90 DEGREE BENEFITS

A Turn For The Better

Exploring

Reference-Based Pricing

Best Practices in Offering a Reference-Based Pricing Benefit Plan

This whitepaper provides a high-level overview of how reference-based pricing for healthcare service payments can increase transparency, health literacy and the bottom line for both an employer and their employee population.

The Right Turn
for Your Benefits

TABLE OF CONTENTS

What is Reference-Based Pricing in Healthcare?

The increase in both the employer and member expense has driven the market to consider multiple strategies and tactics to increase cost-controls without sacrificing quality, like the use of Reference-Based Pricing (RBP) models. In its simplest terms, RBP is the establishment of a maximum amount that an employer plan sponsor will pay providers for certain, specified medical or prescription services in a group benefit plan. Often, these services have a wide cost variation between providers with no discernible differentiation in quality. The reference payment amount is usually based on a framework established by a third party, like Medicare (CMS), and the services are typically geared toward facility expenses where costs are experiencing record-breaking trends.

Enrollees who seek care from providers charging more than this "reference price" are responsible for paying the difference between the actual price of the service and the established plan price. Additionally, this excess amount, called "balance billing," does not count toward the patient's deductible or annual out-of-pocket maximum.[1] Patient advocacy, transparency and education for the healthcare consumer are essential to protect from balance billing. The traditional use of provider networks in RBP health plans is usually limited to the professional component only, if used at all. By their nature, emergency services are typically excluded.

Market Adoption of Reference-Based Pricing in Healthcare: A Look at the Numbers

According to a recent healthcare survey of more than 1,230 employers covering more than 10 million employees, 68% plan to adopt reference-based pricing in the next 2-4 years.[2] In the same survey, 92% of the employers plan to offer cost transparency tools whereas only 49% do so today. Some of the early evidence from 2013 suggests that RBP may be a promising cost-control strategy when applied to frequently performed, non-emergency tests and procedures where the prices charged vary widely across providers, but the quality of results remains largely similar.[3]

Another survey from 2013 showed RBP was being used by 10% of employers with more than 500 employees and 22% were considering it. Out of the very large employers (>10,000 employees), 15% used RBP and an additional 30% were considering it.[4]

[1] Employers Turn to Reference-Base Health Pricing", Society for Human Resource Management, July 28, 2014
[2] Aon Hewitt Survey Shows US Employers Interested in Exploring Stricter Rules around Health Benefits and Referenced-Based Pricing as Part of their Health Strategy" June 11, 2014
[3] Robert Wood Johnson Foundation Publication, "Exploring the Use of Reference Pricing by Insurers and Employers", July 2014
[4] Mercer Article, "Understanding the New FAQ on RBP", October 16, 2014
[5] National Action Plan to Improve Health Literacy. (2010, May). U.S. Department of Health and Human Services.

Is health literacy important?

9 out of 10 adults have difficulty understanding the health information that is available in our healthcare facilities, retail outlets, media and communities.[5] According to the National Institute of Health (NIH), this deficiency in health literacy is estimated to cost the nation $106-$236 billion annually.

Savings Opportunities: Reference-Based Pricing

Medicare is the most recognized single reimbursement methodology in our healthcare system. For many providers, it can work effectively as a reimbursement methodology, assuming the percentage of Medicare is set reasonably. Medicare fee schedules will fluctuate year after year and need to be monitored by the plan administrator annually to ensure adequacy of payment. Stop-loss carriers must be educated by actuaries to be able to apply appropriate discounts off of traditional PPO payment methodologies.

It has been our experience with stop-loss reinsurers that an appropriate Medicare pricing schedule, determined by geographic area, will lead to both a specific stop-loss discount and aggregate stop-loss factor reduction ranging from 18% to 35%. Reference-Based Pricing plans allow plan participants to access any and all physicians and facilities. However, this may result in balance billing if the provider's charges are not transparent prior to receiving scheduled services. There is a distinct advantage for both the patient and plan to know the price and quality of the provider in advance. Patients must learn to become healthcare consumers in order to benefit from the significant pricing advantage of Reference-Based Pricing.

Can health literacy improve outcomes & cost?

An informed consumer can make better choices inthe selection of healthcare services and the management of health conditions. Health literate patients are more likely to seek out high-value preventive health services and screenings and less likely to use expensive services such as emergency departments. Health literate consumers are best positioned to respond to incentives embedded in their benefit plan that encourage them to seek value and improve wellness. In short, health literate patients have the potential to achieve better health outcomes for lower total cost.

