim, the RBP vendor performs the following functions:

- **Re-pricing claims** – Vendors apply a Medicare multiple to the claim's codes to arrive at the reference-based payment amount
- **Editing claims** – Vendors verify that claims are coded appropriately with sufficient documentation
- **Auditing claims** – Vendors meticulously and thoroughly examine high-cost claims with the intent of preventing the plan sponsor from overpaying. Some RBP vendors apply this level of scrutiny to any claim greater than $2,000 and assert that the savings they produce by catching inappropriate billing is nearly comparable to the savings from claims re-pricing.

A TPA partner retains some of its core functions when paired with RBP. It holds responsibility for executing provider payment (i.e. paying the claim). More visibly, it usually provides clinical services such as utilization management and case management, and fields customer service requests unrelated to RBP.

2. Purchasers can configure and customize their RBP solution

> "When employers understand that RBP doesn't just service the plan, it's also for the members and what's coming out of their members' pockets, their dollars are now going further. If you're able to start reducing premiums, and enhancing plan designs, that feels like a really big win."
>
> Ryan Day, CEO, HST

If the idea of replacing a PPO network entirely with RBP sounds precarious, the good news is that a purchaser can opt to implement RBP incrementally, expanding (or not expanding) its application as the purchaser deems appropriate. For example, a purchaser can apply RBP to out-of-network coverage only, or to facility care only, or to specialist, pharmacy or other ancillary services. The TPA's PPO network fills in the gaps that remain.

Purchasers can also customize the Medicare multiple that they pay to providers. For example, a purchaser may initiate an RBP program paying providers 200 percent of Medicare, and then gradually ratchet the rate down once the purchaser and its plan participants have acclimated to the plan, become adept at knowing how to manage balance bills when they

occur, and have re-routed utilization to providers most likely to accept RBP. Another configuration model is to allow the RBP vendor to negotiate within a corridor on the purchaser's behalf. For example, an RBP vendor might pay providers at 150 percent of Medicare, but then obtain leeway from its clients to negotiate as high as 175 percent without seeking authorization from the purchaser. The average hospital in the United States commands about 250 percent of Medicare, so purchasers can permit these corridors and still achieve substantial savings.

3. The balance billing risk may not be the 800lb gorilla of RBP

Because purchasers are so averse to plan member disruption and dissatisfaction, the idea of a health insurance plan without formal provider contracts might sound outlandishly dangerous. If a provider is accustomed to receiving 300 percent of Medicare, and an RBP vendor offers half as much, it seems obvious that the provider would seek full remuneration from the next available pocketbook: the patient's. And yet, the RBP vendors in CPR's study assert that less than 2 percent of their total claims result in a balance bill (for facility claims, the number is more like 10 percent) and that with diligent patient education and communication, no plan member – *ever* – should pay out of pocket as a result of a balance bill.

Balance billing frightens both purchasers and plan members because traditionally, when patients receive balance bills, it is because they sought care outside of their health plan's network. Although health plans may offer some negotiation services on behalf of patients when they receive balance bills, this type of advocacy is unusual; it is likely more common that everyone blames the patient for seeking care out-of-network.[14]

RBP plans are different. Core to their business model is the ability to fight toe-to-toe with providers, negotiate strategically, and levy their cavalry of patient advocates and litigators to make sure that the patient never has to pay the balance bill. The primary challenge for RBP vendors, therefore, is to make sure that their clients' plan members understand what to do when they receive a balance bill and know that under no circumstance should they preemptively pay it.

4. Carrots and sticks explain providers' motivations to accept RBP payment

[14] As a side note, *surprise billing,* which occur when a patient receives care at an in-network facility but an out-of-network physician/professional provides some of the care, are a different class of balance bill, and subject to a different set of laws and regulations. For more information, see: https://www.benefitspro.com/2021/03/29/the-no-surprises-act-what-is-a-surprise/

"Eventually deductibles will get so high or the cost of health care will escalate to the point where people won't be able to afford insurance. Then you'll start to get patients walking through the provider's door who are completely uninsured. And then, instead of negotiating with a TPA or health plan, they have to negotiate directly with somebody who works construction, and actually can't afford the cost of their health care."

