# Reference-Based Pricing Is Being Redefined

*by* | **Kenneth B. Berry**

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In health care, reference-based pricing (RBP) primarily is thought of as a tool to help engage health plan participants in their purchasing decisions. But RBP also can be the basis for more reasonable provider reimbursements—and a new method of health cost control.

By using as a reference point the amount Medicare pays doctors, hospitals and other providers for their services, plan sponsors may be able to save significantly over the more traditional payment system based on discounts for using provider networks. This type of RBP can be a more transparent and equitable approach to paying for health care.

## Traditional Meaning of RBP

In a health care market where different providers often charge widely differing prices for the same procedure, RBP originally was introduced to help make health care consumers aware of the cost differences among providers.

Americans typically are diligent about being smart consumers. It's difficult to think of an example where most consumers would buy something without asking the price. But in health care, it happens all the time. If a physician tells a patient to go down the street and get a colonoscopy, the patient goes down the street and gets a colonoscopy. The patient typically doesn't ask the doctor the price or quality of the provider performing the procedure—even though more and more preferred provider organizations (PPOs) and others have cost-comparison tools to help consumers.

Table I is an example of the results found from a major insurance company's cost-comparison tool, when searching for PPO providers that perform routine colonoscopies within a 20-mile radius of the desired ZIP code.

As Table I shows, the cost can vary tremendously from one provider to the next—In this case, there's a tenfold difference between the highest and lowest cost providers. And keep in mind, these prices are after the PPO discount.

By negotiating payments to health care providers based on the amount Medicare pays for the same procedures, plan sponsors may be able to cut spending substantially.

TABLE 1

**Comparison of Colonoscopy Costs**

| Provider Name | Location | Distance | Typical Cost Low | Typical Cost High | Number of Procedures Performed Annually |
|---|---|---|---|---|---|
| Physician ABC | Southern Bay Area | 24 miles | $530 | $586 | 15 |
| First Endoscopy Center | Central Bay Area | 6 miles | $842 | $1,194 | 161 |
| Medical Corporation | Central Bay Area | 6 miles | $911 | $1,213 | 150 |
| Surgery Center A | Northeast Bay Area | 9 miles | $911 | $1,579 | 100 |
| Surgery Center B | Southwest Bay Area | 5 miles | $988 | $1,703 | 127 |
| Second Endoscopy Institute | Southwest Bay Area | 5 miles | $1,008 | $1,549 | 107 |
| Third Endoscopy Center | Central Bay Area | 13 miles | $1,094 | $1,277 | 71 |
| Endo-Surgery Center | Northeast Bay Area | 14 miles | $1,108 | $1,856 | 137 |
| Hospital One | Northeast Bay Area | 16 miles | $1,274 | $2,059 | 24 |
| Surgery Center C | Southern Bay Area | 15 miles | $1,344 | $1,606 | 210 |
| Surgery Center D | Southeast Bay Area | 4 miles | $1,672 | $2,227 | 64 |
| Hospital Two | Central Bay Area | 14 miles | $2,426 | $2,682 | 9 |
| Medical Center A | Northeast Bay Area | 9 miles | $4,321 | $5,246 | 73 |
| Medical Center B | Central Bay Area | 14 miles | $4,931 | $5,929 | 167 |

Lowest price for this procedure is $530.

Reference-based price maximum allowable is $1,200.

Highest price for this procedure is $4,931.

The entity determining the RBP amount—often an insurance company—comes up with a "not-to-exceed" amount. In the example, the RBP amount was determined to be $1,200. Therefore, if the doctor or participant picked the provider that charged $4,931, the participant would have to pay the difference, or $3,731. Conversely, if the doctor or participant chose the provider that charged $911, the participant would have no additional out-of-pocket expense.

Many insurance companies say they have an RBP program, but how they define their program can vary greatly. In almost all cases, the not-to-exceed amount varies from one insurance company to the next, creating confusion on the part of the health care consumer. Adding to this confusion, most companies claim that the way they determine the not-to-exceed amount is proprietary and can't be disclosed. That makes comparing this type of RBP program against another RBP program almost impossible.