REAL EXAMPLE OF GROUP SAVINGS USING RBP

	Total Billed Amount	In-Network Accepted Amount	Network Discount	Allowed Amount Payable by Plan	% Network Savings/ Discount
Typical PPO Network	$2,435,765	$2,166,152	$159,661	$2,006,490	7.40%

	Total Billed Amount	RBP Method	Allowed Amount Payable by Plan	% RBP Savings
RBP Plan	$2,435,765.69	150% of Medicare	$900,591.16	63.00%
		175% of Medicare	$1,040,106.07	57.30%
		200% of Medicare	$1,179,620.98	51.69%

Understanding the Value of Transparency

In a press release by the Society of Actuaries, they disclosed the findings of two surveys, which indicated that more transparency in the U.S. healthcare system would help bend the cost curve downward, as thought by both consumers and actuaries.[6] As consumers are given the opportunity to exercise more free choice in providers and the respective pricing, the potential to help reduce costs is increased. Providing consumers with clear, comparative information on the cost of services is paramount to reducing healthcare costs.[7] By way of example, CalPERS reported a $16 million savings in 2010 when they instituted a limited price transparency and RBP with high-value providers for just hip and knee replacements.[8]

Consumers need to become better educated on healthcare quality, costs, and necessary services so they can make better choices, regardless of whether they have coverage or not. Recent studies show over 47% of U.S. adults lack the literacy skills to meet the demands of the current system.[9] For the healthcare system to function at maximum efficiency, consumers and patients need access to reliable, accurate and comprehensible information to effectively execute decisions about their healthcare, including price and quality information. In absence of such information, consumers are prevented from engaging in comparative shopping based on price, quality and family needs and are still in need of a better understanding of their healthcare finances to make proper decisions.

According to Don Berwick, former head of Centers for Medicare and Medicaid Services (CMS), "the lack of transparency and competitive pricing is responsible for between $84B and $174B in wasteful spending."

With healthcare spending approaching 20% of the country's gross domestic product (GDP) in the near future, some industry experts believe that price transparency might have the single biggest effect in educating the public about healthcare costs and could support a more efficient healthcare delivery system in th United States.[10]

How much waste is in the healthcare system?

As the nation focuses more on ways to provide safer, higher-quality care to patients, the overuse of healthcare resources is an issue of considerable concern. Many experts agree that the current way healthcare is delivered in the US contains too much waste. In fact, the Dartmouth Institute for Health Policy and Clinical Practice determined that as much as 30% of care delivered is duplicative or unnecessary and may not improve people's health.[11]

[6] Society of Actuaries, "Actuaries Believe More Transparency in the U.S. Healthcare System Would Help Bend the Cost Curve Downward", Press Release-2010
[7] Truven Health Analytics, "Fact File: Price Variation and Transparency", March 2014
[8] Catalyst for Payment Reform Action Brief, "Price Transparency – An Essential Building Block for a High-Value Sustainable Healthcare System"
[9] Neilsen-Bohlman, LI, Panzer, A.M. & Kiondig, D.A. (2014). Health Literacy: A Prescription to End Confusion. Retrieved from http://www.iom.edu/Reports/2004/Health-Literacy-A-Presecription-to-End-Confusion.aspx.
[10] Robert Wood Johnson Foundation, "How Price Transparency Can Control the Cost of Healthcare", March 2016
[11] Enthoven AC (2016) What is an Integrated Health Care Financing and Delivery System (IDS)? and What must would-be IDS Accomplish to Become Competitive with them? Health Econ Outcome Res Open Access 2: 115.

Waste has a big impact.

According to a September 2012 Institute of Medicine report, $750 billion was estimated as being wasted in U.S. healthcare annually. These areas include: failures of care delivery and care coordination, over-treatment, administrative complexity, fraud/abuse and pricing failures. Pricing failures occur when the price of a service exceeds that found in a properly functioning market *(cost of production plus a reasonable profit).*

The Value of Transparency Tools

Transparent information in healthcare pricing and quality can drive innovation in the marketplace, which has the potential to improve the purchasing patterns of consumers, educate the public about how to be accountable for their healthcare purchases and reduce the cost of care in the U.S.[12] When previously uninsured people became consumers in the insurance market, many purchased the least expensive plans which left them with significant out-of-pocket expenses. These consumers were unaware of healthcare pricing disparities wherein, for example, a patient could pay anywhere between $458 to $56,000 for an appendectomy. [13]

Although there is much discussion about the various types of innovation in the market, it is undeniable that there is growing popularity in search engines to compare the pricing and quality of providers and services in healthcare delivery.[14] These tools were not available until recent years, so even if hospitals and providers had been prepared to disclose their pricing and quality standards, it would have been difficult to obtain and compare. Now there are many tools to select from, each with their own unique attributes, such as:

