Health Care Cost Management for Employers

(including Reference Based Pricing)

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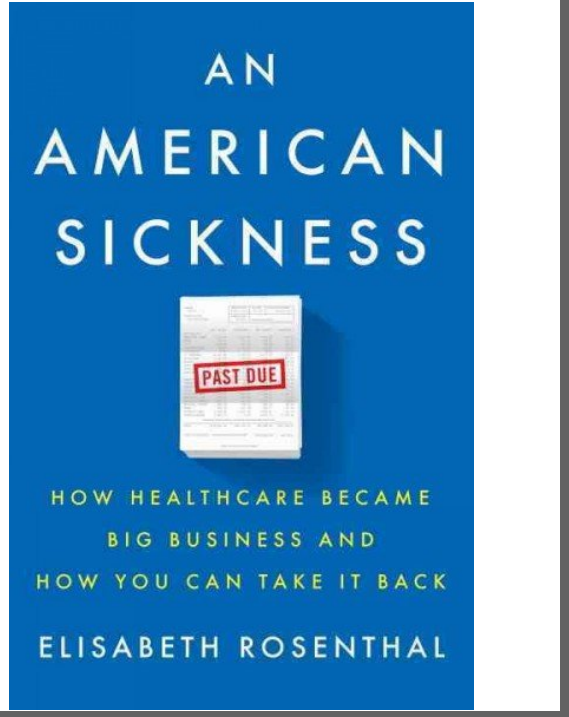
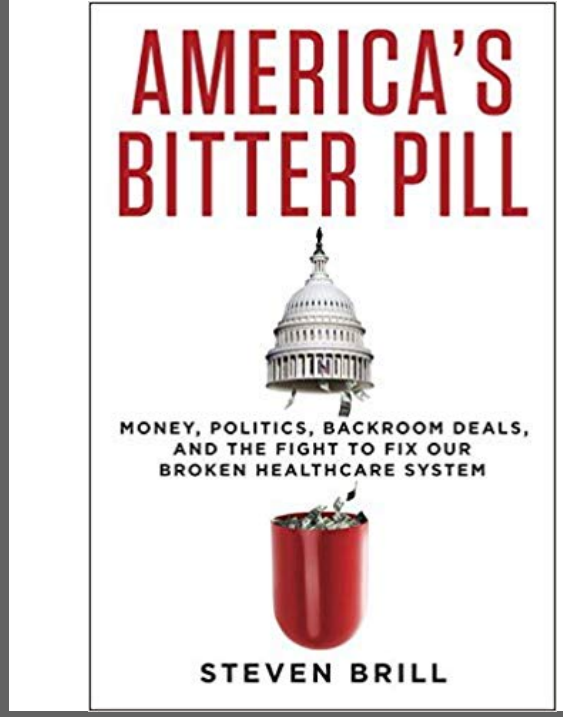
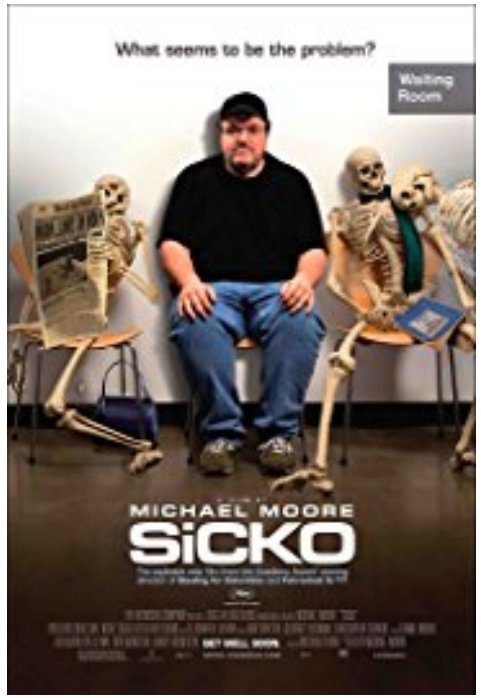
It's no secret that America is in the midst of a health care crisis…

- Numerous reports detailing the cost of health care in America have come out – and are getting a lot of notice:
  - "***America's Bitter Pill***" by Steven Brill
  - "***An American Sickness***" by Elisabeth Rosenthal
  - "***Sicko***" by Michael Moore
- These and other investigative reports clearly show that there is **something wrong in the American health care system**:
  - On the one hand, the U.S. is the most expensive place to purchase health care (nearly 20% of our GDP is spent on health care – **rank #1 ranking in the world**)
  - On the other hand, health care results are poor when compared to other countries **(rank #36 in the world** in terms of overall quality indicators)
  - In other words, **spending more money on the problem doesn't improve results!**
- Consider the current state of health care from the perspective of someone **who pays the medical bills for millions of people** through employer-based health plans:







"There is a Health Care OPEC in America.."