Dan Meylan, Senior Vice President
Broker Relations, Payer Compass

Imagine a local grocery store where the produce manager sells oranges at three times the price it pays wholesale. One day, a new customer walks in the door and says, "I will offer you half as much – it's still 150% above what you pay wholesale and this is what's fair. And by the way, I'm leaving the money on the counter and walking out of the store with my oranges." It seems unlikely that the produce manager will accept this lying down, and even *less* likely that the "150% customer" will be welcome in the grocery store again.

Why then are RBP vendors able to establish deals with providers at dime-store rates, when these providers can command twice as much from traditional payers? More importantly, why don't more RBP claims result in balance bills, and how can RBP vendors guarantee that plan members will never be compelled to pay out of pocket? There is no singular answer.

Multiple and overlapping motivations persuade providers to accept RBP, including the following:

IT'S AN OPPORTUNITY TO GAIN MARKET SHARE: A hospital in a competitive market whose rival hospital refuses to accept RBP may decide that it's preferable to attract more patients – even at a thinner margin – than forego new business altogether.

"If you're getting a reasonable reimbursement for your product or service, then making the choice to drive your customer to a competing provider is a difficult choice to make. We've seen this play out in the market where hospitals decide that they don't want to accept reference-based pricing, and so we move or encourage patients to go to competing providers. I think that's a wake-up call for hospitals that have not had to compete."

Scott Ray, CEO, 6Degrees Health

"There are providers out there who look at an RBP model and say, 'wait a minute, we can make this work for us because we're going to run our hospital better than the people across the street who weren't paying attention.' The hospital is ready to go market directly to the employers in the community and say, 'Hey, why don't you come to us, we have a better price for the same deal!'"

Dan Meylan, Senior Vice President
Broker Relations, Payer Compass

"So many people these days have high deductible plans that end up shifting costs on to the provider. Then the provider has to go chase the member down or write it off as bad debt. So, if we're able to reduce the collection efforts of the health systems, they're definitely more than willing to entertain discussions."

Ryan Day, CEO, HST

HOSPITALS RECEIVE PAYMENT MORE QUICKLY AND RELIABLY: When an RBP vendor establishes a relationship with providers, they usually do not require patients to pay co-pays or coinsurance. This saves providers from the time and energy spent chasing down the patient's portion of the payment.

FIGHTING WITH PATIENTS IS A NEGATIVE PUBLIC RELATIONS MOVE FOR PROVIDERS: In fights between *insurance companies* and providers, providers have the automatic upper hand in the court of public opinion. Not so when they're fighting individual employers and patients. When cases do go to court, providers have to open up their books and explain and justify their chargemaster rates. The legal cost, tax on their reputation and demands for transparency make the juice unworthy of the squeeze.

"While some hospitals may initiate litigation on balance bills, they generally settle before the discovery phase. In discovery, attorneys can request data that is generally considered proprietary, such as network discounts across all of their payors, as well as specific cost and expenditure information. The inner-workings of a hospital's financial model is very complex, including using commercial market reimbursements to subsidize revenue to offset lower reimbursements by government programs. Attorneys can use this to paint a very negative picture, one that given the complex financing, hospitals have a hard time defending to a jury."

Justin Curtis, Alliant Employee Benefits

COURTS HAVE HISTORICALLY SIDED WITH PATIENTS IN RBP LITIGATION: In the early years of RBP, providers tried to fight the RBP vendors and their health plan members in court. It proved – for the most part – a dead end. In a landmark case in 2017, St. Anthony's hospital in Denver sued an ELAP Services plan member for $230,000, which was the difference between the hospital's billed charges and the amount the hospital received from the RBP plan.

A jury ruled on the patient's behalf, finding that "the patient had a contract with St. Anthony, but that the contract could not reasonably be interpreted as an agreement to pay over $300,000 for a surgery that cost the hospital a mere $31,655.05."[15] A similar case in Georgia in 2012 granted summary judgment to dismiss another hospital's lawsuit against an RBP plan member.