- **Healthcare Bluebook**
- **Hospital Compare**
- **Castlight**
- **HealthSparq**
- **Mpirica**
- **Health Grades**
- **Leap Frog**
- **Health Advocate**
- **New Choice**
- **Good Rx**
- **Amino**
- **MediBid**
- **SaveOn Medical**

[12] The Commonwealth Fund, "Healthcare Opinion Leaders' Views on Transparency and Pricing", October 2010
[13] George Washington University study, cited by Robert Wood Johnson Foundation, "How Price Transparency Can Control the Cost of Healthcare", March 2016
[14] National Business Group on Health, "Price and Quality Transparency Are Essential to Quality Improving, Competitive, Consumer-Driven Healthcare"

The Consumer Experience & the Value of Advocacy: A Must-Have Service

As employees start participating in the purchasing process of healthcare, they rapidly realize how unprepared and uneducated they are as consumers. The prices are a mystery and there is significant price disparity between providers without a quality differential. They have no idea how to navigate the healthcare process and yet they are trying to put together the financial and care pieces they need to get the proper treatment. This is where an advocate and the right tools can not only make the difference in the experience, but introduce opportunities to save money for the both the patient and plan.

Patient advocacy plays a critical role in bringing transparency and health literacy together to aid the enrollee in making wise decisions about their care. Advocates use cost comparison tools, quality evaluation tools, benefit guides and other services to help patients when they need to make important care decisions. Patient advocates – also known as Health Advocates, Patient Concierge or Patient Navigators – help employees and their families navigate the healthcare maze, as well as their health events. 90 Degree Benefits uses highly trained clinical, benefits and claims experts who are dedicated to getting the right answers and help employees get the right care at the right time. By analyzing the data, they help target the drivers of healthcare costs and the related quality standards, while assisting with maximizing potential savings. This assistance maximizes benefits, enables employees to focus on work as outcomes improve, and lifts the burden on HR. This is a critical tool in creating a meaningful transition to educating employees that have been sheltered from making these key decisions.

Comfort of Safe Harbor Facilities & Concierge Services

The transition to RBP needs to be done thoughtfully and adapted to the needs of an employer's population. The identification of a facility that is willing to take a percentage of Medicare at a level that would ensure the savings to the plan, can ease the process for the employees and save the employer money. Typically, the identified facility agrees not to balance bill the patient at the referenced price if the plan includes the proper incentives, such as no patient out-of-pocket at the point of care. This protects the plan and the patient – a win-win for both.

Selection of the right facility is pivotal. Often, employers have relationships with a local hospital board or other contacts, which open the door to negotiating the right contract. Typically, 90 Degree Benefits provides a simple, direct contract between the employer and the identified facility which includes terms on the percentage above Medicare, no balance billing and other steerage requirements. Communication and steerage to the safe harbor facility needs to be constant and clear to the employees, their families and plan advocates. Plans also use engagement tools to serve an on-going role with the use of web portals and online decision making tools.

The growing interest in reference-based delivery methods has opened up the idea of bringing concierge medicine into plan design. There is an ever-growing market of physicians who prefer to provide a medical home for employees/families on a capitated fee basis. The comprehensive care approach can be integrated with the safe harbor facility, assuming privileges for the physician to practice at the facility exist. The concierge physician works closely with the plan administrator to make sure proper documentation of care for the risk takers

Transparency is Critical.

In order for pricing information to be transparent and more meaningful to the public, it must be provided or made available prior to care, with the exception of true emergency care. Since approximately 85% of all surgical procedures are scheduled in advance, this means there is a huge need for pricing and quality information to be made available prior to care being received.

is in place. Caution needs to be taken to ensure the physician does not over-charge for monthly services. If structured properly, the physician plays a key role in getting the price and quality of care at the right facility. Typically, there is no balance billing in concierge medicine.

Studies have also shown that health advisory services, like those offered through a physician concierge model with health advocates and thoughtful second opinions, can optimize outcomes and avoid needless expense. In a review of patient intervention data over a three-year period, a sampling of 1,000 cases showed that almost 77% of medical interventions led to changes in diagnosis, treatment and/or the treating physician.[15]

Another safe harbor option includes a concierge service to assist members with MRI and imaging needs. Early on, one of the largest disparities in pricing was the delivery of imaging and MRI services. It is not uncommon to see physicians with ownership in an imaging facility, so they steer their patient to the places that support this endeavor. Unfortunately, this has contributed to even greater price disparity, so the use of a separate network of MRIs, CT scans and PET scan facilities helps manage the cost and results in a better consumer experience for the patient. A nationwide network of over 2,900 radiology and diagnostic facilities creates considerable savings while providing concierge services. Geo-access reports match the zip codes of the employee population with the imaging providers in the area. If deemed inadequate, requests for custom contracts are submitted to expand appropriate coverage. The imaging concierge service brings together the appointment, type of equipment (closed or open MRIs) and price for the patient.