- **Hospitals**: Make their own pricing, Unregulated Utilities
- **Physicians**: Greater Utilization = More Income
- **Pharmacy**: Unabated Greed, No governors on price or profits
- **Ancillary Services** (labs, etc.): Greater the turmoil, the greater the need
- **Medical Device Manufacturers**: Huge distribution mark-ups including commission to hospitals and doctors who "sell" their products
- **Health Insurers**: Are guaranteed a 15%-20% profit margin per the ACA (MLR rule)

The 2 Largest Payers of Health Care

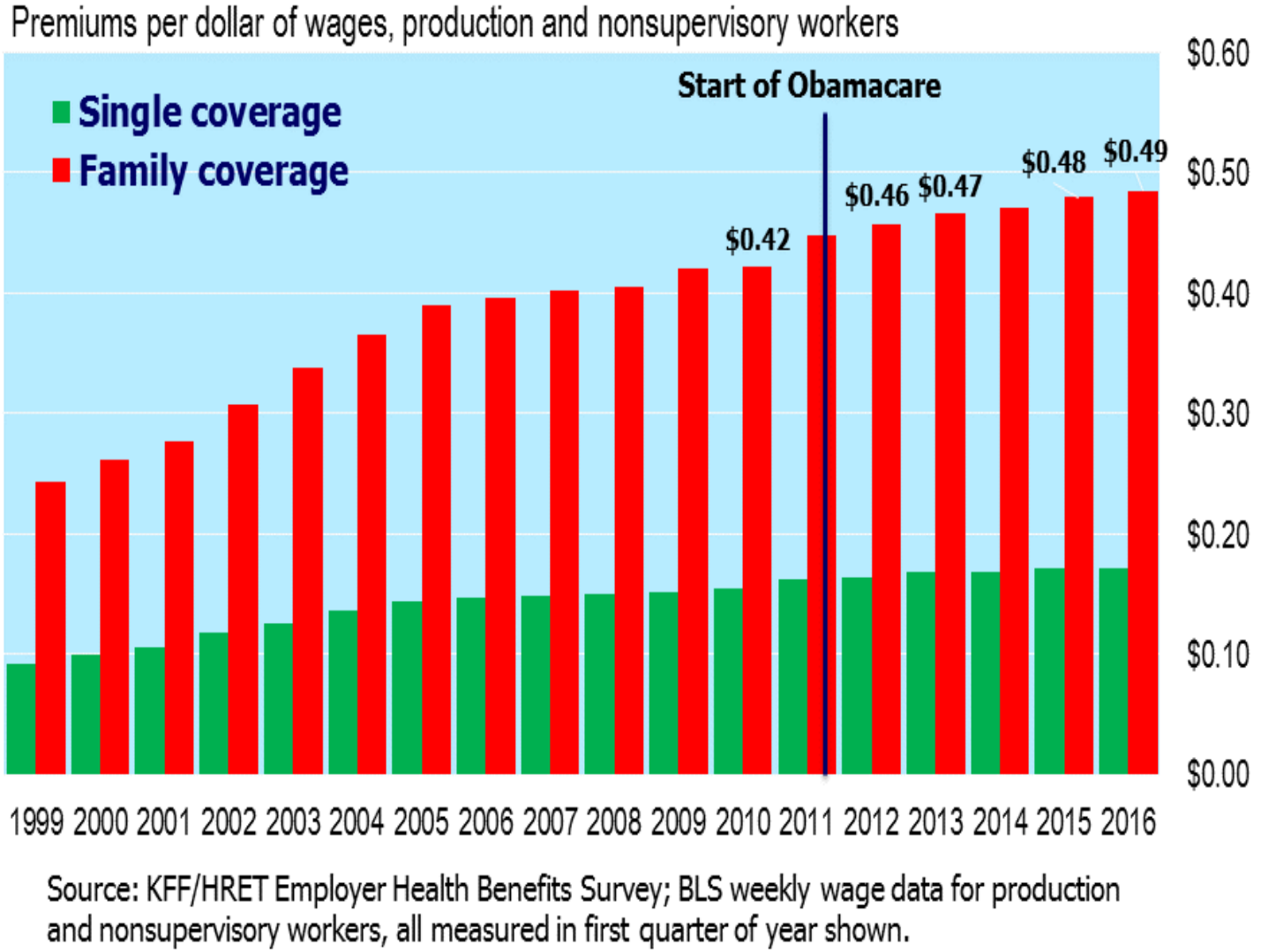
- **Government** through public programs such as Medicare & Medicaid
  - Funded through **taxes on payroll and other fees**
- **Private Employers** who provide **tax exempt** health care benefits to their workers
  - ***Large employers*** are now mandated to offer coverage and provide a "subsidy" that limits employee share of cost to less than 10% of their wages
  - ***Small employers*** are/were provided incentives to offer coverage to their workers
- **The combination of Government/Employer coverage amounts to about 90+% of the cost of health care in the U.S.**

Where are employers at with regard to providing health care benefits?