## A New Definition of RBP

Some insurance companies, consultants and health plan sponsors are now using the term *reference-based pricing* differently to describe a new medical cost-containment strategy, with some dramatic results.

For years, payers have evaluated the effectiveness of PPO discounts in terms of the percentage discount off billed charges. For example, a PPO provider's contract rate might discount "billed charges" by 60%, meaning the plan sponsor pays 40% of billed charges. And, for years, plan sponsors have thought they were getting a great deal. But with more and more price transparency, plan sponsors have found that paying 40% of billed charges to one provider may be significantly different from paying 40% of billed charges to another provider. Plan sponsors need a way to level the playing field so that they can compare the cost for a similar service at one provider with the cost at another provider. The solution may be to use the Medicare Allowable as the basis for determining fair reimbursement rates.

Before a provider is accepted into the Medicare program, the provider must file its actual cost data with Medicare. In the case of hospitals, Medicare uses a grouping system known as *diagnostic-related groups (DRGs)* that allows it to compare cost data among hospitals. A DRG is a unit in a statistical system of classifying

any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement.

To illustrate how Medicare analyzes the cost of the hospital in this example against the costs at other hospitals, Table II shows a claim for DRG 055: Nervous System Neoplasms w/o MCC (major complications). Medicare uses this cost data to come up with a *Medicare Allowable* (the amount Medicare will pay the hospital for this particular DRG). This hospital's cost is $6,250. Medicare also captures costs for this DRG at other hospitals in the same county, state and neighboring states to determine what the Medicare Allowable is for this hospital, as outlined in Table II.

The average cost for DRG 055 at other hospitals in the same county is $6,134.00. As further comparison, the average cost for DRG 055 at all the hospitals in the state is $6,567.33.

In determining what it will pay the hospital in the example—i.e., the Medicare Allowable—Medicare takes into account all of the cost data it compiles on all hospitals in the area. Table III shows that the Medicare Allowable for this hospital is $6,448.22. Furthermore, the Medicare Allowable amounts for hospitals in the county averaged $6,438.64 and, for all hospitals in the state, the average was $10,687.82. (Note in Table II that the facility count in the cost table is different than the facility count in the Medicare Allowable table. The reason for this difference is that, in order to guard against the potential for protected health information (PHI) being revealed, Medicare does not show the costs for hospitals that performed fewer than ten procedures for any one DRG. With the Medicare Allowable amounts, all hospitals are listed; thus, the facility counts are higher in Table III.)

These results highlight a couple of important points. First, as outlined in the *2015 Report to the Congress Medicare Payment Policy* by the Medicare Payment Advisory Commission (MedPAC), the profit margins Medicare allows in its payment vary depending on whether Medicare classifies hospitals as efficient or not. As outlined in the report, the overall Medicare margin for all hospitals was -5.4%. Conversely, the median hospital in the efficient group had an overall Medicare profit margin of +2%. (For example, if a hospital's cost to perform a procedure was $100, a less-efficient hospital might receive $95 from Medicare, while an efficient hospital would receive $102.)

The second observation is that although the hospitals in the state had a higher cost, they did receive a higher proportionate reimbursement than the other hospitals in the county and the example hospital. This higher reimbursement would suggest that some of the hospitals in the state may be teaching hospitals or have a higher indigent population. Table III summarizes the Medicare Allowable for DRG 055.