[15] "Refusing to Negotiate: Why Surprise Medical Bills May be Unenforceable," *Journal of Health and Biomedical Law*, February, 2020. https://sites.suffolk.edu/jhbl/2020/02/07/refusing-to-negotiate-why-surprise-medical-bills-may-be-unenforceable/

5. Access to care may be the bigger gorilla

At present, providers who are averse to RBP have weighed the costs versus the benefits of suing patients and concluded that they are better off avoiding patients on RBP plans altogether. In some markets, a dominant health system's decision to refuse RBP patients creates an opportunity for small independent providers to attract more business – but in others, there may be no accessible alternative. As the trend of provider consolidation continues, powerful health systems can cement a grip on the market by buying up independent physician practices and locking in referrals.

In a market where a single hospital or health system has 100 percent market share, RBP may not be a viable solution. Then again, a market where a single hospital holds a monopoly offers *very* few cost containment options. Network solutions and even alternative payment models require either a willing hospital partner or some degree of market leverage. However, even highly consolidated markets present options. For example, the number of ambulatory surgery centers (ASCs) has grown steadily, and currently 72 percent are independently owned and operated.[16] Over the past 15 years, the percent of outpatient procedures performed in hospital-owned outpatient surgery centers dropped from 60 percent to 40 percent, and experts expect the market share of independent ASCs to grow by another 27 percent by 2027.[17] Elective surgical procedures offer one of the few opportunities for hospitals to push back against RBP, and the market appears to be rapidly producing competitive alternatives.

With that said, powerful health systems that are accustomed to exercising their market power won't take this lying down. In CPR interviews, one RBP customer recounted a local hospital's efforts to challenge RBP plans by demanding upfront payment directly from patients. The purchaser relayed that when this hospital receives a referral from a patient with an RBP plan, "they'll call the patient and tell them 'we don't accept your health insurance, so if you pay us $12,000 up front, *then* you can have your procedure done here.'"[18]

In some markets, a dominant health system's decision to refuse RBP patients creates an opportunity for small independent providers to attract more business – but in others, there may be no accessible alternative.

[16] Laura Dyrda, "100 things to know about ASCs | 2020," *Becker's ASC Review*, September, 2020. https://www.beckersasc.com/asc-news/100-things-to-know-about-ascs-2020.html

[17] Thomas A. Blasco, MD., "Can your hospital survive the growing dominance of ASCs?" *OR Manager,* January 2020. https://www.ormanager.com/can-hospital-survive-growing-dominance-ascs/

[18] CPR interviews, March 2021.

RISK MITIGATION STRATEGIES

Even though balance billing may be more paper tiger than 800-pound gorilla, RBP vendors strive to avoid and prevent balance billing in the first place and protect purchasers and plan members when it happens. These mitigation strategies fall into four basic categories: negotiation, education, navigation and advocacy.

"RBP is not an all or nothing game anymore. There's an awful lot of negotiating that takes place. So, a lot of providers are willing to come to a fair agreement with a reference-based pricing company that is willing to pay them fairly."

Tom Wittick, SVP Growth, ELAP Services

NEGOTIATION

Earlier, we describe RBP as "reference-based contracting but without a contract." In fact, many RBP vendors do have direct contracts with certain providers. With others, they have hand-shake agreements, or know from experience which providers will accept the reference price. The upfront work of introducing providers to the concept of an RBP plan and establishing relationships with them (formal or informal) underpins any successful RBP program.

"Our balance bill program starts well before a patient is balance billed. It begins with education during open enrollment, at the time a claim is processed at a non-contracted rate, and throughout the plan year through communication pieces that we distribute through the employer. If a balance bill does occur, these communications are crucial to ensure the member reaches out to us quickly so that we can begin the dispute process."

Andy Orear, Vice President of Distribution, ClaimDOC

EDUCATION

The most critical step in member education services is instructing members who receive balance bills not to pay them. Additionally, RBP vendors should offer proactive, multi-channel education and ongoing communication to ensure that members understand how to use their new benefit design, and where and when to seek help.