- The **ACA remains the law of the land and the Employer mandate remains in place** – and IRS has begun collecting penalties
  - Employers must offer at least **Minimum Essential or Minimum Value Coverage**
  - **A**nd must ***pay for a portion of the cost of that coverage***
- **82% of <u>large</u> employers (500+ employees) are "self-insuring" their group health benefits**
  - This percent continues to rise since passage of the ACA, especially among **mid-sized employers with 50 to 500 employees**
  - Unfortunately, some states **prohibit or discourage** "***small*** employers" from self-funding their group health benefits (California SB-161)
    - This doesn't allow small employers to see the true cost of health care upon which their rates are based…

What have employers done to contain their health care costs up to now?

- ***Shifted some of claim costs*** to employees in the form of deductibles, coinsurance, copayments including implementation of ***Consumer Directed Health Plans***
- Added ***management/cost containment features*** such as ***utilization review***, ***second opinions***, c***ase-management***, etc. to most of their plans
- Moved majority of employees to some type of ***managed care plan*** (HMO, PPO, EPO) which ***limited provider choices***, required ***gatekeepers*** and ***pre-certification*** of all non-emergency services
- Took on more risk by setting up ***alternative funded plans*** (self-funded, level-funded, HRA, HSA, etc.)
- *When employers began to see what the cost of health care really was, they began to take more aggressive measures including* ***direct contracting*** *with providers*



Source: KFF/HRET Employer Health Benefits Survey; BLS weekly wage data for production and nonsupervisory workers, all measured in first quarter of year shown.

Direct Contracting Strategy…

- Employer sponsored benefits **started out this way**
  - ***Texas school teachers*** with hospitals (BCBS)
  - ***Kaiser shipbuilders*** with local clinics and hospitals
  - Large employers with a workforce concentrated in one area (i.e. ***Boeing Aerospace*** in Seattle)
  - **Taft-Hartley Trusts** (jointly managed union plans)
- Large numbers gave employers negotiating clout in local areas
  - **Eventually established own clinics, employed doctors and contracted with local non-profit hospitals**
- Sophisticated employers **review cost and utilization data** and make changes to keep overall costs in check
- In the 1990's employers began to purchase coverage through **cooperative or private exchange arrangements** – copying what many States were doing with regard to purchase of benefits for state workers
  - Which brings us to the CalPERS story…

The CalPERS Story

- ***California Public Employees Retirement System*** is one of the largest self-insured plans in the U.S. with more than **1.4 million members**
- They adopted a new pricing strategy in the early 2000's
  - Initially focused on **elective knee and hip replacements** which were costing between **$20,000 to $120,000 per procedure**
  - ***CalPERS could not find any correlation between higher price and an increase in quality (outcomes)***
  - Established a **$30,000 reference point** it would pay for these two procedures
  - Designated **41 hospitals to provide this service** based on **quality measures rating of average or above average** (and met the ACA requirement of insured quality)
  - Member paid a **10% copayment if the procedure cost $30,000 or less**
  - Member paid a **10% copayment + 100% of cost over $30,000** if they went out of network
- **Results**: Saved nearly **$6 million in the first two years of the program** with **other hospitals "knocking on the door" to get approved** to provide the service to CalPERS members

"Capitated Risk"…

- Not new – became a key strategy in the **1990's**
- Large hospital chains and medical groups negotiate for **fixed payments** and are at risk if actual costs exceed payments
  - For small employers, **capitated risk arrangements may be their best bet to containing health care costs** since the risk is borne more by the provider than by the insurer/health plan
- Outside of CA, many **large employers enter into capitated risk arrangements** and have for many years with varying degrees of success
- The ACA encouraged the formation of ***Accountable Health Plans*** and this has spawned new initiatives in states that have high managed care participation
  - Effectively the provider takes on more risk while the insurer provides catastrophic risk protection and administration of the program

In spite of *payment initiatives* there is still a need for a "fee-for-service" model

- Some employees or dependents ***don't reside in an HMO or PPO service area***
- Some employers want the flexibility of a benefit that allows ***in and out of network services*** and/or ***self-referral*** without a "gatekeeper"
- Many employers want more ***control over their money*** so they set up a self-funded program which returns surplus funding dollars at year-end
- If they cannot enter into capitation arrangement then they will offer a ***controlled fee-for-service*** program using either a PPO or a metric-based pricing arrangement – also called "***Reference Based Pricing***"

Reference Based Pricing took off after passage of the *Medicare Modernization Act*

- **Signed into law in 2003**, the MMA did many things including:
  - **Part D drug benefit** introduced through private insurer/health plans
  - **Provider payments** based on **provider costs and a reasonable profit margin** to provide those services
- **Government contracts with four companies** to gather all cost and payment data from health care providers in their geographic region who are participating in Medicare
  - A **provider must supply this information** to the government annually in order to have their fees considered for reimbursement
  - **Payments vary by *location*, *severity* of service and *other factors*** that providers have agreed upon
- Prior to MMA, less than **50**% of U.S. providers participated in Medicare
- Today that number is over **90%**

Metric Based Pricing or Reference Based Pricing

Most arrangements use Medicare as the reference point and pay a percentage of what Medicare pays (i.e. 125%, 150%, 175%, 200%, etc..)