SAVINGS EXAMPLE FROM CONCIERGE IMAGING SERVICE PROVIDER[16]

Service	70th Percentile UCR	Savings $	Savings %
MRI Cervical-72141	$1,750	$1,100	63%
MRI Lower-737211	$1,824	$1,075	61%
MRI Bilateral-77059	$2,490	$1,740	70%
Total Savings on Block			**76.02%**

[15] Concierge Medicine Today, "RESEARCH: New data demonstrates the potential for health advisory services and second opinions to optimize outcomes and avoid needless expense." PinnacleCare Study, February 5 2015

[16] 90 Degree Benefits, Inc. claim data results 2016

Balance Billing Reality & Cash Pricing Advantage

Balance billing is the practice of a healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge. Balance billing can occur with any insurance plan, whether that is a RBP plan or a PPO network plans in which the provider charges more than the allowed amount. Since patients are financially responsible for balance bills, and any such payments do not accumulate toward the maximum out of pocket limits set annually by the federal government, balance billing has become a hot button issue for employers seeking coverage.

The increase in billed charges for out-of-network providers has garnered considerable attention. In the private insurance market (PPOs/HMOs/POSs), it is common for emergency room providers, radiologists, anesthesiologists and pathologists who have privileges in a network facility to charge significantly higher fees because they consider themselves out-of-network providers for that specific service. Even though hospitals know their facility participates in the network, they allow and encourage non-network providers to bill and service the in-network patients. The patient has little or no knowledge of the use of these providers, nor a say in which provider they prefer, and yet, they are routinely balance billed for their services.[17]

The best way to avoid balance billing is for patients and/or their advocates to discuss the provider's fees in advance of non-emergency care and ensure that they do not exceed the amount allowed by the plan. Advocates provide key assistance in determining provider billing amounts and avoiding balance billing whenever possible.

As consumers have become savvier about shopping for healthcare, they may find an interesting phenomenon – many hospitals, imaging centers, outpatient surgery centers, physicians and pharmacy chains will give deep discounts if they pay cash instead of using their plan.[18] This cash price is often called "self-pay" and can be integrated into a self-insured group health plan with the proper tools and payment process through the plan administrator. It is important that the advocates participate to ensure the proper coding is retrieved to comply with any stop-loss policy provisions. These cash programs can easily be integrated into a self-insured health plan and when coordinated with an advocate, the potential for balance billing is mitigated significantly, if not eliminated. Based on early RBP data, balance billing is occurring on less than 2% of all claims received.

The free market has responded so patients have an increasing amount of websites and tools available to research alternative cash payment options.[19] As employer sponsored plans start to integrate a shared savings program with patients who seek more affordable care, the pressure for true price and quality transparency will continue to rise.

The Cash Advantage

Patients who pay cash upfront for medical services can sometimes make out better than they would by using their insurance, especially if they have a high-deductible plan and pay the insured rate in full. Some examples include:

PROCEDURE	FACILITY AND CITY	SELF-PAY RATE	INSURANCE RATE	INSURANCE COMPANY
MRI of the foot	Regional Medical Imaging Flint, MI	$379	$445	Aetna
Tonsillectomy	Banner Desert Medical Center Mesa, AZ	$2,858*	$5,442	Arizona Blue Cross Blue Shield
MRI of the knee	Boulder Community Hospital Boulder, CO	$600	$1,100	Arizona Blue Cross Blue Shield

Note: Insurers' rates may vary by plan. Not including physicians' fees, typically $1,000 to $1,400. Sources: the providers; Ubsyreres; cost-estimator tools. THE WALL STREET JOURNAL.

[17] AHIP, "The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Healthcare Costs: A Survey of Charges Billed by Out-of-Network Physicians", August 2009
[18] Wall Street Journal, "How to Cut Your Health-Care Bill: Pay Cash", February 15, 2016
[19] The Self-Pay Patient, "Affordable healthcare options for the uninsured or those with high deductible insurance", www.selfpaypatient.com

Sample Plan Design Components: Free Market *"Open Access"* Option

The chart below describes the various services and fees for an RBP plan that can replace a typical PPO plan or could be used as a secondary option with a traditional network plan. If used as a standalone network, the employer would be urged to use lower employee/family contribution rates as incentives to participate in the open access plan. Any additional cost savings components like "Direct Primary Care Concierge" or "Spousal MERPs" could be integrated into the offering, thereby reducing overall spend. There are full-service, third party administrators (TPAs) that have expertise in all of these areas and coordinate the components on a group basis.