NAVIGATION

Some providers will accept RBP, but others will not, and it's crucial that plan members can make this distinction prior to seeking care. RBP vendors should offer navigational support through multiple channels, accommodating the

"The transparency and pricing laws that went into effect are going to go a long way to promoting accountability. I think that's fantastic. I think it's here to stay. I'm very excited because that's all we're trying to do. It's like, hey, let's get a fair price."

Ryan Day, CEO, HST

needs of members who prefer to search for care independently using an app or website, and those who need more hands-on support through phone consultation. At a minimum, RBP vendors should collect and display data showing which providers have contracts with the vendor and are therefore "safe harbor." Beyond this baseline, RBP vendors should track and report the proportion of claims that result in balance bills by provider practice and facility, and by type of service and procedure. The more precise RBP vendors can be about the probability that a provider will accept a reference price, the better.

ADVOCACY

Member advocacy is the broad suite of services that the RBP vendor should offer to protect purchasers and patients in the event of a provider dispute. If a patient receives a balance bill, legal support is crucial, but RBP vendors should also offer member protection like free credit repair, and proactively discourage providers from engaging collection agencies. Finally, some RBP vendors act as ERISA co-fiduciaries. ERISA co-fiduciary responsibility is a significant dividing line among RBP vendors. Those who assume co-fiduciary responsibility highlight this commitment as a hallmark of their value proposition. Those who are not ERISA co-fiduciaries assert that the value is over-played. We examine this issue in detail in the following section.

Spotlight on RBP Vendors and ERISA Co-Fiduciary Responsibility

No discussion of RBP would be complete without mentioning the Employee Retirement Income Security Act (ERISA) and what it means if a vendor accepts ERISA co-fiduciary responsibility as part of its RBP program. ERISA establishes a series of obligations and responsibilities for plan sponsors (i.e. self-insured health care purchasers) to prevent them from using employee benefit funds to line their own pockets. ERISA fiduciaries, therefore, must "Act solely in the interest of plan participants and dependents with the exclusive purpose of providing benefits to them."[19]

The implications of co-fiduciary responsibility arise when an RBP plan member receives a balance bill. When the plan member engages its RBP vendor to help resolve the dispute, the vendor has two choices: fight the claim or negotiate a compromise settlement with the provider, which the plan sponsor will cover. From the vendor's perspective, compromise

[19] Employee Retirement Income Security Act, 29 USC §1001 et seq., 29 CFR Part 2509 et seq., https://webapps.dol.gov/elaws/elg/erisa.htm

and settlement may be the best outcome, since litigation requires time and resources. Additionally, the RBP vendor may intend to build a relationship or eventually contract with the provider who issued the balance bill. A heated altercation could destroy those prospects.

However, from the purchaser's perspective, it is *always* financially preferable to avoid paying any amount above the reference price. This is where ERISA law guides the RBP vendor's hand: if the RBP vendor is an ERISA co-fiduciary, it must act in the plan sponsor's best interest and put its own interests aside.

While an RBP co-fiduciary must act in the best interest of the plan sponsor, those interests may diverge from the financial interests of an individual plan *member.* The RBP vendor's co-fiduciary role may prevent it from negotiating a generous settlement with a provider, but it does not compel the RBP vendor to fight on behalf of the patient. Both the RBP vendor and the plan sponsor could turn their backs on a patient who has received a balance bill without being in violation of ERISA law. In reality, no health care purchaser with any integrity desires a situation that leaves plan members hanging out to dry. The takeaway, however, is that *ERISA law* only protects the plan sponsor, not its covered population.

This is not to say that there is no value in ERISA co-fiduciary liability from an RBP vendor. A purchaser who signs onto an RBP plan should expect that some of its plan members will eventually be balance billed, and that some of these balance bills will require legal intervention. RBP vendors who act as ERISA co-fiduciaries have in-house counsel available or on call to litigate these disputes as they occur. Vendors who do not act as co-fiduciary may offer legal services as a buy-up or recommend legal counsel who specialize in these types of provider disputes. Consequently, the value to a purchaser of an RBP vendor's ERISA co-fiduciary responsibility depends on two things:

1. Whether the purchaser prefers an "all-in-one package deal" that includes the RBP vendor's legal services, as opposed to a preference for hiring legal counsel independently on an as-needed basis
2. Whether the purchaser believes that price of the RBP vendor's legal services is cost-effective compared to what the purchaser can procure on its own

Ultimately, it's the difference between buying an "all you can eat buffet" versus ordering off the menu a la carte. All employers who launch an RBP plan will need legal support and assistance – the question is *how much* and at what price.