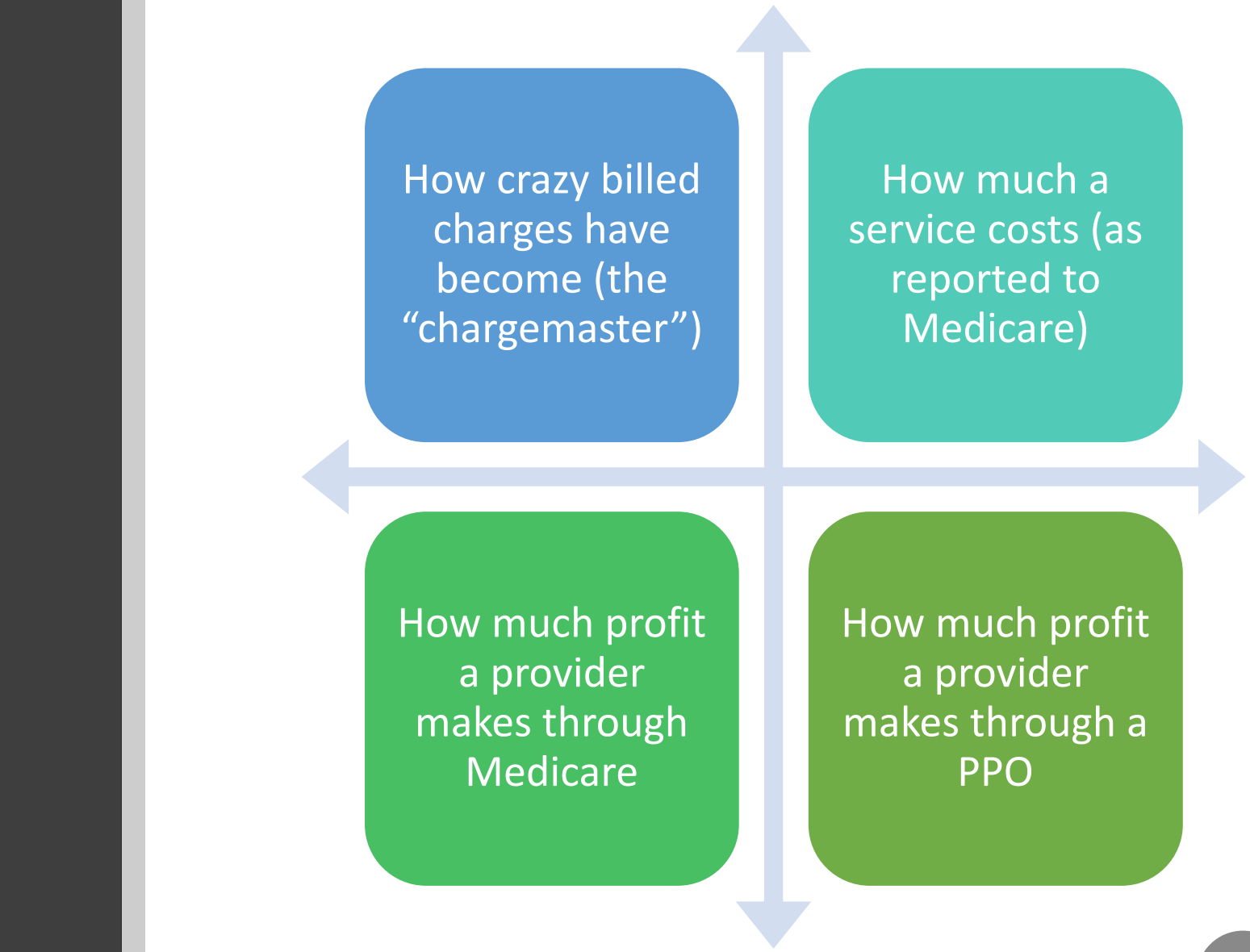
Typically includes the following services: **Hospital or Facilities**; **Laboratory and Diagnostic**; **Medical Devices and Supplies**; **Physician** and **Professional Services**

Some programs **exclude physician services** (stay with a PPO) and require all others to be subject to a reference price point