TABLE II

**Costs Medicare Compares for DRG 055**

| Region | Average Cost | Facility Count |
|---|---|---|
| Facility | $6,250.00 | 1 |
| ZIP Code | — | 0 |
| County | $6,134.00 | 1 |
| State | $6,567.33 | 9 |
| Neighboring States | $8,123.89 | 21 |

TABLE III

**Medicare Allowable for DRG 055**

| Region | Medicare Allowable | Facility Count |
|---|---|---|
| Facility | $6,448.22 | 1 |
| ZIP Code | — | 0 |
| County | $6,438.64 | 8 |
| State | $10,687.82 | 10 |
| Neighboring States | $8,250.53 | 24 |

Using the Medicare Allowable as a "reference point" to determine a fair reimbursement for the hospital provides much better insights for evaluation than the previous PPO method of a percentage discount off billed charges.

Table IV shows an RBP claim analysis comparing the cost of a procedure using the PPO discount and the amount Medicare would pay for the procedure. In this example, the hospital's billed charges are $94,212.00, or 14.61 times the

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## TABLE IV

### RBP Claim Analysis

**Claim Profile #347982**

| | |
|---|---|
| Provider: | ABC Hospital |
| DOS: | 02/23/2015-02/28/2015 |
| Review Date: | 06/22/2015 |
| Billed Charges: | $94,212.00 (14.61 x MAP) |
| PPO Discount (66.12%) | ($62,294.73) |
| PPO Allowed: | $31,917.27 (4.95 x MAP) |
| Medicare Allowable Price (MAP): | $6,448.22 |
| Recommended Reimbursement: | $9,672.33 (150% x MAP) |
| Pricing Differential: | $22,244.94 |

hospital's Medicare allowed payment. When the PPO discount of 66.12% ($62,294.73) is applied to the billed charges, the PPO allowed amount is $31,917.27—or 4.95 times the Medicare allowed payment.

Stated another way, the plan will be paying this hospital almost five times what Medicare would have paid the hospital. Two questions immediately come to mind. First, how does a hospital justify a payment of almost five times what it would receive from Medicare? Second, how does the entity contracting with the hospital allow that kind of reimbursement? As Table IV shows, if the payment were based on 150% of the hospital's Medicare Allowable, the plan would have paid $9,672.33, resulting in additional savings of $22,244.94.

Although the previous summary is in no way intended to describe the entire process the Centers for Medicare and Medicaid Services go through in determining the Medicare Allowable, it shows that using the hospital's unique Medicare Allowable for each DRG as a reference point ensures that the plan's reimbursement to the hospital is fair and reasonable.

Health plans use RBP programs in a few different scenarios. For example, RBP can be used to price out-of-network facility charges. Typically, a claims payer subscribes to a usual, customary and reasonable (UCR) database that is used to discount the billed charges, and the typical discount is somewhere in the range of 20% to 30% for out-of-network charges. In comparison, with RBP reimbursement at 150% of the Medicare Allowable, a cutback of roughly 75% off billed charges is typical.

Some health plans are incorporating RBP to arrive at a price to reimburse providers, allowing them to avoid contracting with a primary PPO network. Instead of basing payment on a PPO contract rate, the plan pays providers the RBP recommended reimbursement. This eliminates the need for a contract with a primary PPO network.

However, some vendors retain a PPO network for the professional (physician) claims and use RBP only for the facility claims.

Because there is no contract in place, in theory, the service provider does not have to accept any amount lower than its billed charges and can bill the patient for the difference between what it billed and what was paid—a practice called *balance billing*. Many providers offering RBP programs estimate the prevalence of balance billing to be about 2% of all claims paid using RBP as the payment basis. Many of these providers also have a patient advocacy center (PAC) that can assist the patient in resolving a balance billing issue. However, the way the RBP vendor resolves a balance billing issue differs between vendors. Some RBP vendors stand firm on the price determined by the RBP analysis and use attorneys to defend the plan participant against any

## takeaways >>

- Medicare provider payments are based on, among other factors, the actual cost of providing care and the quality of care.
- Using the Medicare Allowable as a reference point is more likely to result in a fair and reasonable reimbursement.
- RBP can be used for out-of-network charges, rather than arriving at a discount using the usual, customary and reasonable database.
- By using RBP programs, plan sponsors can avoid contracting with a primary PPO network.
- RBP programs handle the issue of balance billing differently, including by having a patient advocate help the patient resolve a balance billing issue, using attorneys to defend the plan participant or having an RBP vendor negotiate a fair settlement with a provider.
- Although determining a fair price using RBP is evolving, the industry is settling on 140% to 150% of the Medicare Allowable.

balance billing. Other RBP vendors obtain prior authorization from the health plan's board of trustees to negotiate a fair settlement.