FURTHER CONSIDERATIONS FOR HEALTH CARE PURCHASERS

CPR's evaluation of RBP vendors identifies attributes that can help purchasers understand vendors' value proposition and service offerings. **This section lays out the most important questions a purchaser should ask when deciding whether an RBP solution is appropriate for its population, and considers the attributes purchasers should seek in an RBP vendor.**

Above all, purchasers want assurance that their plan members will receive care that is high-quality (as well as lower cost), that members will be well-equipped to understand and navigate their benefits, and that members will be protected from financial harm and emotional stress if they receive a balance bill.

Specifically, purchasers should ask the following questions:

How can I be assured that my plan members receive high-value health care?

Although RBP arose originally as a cost containment strategy, the most progressive RBP vendors also use quality metrics to ensure that their product delivers high-quality care.

There are three general applications for quality data under RBP:

1. To guide plan members to high-performing providers. In addition to information about likely procedure costs and the likelihood that a provider will accept RBP, vendors should *also* offer service-specific and physician-specific quality performance insights through websites, apps, or other navigation services.
2. To reward providers for superior outcomes. Some RBP vendors now incorporate alternative payment models into their provider contracts (where they have contracts). Others adjust their Medicare multiple payment rate according to quality outcomes. In our research, CPR has found examples of RBP vendors who contract with providers under gain-sharing agreements, episode bundled payment and partial capitation, and vendors who will *only* contract with providers who meet threshold performance on quality metrics.
3. To demonstrate program success. Although RBP vendors may be new to the game of rewarding providers for outcomes – either by paying them more or directing more business to them – they should *all* provide metrics on the quality of care alongside their cost-of-care and cost trend reporting.

Q2

How will my members know which providers will accept RBP payment?

As noted in the previous section, RBP vendors should provide multi-channel navigation services to allow members to access information about providers independently, or directly through communication with the vendor's support team.

Navigation services should clearly communicate:

- Which providers have a direct contract with the RBP vendor
- Which providers are not contracted with the vendor, but have a high acceptance rate of RBP payment (i.e. they rarely balance bill)
- Which providers are *least* likely to accept RBP and are most likely to balance bill

Plan members should have access to this information at the provider service level. If Hospital A accepts RBP payment for cataract surgery 100 percent of the time and accepts RBP for hip replacement surgery 0 percent of the time, the average acceptance rate of 50 percent is neither representative nor particularly useful.

Q3

How will my plan members learn to navigate their new benefit plan, and how will they know what to do if they receive a balance bill?

Plan member education is vital, and RBP vendors should commit to a robust education program to ensure success for the purchaser and its plan members.

This can include providing multi-media materials (print, online, in-person) and making them available through formalized trainings as well as on demand; customizing materials according to membership needs; offering on-going support (not just at open enrollment) and even coming on-site if needed to support the benefits management team.

Q4

What protections are in place for members who are balance billed?

Beyond legal services and the question of co-fiduciary responsibility (see spotlight segment on ERISA law and RBP) any above-board RBP vendor wants to shield members from credit damage by offering services to repair wrongly-damaged credit.

Hospitals frequently threaten credit score damage to coerce plan members into paying balance bills. The Fair Debt Collection Practices Act (FDCPA), the Fair Credit Reporting Act (FCRA) and ERISA prevent providers from attacking a patient's credit if the debt cannot be validated because it is under dispute.[20] Nevertheless, RBP vendors should take proactive measures to protect a member's credit if a member receives a balance

[20] Erin C. Fuse Brown, "Consumer Financial Protection in Health Care," *Washington University Law Review*, 2017. https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=6266&context=law_lawreview ; CPR vendor interviews.

bill. Steps may include outreach to the provider or to major credit agencies to prevent the former from selling the debt to a collector and the latter from damaging the member's credit score. And, in the event that a member's credit score *is* damaged because of a balance bill, the RBP vendor should offer services to repair the member's credit at no additional cost.