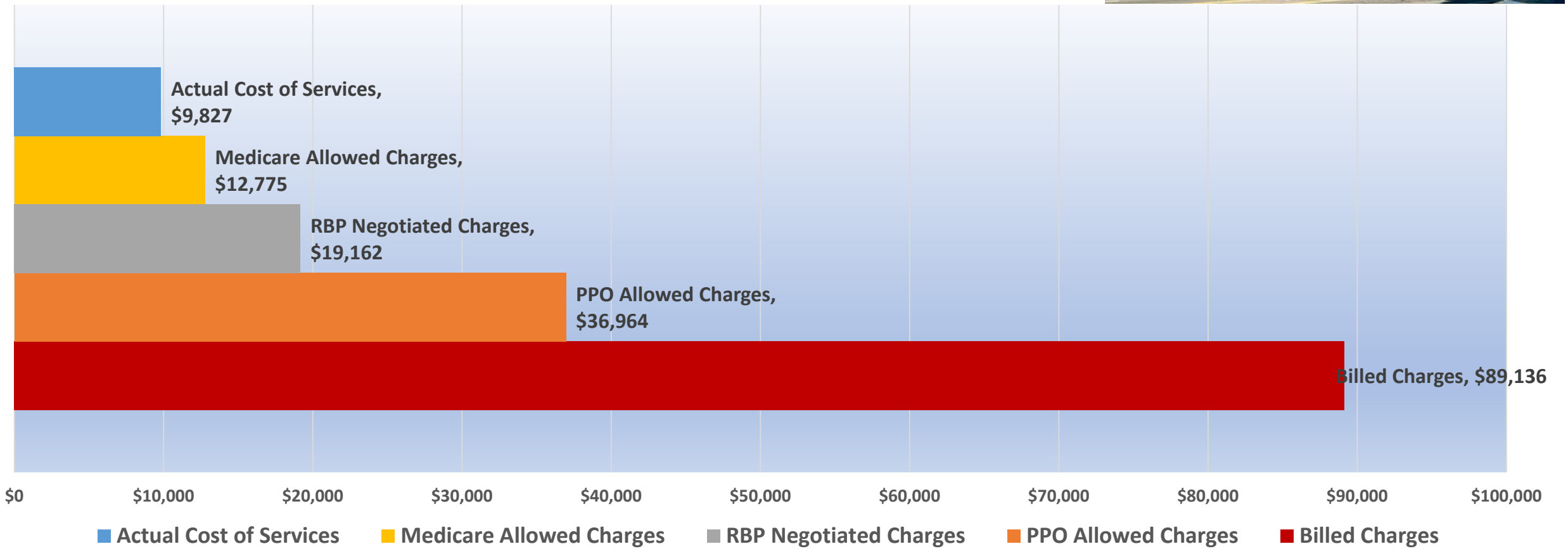
Key Point: **Provider agrees to a percentage of the reference point and not to balance bill the patient for the difference!**

