RBP PLANS: A HEALTHY ALTERNATIVE

Reference-based pricing plans can be a highly effective form of alternative provider network, if they are implemented in a reasonable way to all parties involved, according to Phillip Giles of QBE

Self-funded employers are uniquely empowered with the ability to design plans that have an increased focus on controlling risk within their underlying benefit plan, to generate greater loss-cost savings. This is especially true of employers using or participating in a captive for their medical stop-loss coverage.

One strategy that is gaining popularity with self-insureds and stop-loss captives is the use of referenced-based pricing (RBP) schedules within the plan of benefits. In RBP, the healthcare plan sets the maximum amount it will cover for a particular healthcare service. RBP plans provide a more defined, or at least a less ambiguous, fee structure—as opposed to "usual and customary" definitions—by tying provider reimbursements to a specific reference point, such as a Medicare fee schedule, plus a defined margin. The margin is usually between 40 percent and 100 percent, for example, Medicare plus 60 percent.

RBP plan design can also take the form of a defined benefit schedule. This type of schedule specifically defines the maximum dollar amount assigned by the benefit plan for each specific treatment or procedure. Some hybrid plans will use usual and customary schedules for most procedurals but incorporate RBP defined schedules to specifically target and limit high-margin hospital charges such as infusion and dialysis treatments, durable medical supplies, and multi-night hospitalisations. As self-funded plans have more plan design flexibility, RBP designs have become increasingly prevalent as a cost-containment strategy. RBP plans can help an employer reduce plan costs by targeting specific areas of excessive cost leakage for containment through defined procedural schedules.

Common RBP plan-design approaches

The first method is a defined, or capped, price schedule for procedurals. The caps can be limited to specific procedures or apply to all treatments. Any charges above the plan's defined maximum become the responsibility of the insured individual. This approach is frequently paired with a high deductible plan structure and designed to encourage increased-price shopping, aka consumerism, on the part of employees for treatment. Even with increased provider price transparency and increased availability of user-friendly platforms supporting enhanced consumerism, this RBP format has been slow to catch on. Many individuals do not yet feel confident or comfortable shopping for medical services and prefer to seek direction from their trusted primary physician. Without a dedicated plan advocate to provide insureds with plan navigation and appropriate provider advice, this RBP structure will continue to experience difficulty in adoption.

A second, and more common, approach is one that seeks to augment or ultimately replace a preferred provider organisation network through deeper procedural discounting from providers. As mentioned earlier, the reimbursement structure is normally based on Medicare as the reference base with an additional defined profit margin. It is important to point out that, in order for this approach to be viable, the potential for "balance-billing" must be eliminated. Balance-billing occurs when a provider expects a larger reimbursement than the amount actually received from the self-insured plan. The provider subsequently sends a bill for the remaining balance to the insured individual. To be effective, RBP structures should be pre-negotiated (or simultaneously, or post-

treatment, in a non-adversarial manner) with providers. Unpaid or contested balances can lead to financial duress and negative credit implications for insureds, and spur litigation between the insureds, employer and providers, and ultimately dilute the value of the health plan as an employee benefit.

Contributions and complications to consumerism

The increased use of RBP plan structures, require employees to become better educated healthcare consumers for non-emergency procedures. Insureds will need to shop for practitioners willing to provide services within their plan's RBP fee schedule. As mentioned earlier, without appropriate advocacy guidance, insureds prefer to seek referral direction from their primary physician.

Complicating efforts to objective consumerism is that few truly independent practitioners actually exist anymore; most have become employee practitioners after being acquired by larger health systems. Care referrals from these physicians are now likely to be directed to facilities within the physician's domestic health system in order to pyramid revenue generation.

The good news for consumers is that providers are facing increasing pressure to publish their pricing structures, making them more accessible to consumers, thus allowing covered employees to shop for the best price. There is a significant variation in medical prices, even for the most common procedures, within most geographic areas. Increased provider transparency will ultimately contribute to more competition, lower costs and reduced spending.

Many large insurance carriers are now publishing the fee schedules of their contracted providers. A number of online 'transparency tools', such as Castlight Health, Mpower360, and Healthcare Blue Book, make provider pricing information widely available. With enhanced transparency, more providers are becoming increasingly willing to negotiate and accept realistic Medicare Plus structures.

It is also important to note that there is usually little correlation between quality and price with regards to medical care. However, insureds should not select providers based solely on price. Just as pricing has become more transparent, so have the qualitative patient outcome scores of providers.

These scores measure the success and related complication and readmission rates against the number of the specific procedures performed by providers to determine a qualitative score. Precise qualitative scoring is currently a difficult measurement, however, when available, it can be paired with pricing data to effectively find the best care at the best price.

Continued evolution

For many self-funded plans, preferred provider organisation networks will gradually evolve into or be replaced by negotiated RBP networks. These will contemplate both pricing and quality of care into the provider reimbursement schedule. RBP plans can be a highly effective form of alternative provider network if they are implemented to mutual equitability for all involved such as, insureds, providers and plan sponsors.

Larger self-funded employers, including single-parent captives and group captives, having greater concentrations of employee populations in specific geographic locations can work locally to develop deep discount RBP arrangements with select providers in return for increased or exclusive patient steerage from the employer. RBP plans are most effective in higher density population areas where provider selection, competition and the potential for leveraged discounting is strongest.

A 2016 study published by the Employee Benefit Research Institute concluded that RBP plans can "save billions in healthcare costs". The combined advantages associated with self-funding and implementation of a well-planned RBP schedule can ultimately deliver decreased provider charges and improved patient outcomes to significantly enhance a plan's overall financial performance. **CIT**

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