SERVICE	DESCRIPTION	FEE EXAMPLE
Professional Services	*Physician/Professional only network; with or without concierge services; no balance billing with network/ concierge*	*TBD*
Inpatient/Outpatient Facility Services	*Medicare Plus for all services (emergency accepted when admitted)*	*120 to 200%*
Direct Primary Care Concierge Services	*Virtual (telephonic with biometrics); full service (in office setting/brick & mortar)*	*Capitated*
Safe Harbor Facility	*Determine facility of choice in employer service area (no balance billing/100% with no out-of-pocket)*	*Contract Direct*
Safe Harbor MRIs/Imaging	*Direct contract with service provider, One Call Care; concierge service for MRIs and imaging services with no balance billing*	*Custom Contract with Top non-hospital providers*
Safe Harbor–Telemedicine	*Telehealth services available 24/7 from any location lessens physician, urgent care, emergency room use; includes Rx coupons, shopping options, directions, etc.; not necessary with direct primary care but optional; no balance billing*	*Capitated*
Cash Pay/Self-Pay	*Use Payment at Time of Service process to eliminate payments from members; share savings with members*	*Determine a flat or % of savings*
Incentives	*Travel allowance for bidding/safe harbors; no out-of-pocket for safe harbor facilities; share savings with member through a MERP or as a taxable event*	*$1000* *No Out-of-Pocket* *Cash Back to Member*
Advocacy	*Medical Helpline/patient advocacy services; nurse navigators for bidding service coordination; nurse case managers assist with acute care needs*	*Monthly Fee* *Hourly rates for case management*
Transparency Tools	*Healthcare BlueBook (price/quality service)*	*PEPM*
Consumer Experience	*Enformed+ (mobile app/claim info/ benefit info); videos – fulfillment packages; engagement tools – email/ text/mobile apps; EASI enrollment & decision making tools*	*TBD*

Modified Sample Plan Design Components: *"Walk Before You Run"* Option

The chart below details a hybrid plan approach, incorporating the traditional components of a network plan but with incentives in place to guide the consumer towards a more hands-on approach to selecting medical care. Incentives that are incorporated into the traditional model are designed to reward those members who save money for the plan.

SERVICE	DESCRIPTION	FEE EXAMPLE
Direct Primary Care Concierge	*Virtual (telephonic with biometrics); full service (in office setting/brick & mortar)*	*Capitated*
Cash Pay/Self-Pay	*Use payment at time of service process to eliminate payments from members; negotiate deeper discounts for cash payments*	*Determine a flat rate or percentage of savings*
Incentives	*No out-of-pocket expense for Safe Harbors; direct contracts with Safe Harbor facilities; share savings with member through a MERP or as a taxable event*	*No Out-of-Pocket Cash Back to Member*
Advocacy	*Medical helpline/patient advocates; nurse case managers assist with acute care needs*	*Monthly fee; hourly rates for case management*
Transparency Tools	*Integrate quality & price shopping on customized Healthcare BlueBook with patient advocates*	*PEPM*

Conclusion

With so many opinions regarding the effectiveness of Reference-Based Pricing, 90 Degree Benefits believes that one thing is clear: an experienced partner makes all the difference. 90 Degree Benefits has been delivering RBP plans that save employers money while promoting health literacy and improving transparency for over 40 years. Not all RBP plans or partners are alike; with the proper team in place, employers will experience the savings and employee empowerment that a well-designed RBP plan can deliver.

The result of an RBP plan with 90 Degree Benefits?

A healthier population, lower healthcare costs and a higher standard of living for all.

90 Degree Benefits strongly believes that RBP supports free market principles by encouraging competition, thereby lowering the cost of healthcare. RBP inspires patients to shop, based on quality of services or outcomes. Most importantly, RBP empowers and educates people by engaging them in the healthcare system as well as their own health.

A Turn For The Better

When it comes to matters of principle, stand like a rock.

–Thomas Jefferson

90 DEGREE BENEFITS

A Turn For The Better

For more information about reference-based plan designs and the full range of services offered by 90 Degree Benefits, please email contact@90DegreeBenefitsTX.com, call us directly at 281.368.7878 or visit us online www.90DegreeBenfits.com.