So, first let's talk about Reference Based Pricing and the numbers…

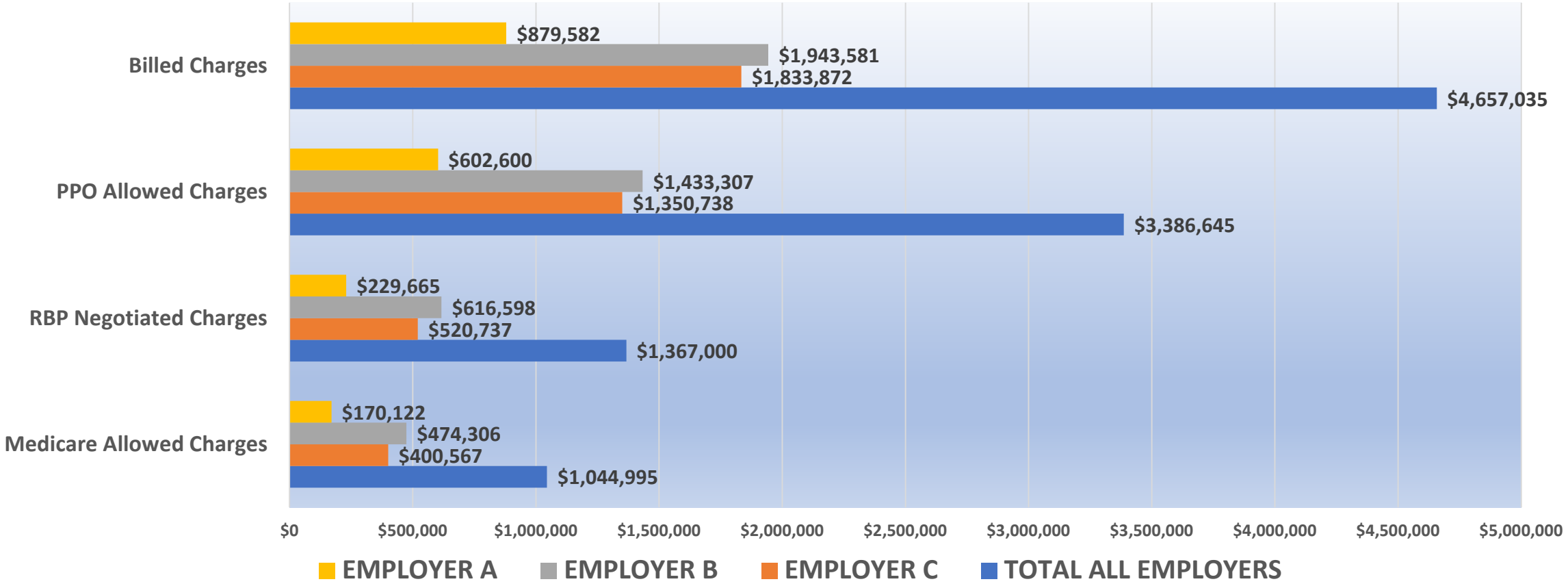
These are real examples



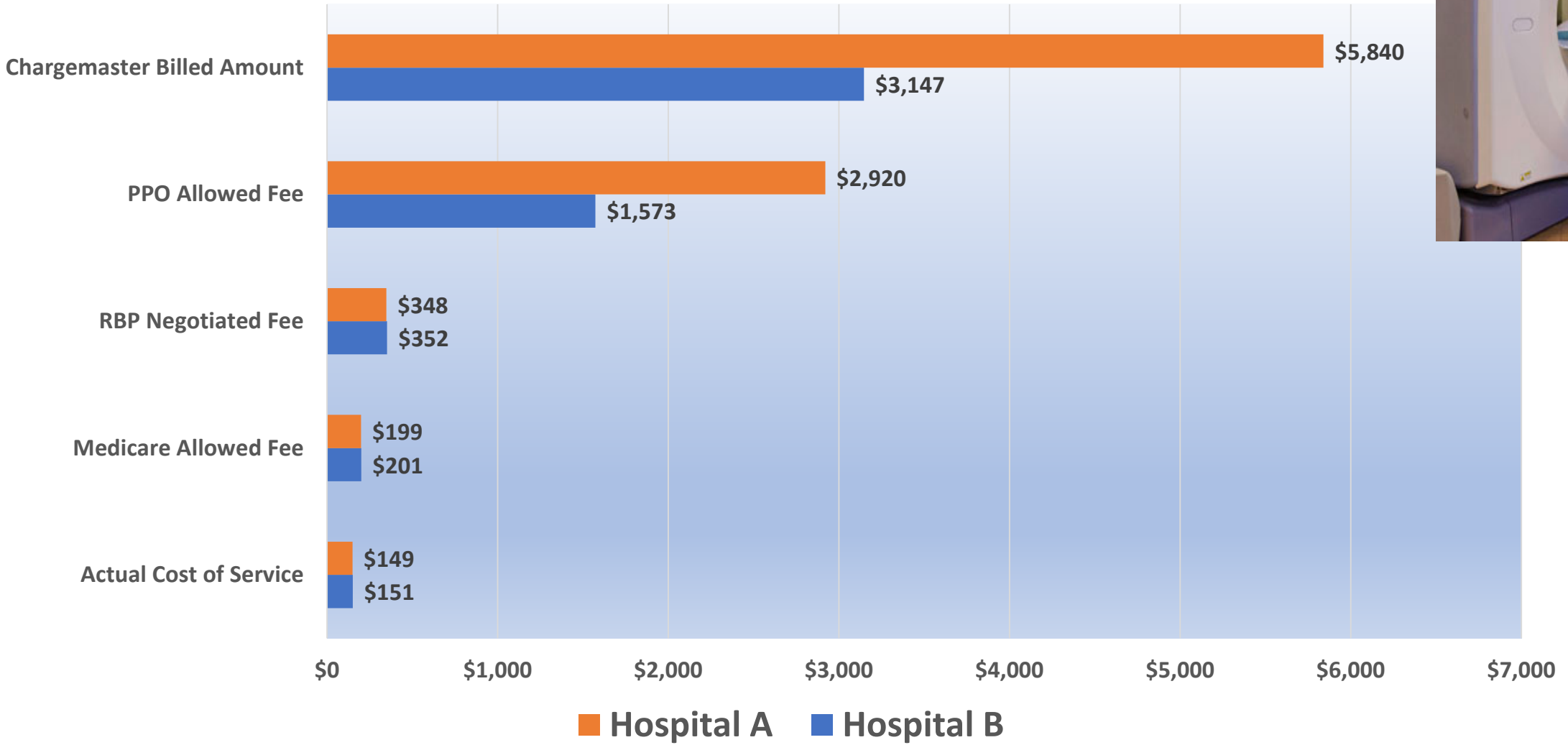
Medicare Payment Price Point
(2-day stay in California Hospital – 2018)



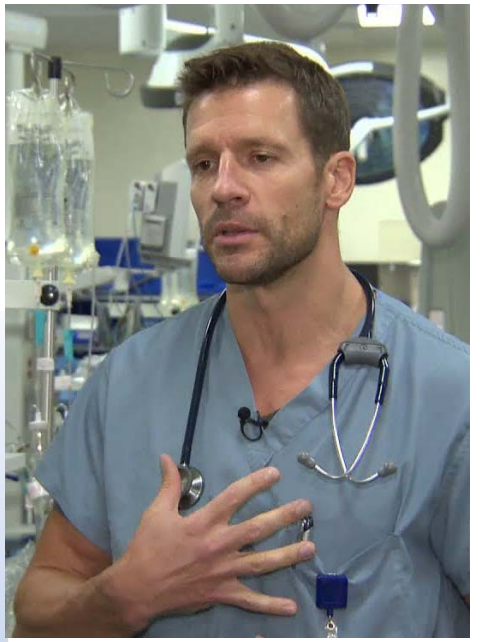
Pricing Variation for Inpatient Hospital Costs
(TPA reports for 2016/2017 Plan Years)