Savings to the health plan from an RBP program that replaces the primary PPO network for facility claims can be huge, ranging from 10% to 30%, which helps to justify the risks associated with balance billing.

The determination of what is considered a fair payment to providers is an evolving discussion. Based on the *2015 Report to the Congress Medicare Payment Policy* by MedPAC, total health care provider profitability from all sources of revenue (private insurance, Medicare, Medicaid, etc.) reached a 20-year high at 7.2%. Some RBP programs reimburse facility claims at 120% of the Medicare Allowable, and certain hospitals are refusing to work with these vendors. As a general rule, the industry is settling into a range of 140% to 150% of the Medicare Allowable.

Some interesting negotiations are coming out of the RBP arena. In one instance, a hospital said it would not accept a reimbursement of 140% of its Medicare Allowable and proposed 160% of the Medicare Allowable. However, after it was determined that the hospital's quality metrics were not up to industry standards, the hospital agreed to accept 140% of the Medicare Allowable until it brings its quality metrics up to a predetermined level.

Using the Medicare Allowable as the basis of payment has an automatic inflation-fighting factor built into the reimbursement process. Again referencing the *2015 Report to the Congress Medicare Payment Policy,* annual growth for inpatient costs per discharge during the period 2010-2013 has averaged 2.6%. Therefore, if the Medicare Allowable were used as the basis for reimbursements, we wouldn't be seeing the average 8-10% increases we have been experiencing every year since 2001.

Another advantage of replacing the primary PPO network and tying facility payments to 140% or 150% of the Medicare Allowable is more stop-loss insurance companies are working with RBP vendors and incorporating this payment level into their underwriting. Similar to the savings seen in overall costs, the saving on the specific premium and the aggregate funding levels are significant, again in the 10% to 30% range. One cautionary note is the plan sponsor should ensure that the stop-loss carrier agrees to accept payments made on balance billed claims, which may come long after the stop-loss claim is closed and the contract has expired. This is because certain providers are not timely in their balance billing efforts, and the bill may come months after the policy has expired. Some stop-loss companies will accept payments up to one year after the expiration of their contract.

## Conclusion

Using the Medicare Allowable as a basis for determining payments to providers gives plan sponsors greater insight into the providers' actual costs and how those costs compare with those of other providers they have had previously. Also, by using RBP to replace the primary PPO network for facility claims, plan sponsors can see significant savings.

The number of RBP programs varies widely depending on geographic location. However, more plans are turning to RBP programs to save money, especially plans that are facing benefit cuts and don't have any new money to fund projected increased costs. The new RBP program is an analytical, rational approach to arriving at reasonable reimbursements.


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**Kenneth B. Berry, CPA,** is president of K B Berry & Associates, a Walnut Creek, California-based consulting firm specializing in cost-containment programs aimed at reducing medical and prescription drug costs. He previously was president of Associated Third Party Administrators and its cost-containment subsidiary, Accelera Health. Berry has served as a third-party administrator (TPA), auditor and consultant and has worked with over 100 employee benefit plans, fund managers, attorneys, benefit consultants, actuaries, trustees, bank custodians, service providers and investment managers on issues impacting the various plans. As a vice president and benefits consultant with the Segal Company, he was responsible for benefits consulting for health and welfare plans, defined benefit pension plans and defined contribution pension plans. Berry also has worked as a registered pharmacist and a certified public accountant (CPA) auditing Taft-Hartley trust funds. He is a member of the American Institute of Certified Public Accountants (AICPA) and the California Society of CPAs.