How will I know that the program is working?

Under an RBP plan, transparent, comprehensive and comprehensible reporting is critical so that purchasers can understand the plan's value and proactively address risks. When it comes to reporting, more is (usually) more.

The following is a list of the minimum set of insights that RBP reporting should convey:

- Program savings – preferably expressed relative to the purchaser's PPO rates rather than the provider's billed charges. The typical RBP program provides cost savings between 20-30 percent. Purchasers should be suspicious of savings in the range of 70-90 percent. Savings in this range are likely calculated relative to billed charges and do not provide a comparison to the purchaser's real baseline – their experience with a PPO.
- Care outcomes – the importance of reporting on quality of care is captured previously. Beyond quality metrics, RBP vendors should also collect data on plan member experience, captured directly from members themselves, and not inferred by proxy (e.g. the average wait time for a customer service representative).
- Utilization patterns and balance billing trends – purchasers will want to know the volume of balance bills and resolution status, but should also look for changes in utilization patterns under the RBP program. Are plan members migrating away from providers who refuse RBP and toward those who do? Are providers continuing to accept RBP payment, and have those patterns changed?

Note that this summary represents a high-level overview of some of the primary concerns of purchasers. CPR's RBP Evaluation Toolkit includes many other questions and recommended specifications, developed in collaboration with and insight from our members, and updated after CPR evaluated nine RBP vendors.

NEXT STEPS AND ADDITIONAL RESOURCES

The resilience of reference-based pricing reveals some surprising insights about how the commercial market pays for health care. In the past decade, national health insurance companies consolidated in a parallel trend alongside providers, as each entity attempted to increase its market power and leverage in negotiations. But when the currency of negotiations is discounts off of the chargemaster, health care purchasers or their plan members see no savings at all. This creates an opening for RBP vendors - organizations ranging in scale from very small to barely mid-sized, but can command payment at a fraction of the price of a national PPO simply by asking for forgiveness instead of permission. Although some providers willingly accept RBP payment, the fact of the matter is that they don't have much choice. Providers have learned the hard way that so long as an RBP vendor can demonstrate that its prices are fair and reasonable, the courts tend to side with the patient.

There's still an important question left unanswered: how much of the success of an RBP program depends on its ability to fly under the radar. Today, only a small fraction of commercial employers pay providers with RBP. But if that fraction should grow, will providers take more drastic action to close off access to patients paying Medicare-based rates? As Ron Peck, Executive Vice President and General Counsel at the Phia Group puts it: "One RBP patient is an ant crawling across the floor. You might let it go. A line of them? Call the exterminator."

At the same time, purchasers should consider the long (long) list of other health care solutions that purported to produce "revolutionary" cost of care savings, but ultimately delivered only marginal results. By attacking prices directly, RBP can theoretically deliver significant savings for purchasers and their plan members, and RBP vendors with the fortitude to focus on both prices *and* clinical quality could emerge as the next generation of value-based care. As demonstrated by the quotes that follow, those in the industry are optimistic.

However, administering an RBP plan requires a great deal of effort. Purchasers must conduct member education, vigilantly monitor utilization trends, and be willing to partner closely with their TPA and RBP vendor to adjust the program as needed. In the words of one RBP customer: "I've become a pessimist over the years about a lot of things in health care… wellness programs, for example, are a feel-good strategy, but don't do a thing to control your costs. RBP is the *only* solution I've found that actually makes a dent. But it's not for everybody." **To put a finer point on it: if you want to play hard ball with the health care delivery system, keep your eyes open, bring a bat and wear a helmet.**

"This is going to be like a grass fire. Right now RBP is burning at the edges of the field. As soon as the wind starts to blow, and we come to the next iteration of rate increases, the wind is going to blow harder and the fire is going to catch and go faster."