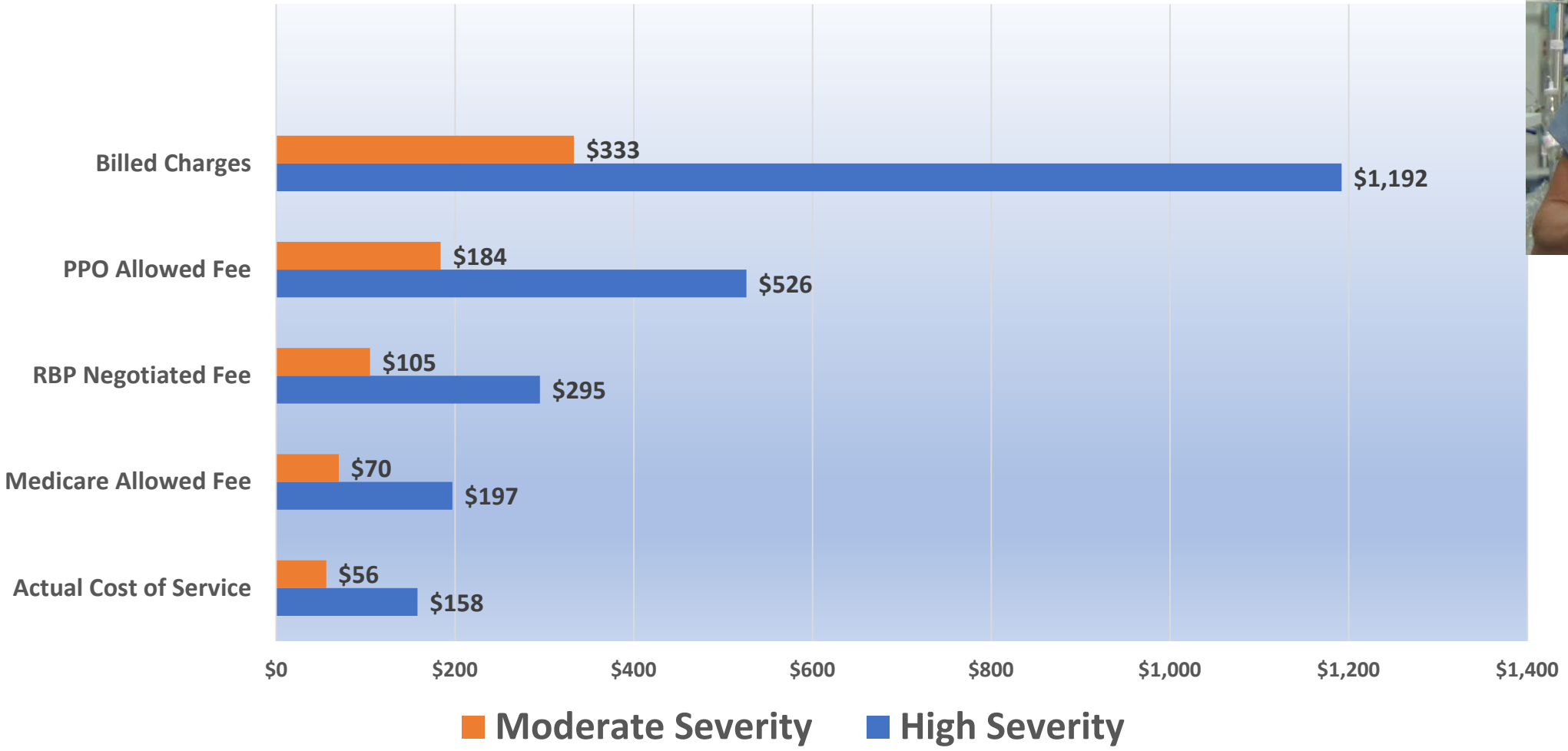


Pricing Variation for a CAT Scan
(2 hospitals in San Diego, California – 2017)



Pricing Variation for Emergency Room Physician Fees
(National Average from TPA paying $600m in claims - 2017)





Reference Based Pricing works best on…

- **Hospital/Facility costs**
  - Medicare payments are now bundled for many common procedures
  - Instead of starting with the chargemaster and working down, ***Medicare now starts with cost and works up***
- **Medical devices**
  - No longer allows for **hospital or physician to mark-up the charge** (eliminates a profit center) for the device
- **Diagnostic Lab / Imaging**
  - Medicare does a good job in sifting out **duplication or unneeded tests** and also conflicts with physician owned or hospital-based services

Some providers still claim to "lose money" when they treat Medicare patients

- But the facts show otherwise
  - **Medicare pays providers to cover their costs and earn a modest profit of 25% to 50%** for the service rendered
  - Some areas, such as Florida, you see hospitals, medical groups advertise to seniors – **would they do that if they were losing money?**
  - Again, more than **90% of providers now accept Medicare patients**
- Perhaps the better way to put this is that *some providers don't make the **profit margin** they want to when they see Medicare patients – is that called price gouging?*
  - ***Yet 75% of hospitals in the U.S. are "non-profit" entities***
- **Unfortunately, *Medicare is prohibited by law from negotiating Rx prices* like the European and Canadian systems do**
  - **Some employer plans are now beginning to contract with PBM's that will purchase outside of U.S. certain drugs with no generic equivalent**

Next, let's talk about *Reference Based Pricing* and how it works…

Reference Based Pricing – step 1

- **Employer Decisions**
  - Will the program be offered as ***full replacement, dual choice or hybrid model***
    - **What *benefit changes* are needed to influence the success of this program – get employees to enroll**
  - How will "***Reasonable Fee***" be defined
  - Who will handle ***provider relations*** including the legal issues surrounding ***balance billing conflicts*** – and how much will that ***cost***
  - What will be ***required of HR, Consultant and TPA*** to see that this is implemented in reasonable timeframe
  - What is the employer ***willing to invest*** to get the program implemented
  - What will be the ***projected ROI*** of this program

Reference Based Pricing – step 2

- **Member Education**
  - Plan document and ID card reflects the ***Reasonable Fee*** payable to providers.
  - Many times a FAQ is included with the ID card as well as website links that include ***audio/visual instructions and explanations*** that can be used by both the member and their health care provider.
  - Most HR professionals report that they need 4-6 months of lead time to get this implemented successfully
    - You can't have too much ***employee*** communication
    - You can't forget about local ***health care providers***

Reference Based Pricing – step 3

- **Provider Issues**
  - Members will want to ***check with existing and new providers*** to see if they will accept a Plan that pays the "***Reasonable Fee***"
  - A good start is to find out if a provider already ***accepts Medicare patients***
  - The TPA should establish a ***provider hotline*** to handle challenges from provider billing offices
  - Educate employees to pass along to their providers the information about how the plan pays a "***Reasonable Fee***" and that such fees are paid quickly and fairly by the Plan Administrator
    - They need to understand that *Reasonable Fee* is a factor of Medicare or whatever pricing point has been adopted
  - Many plans start with **hospital/facility programs** in the first year and leave physicians in a PPO in the short term
    - Then later move into dual-choice, and finally into full PPO replacement within 4-5 years

Reference Based Pricing – step 4

- **Balance Billing Issues**
  - **This is going to happen!**
    - When it does, the Plan Administrator will have a system in place to handle member concerns about balance billing
      - In about **90% of all cases**, the Plan Administrator contacts the provider and reminds them of the fact that the plan pays a "***Reasonable Fee***" for the services rendered – based on a multiple of the Medicare allowed fee
      - In these cases the provider agrees to the payment and does not pursue balance billing
      - In about **9% of all cases**, the Reference Based Pricing administrator **legal assistance team** negotiates with the provider until both parties come to an agreement for payment with a promise to forego balance billing
      - In less than **1% of all cases**, the matter goes to an **arbitrator (or judge)** and the **provider will have to divulge their costs, profit margins**, etc. – which is why such a small percentage of cases go to arbitration

Reference Based Pricing – step 5

- **Constant Review and Modification**
  - TPA and RBP organization provides detailed reports:
    - **Pricing / Savings**
    - **Utilization of services**
    - **Balance billing** issues
    - **Changes in payment recommendations** based on certain procedures / bundling opportunities
      - Provided by government contractor reports which are public information
      - Compare employer plan to Medicare results and try to keep them parallel
    - **HR issues** including member education and challenges
    - **Provider issues** including education and payment acceptability

What Does Reference Based Pricing Cost?

- There are **implementation costs** that vary based on employer commitment to a successful roll-out
  - This should be estimated and an ROI calculated before put into place – using employer claims data and reasonable savings assumptions
- **Ongoing costs** paid through TPA to RBP vendor who signs a service agreement with outline of services
  - PEPM cost is close to what a PPO access fee now costs: **$5 to $20** is the range to expect
    - Some vendors used to charge a ***percentage of documented savings***
    - Some vendors offer ***full menu of services*** including **legal assistance**

Summary: Advantages of Reference Based Pricing

- Some **fully insured carriers** are now using a RBP strategy with providers
- Most **self-funded employers** are now adding RBP as a cost-containment strategy
  - **Maximizes cost savings** by paying providers a **multiple of Medicare** – something which 90% of them already accept
  - **Freedom of provider choice** – can **use any provider** they choose / are not forced to change providers
  - **Increased price transparency** – using tools such as the ***Healthcare Bluebook ™***, patients get a truer picture of provider cost and quality
  - **Claim Advocacy** – most plan administrators enlist the services of a firm who handles ***provider relations and negotiations*** for amounts above the ***Reasonable Fee***

Conclusion

Employers will continue to seek out ways to contain health care costs using **innovative strategies that are proven to work**

Shifting some of the risk to providers is a good strategy in markets where providers are more sophisticated with regard to **health care economics**

Utilization of a **Metric-Based price point** for services is probably the future for fully insured plans in the U.S.

Utilization of **Reference Based Pricing** by self-funded/level-funded employers has picked up steam since 2014 and will **become the norm over the next ten years**