Dan Meylan, Senior Vice President Broker Relations, Payer Compass

"Over the past decade, we've seen that if we focus on the periphery, like changing pre-cert, or doing more case management nothing is going to change. We have to target the true cost drivers: hospital and pharmacy costs. The fact is that we pay too much. Period. As soon as we can get people to focus on that, we will be in a much better place to effect real change."

Tom Wittick, SVP Growth, ELAP Services

"Employers are watching the industry and those "pioneers" who took a chance with a nontraditional product. As they see this success, the program is becoming more of a front runner in considerations each year at renewal. It is no longer viewed as risky or scary; rather, it is innovative, and, for some employers, a necessity to continue to offer benefits. RBP may not be a good fit for every employer, but it is a good fit for far more employers than are currently considering and brokers are realizing that to keep clients, RBP needs to have a seat at the renewal table.."

Andy Orear, Vice President of Distribution, ClaimDOC

For purchasers seeking more information from CPR on Reference-based Pricing, RBP vendors and their attributes, CPR offers the following resources:

RBP EVALUATION TOOLKIT

Purchasers who want to initiate their own exploration of RBP vendors can download CPR's RBP Evaluation Toolkit at no cost; Health plans, vendors, providers and others can also access this resource for a nominal fee. The toolkit includes the following resources:

- RBP Request for Information (RFI) template, which includes evaluation questions and specifications.
- RBP Program Evaluation Template, CPR's reform evaluation framework (REF) for RBP provides purchasers with a standardized tool to measure the cost, utilization, quality and member experience outcomes of an RBP program.

RBP VENDOR SUMMARY AND DETAILED SCORECARDS

CPR evaluated 8 RBP vendors and 1 RBP TPA to produce detailed and summary scorecards that provide insights into each vendor's performance against specified attributes. The vendors we evaluated include:

6 Degrees Health	Azeros	Health Scope Benefits
AMPS	ClaimDOC	HST
Apostrophe Health	ELAP Services	Payer Compass

DETAILED SCORECARDS include ratings for all questions in the RFI and are available to CPR members for free. All other purchasers who want access to CPR's detailed scorecards can contact Ryan Olmstead to discuss membership.

SUMMARY SCORECARDS include ratings for a subset of the most salient and differentiating RFI questions. The set of summary scorecards is available to CPR members for free, and is available for sale to all other health care purchasers and verified brokers and consultants.

Other recommended resources to orient purchasers to Reference-based pricing:

- Guiding Members to High-Value Choices through Reference Pricing: CPR case study profiling the Self-Insured Schools of California's (SISC) pilot of site-of-service reference-based benefits.
- "Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan," Updated results from the Montana State Employee Health Plan's reference based contracting strategy.
- Issue of the Year: Reference-Based Pricing and Balance-Billing: deep dive into legal and regulatory issues for RBP plans from The Phia Group.

APPENDIX: DEFINITIONS AND TERMINOLOGY

Alternative Payment Model (APM): A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Balance bill: Occurs when a provider bills a patient for the difference between the provider's billed rate and the amount the patient's health plan has agreed to pay (also known as the *allowed amount*).

Catalyst for Payment Reform: An independent, nonprofit organization on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

Chargemaster File: The list of prices of all services, goods, and procedures that a health care provider offers; it is used to generate a patient's bill.

Claims Adjudication: The process used by a payer (health plan) to decide if a provider claim should be reimbursed.

Employee Retiree Income Security Act (ERISA): A federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.

ERISA Co-fiduciary: Who manages a health plan's assets and stands in a special relationship of trust, confidence, and/or legal responsibility. That person has a legal and ethical obligation to put the other party's interests before its own.

Preferred Provider Organization (PPO): A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers.

Reference-based Benefits (RBB): A benefit design model that sets a maximum benefit that a health plan will cover for a specific procedure; plan members must cover any amount above the maximum benefit.

Reference-based Contracting (RBC): A payer-convened contracting model that anchors the rates that a health plan will pay health care providers to a multiple of Medicare.

Reference-based Pricing (RBP): A vendor-convened model that anchors payment rates to multiples of Medicare, with or without a formal contract with health care providers.

Third-party Administrator (TPA): A business that delivers various administrative services on behalf of a self-insured health care purchaser

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