Strategic reference-based pricing: A cure for the medical overbilling epidemic

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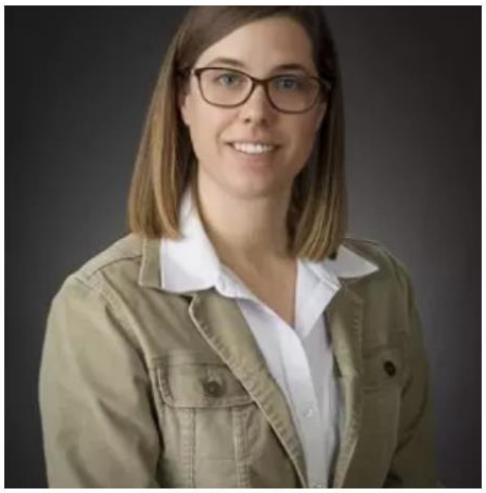

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No one is immune from the nation's medical overbilling epidemic – not even a former U.S. surgeon general. Jerome Adams, who served in that post under President Donald Trump, recently received a staggering $5,000 medical bill for a routine ER visit to treat what turned out to be dehydration. He noted that despite his extensive knowledge and resources, navigating the complexities of healthcare billing proved to be a daunting task. His experience underscores a pressing need for clear and accurate price transparency in U.S. healthcare to avoid egregious bills in the first place.

Adams has plenty of company when it comes to this issue. Many patients are often blindsided by exorbitant medical bills and a lack of transparency, grappling with rapidly rising out-of-pocket costs they cannot ever anticipate or afford, or drowning in a sea of medical debt. The implications are far-reaching, with unpaid medical bills now accounting for the leading cause of personal bankruptcy.

Medical overbilling creates a vicious cycle wherein scores of average working Americans delay or forego important medical care, or ration medicine. In a growing number of households that are unable to save for emergency expenses, even families with employer-provided health insurance face an untenable choice of putting food on the table or being treated by a physician. These factors invariably erode employee health and wealth, which in turn, undermine productivity and competition.

A growing movement is now afoot nationwide to help working Americans erase crippling medical debt, with some state and local governments enacting measures to prevent this scourge from undermining their credit. It's part of a cultural tipping point that acknowledges the financial fragility of both working and middle-class households that struggle to make ends meet.

Passage of the No Surprises Act (NSA), which was signed into law as part of the Consolidated Appropriations Act (CAA), and the Transparency-in-Coverage rule represent a step in the right direction, but there are meaningful marketplace solutions that can make a massive impact beyond greater government oversight.

Short of a post-pay review that includes repricing unreasonably high claims or challenging them in court, there's actually a proven way to help healthcare payers, plan sponsors and members avoid exorbitant costs, a way that fortifies an elevated level of stewardship that is increasingly expected among health plan fiduciaries under the CAA. That way is the strategic implementation of reference-based pricing (RBP), which serves as a healthy dose of preventive medicine.

Tasting the secret sauce

As the name suggests, RBP uses a reference point for pricing high-cost medical procedures that vary widely from one facility or market to another. Plans that employ this strategy often will use a modest multiplier of Medicare in the 120% to 150% range. RBP has become a fast-growing, transparent solution for avoiding unreasonable or excessive provider charges that drive up the cost of employer-sponsored health benefits. It has the potential to transform employee use of health care services by making procedures more accessible and affordable. Attorneys serving this space and involved in litigations view RBP as a transparent and affordable solution that helps employers and providers negotiate reasonable prices and utilize state and federal laws to their benefit.

Not all RBPs, however, are created equal. Just like the wide range of prices they seek to contain, there are variations in plan design and services to consider. This is especially important to consider given that the NSA could significantly increase costs for health plans that use narrow networks, negotiate contracts with providers or employ RBP as the mechanism to price out-of-network claims.

Now here's why: open negotiation and independent dispute resolution (IDR) procedures may trigger a new risk for health plans that apply RBP to non-network providers or plans that directly contract with providers and facilities. The irony is that any added cost associated with making health insurance coverage more transparent easily could be passed onto participants.

To avoid harmful exposure to the medical overbilling epidemic, the most effective approach is to adopt a "pure" RBP plan that does not contract with providers and, therefore, avoids the IDR process based on the guidance received to date. In the absence of any out-of-network claims, direct-contracting fees or need to determine a median in-network rate, these plans will not be adversely affected by the NSA. Further, because in-network charges also tend to vary substantially, pure RBP ensures the suggested reference price applies in every situation.

While all employers face the same pain points associated with legislative loopholes and litigation, there's a way for larger or jumbo groups to avoid the IDR process. If those companies reduced the breadth of their networks and applied RBP, then there is no network qualified payment amount.

Adopting this structure, coupled with tech-driven data support that includes an advanced payment-integrity solution, could potentially lower both the cost of coverage and employee cost sharing. Given the wide variation of provider charges for the same services, without any difference in quality, a pure RBP design offers plans the best opportunity to avoid excessive and unreasonable provider charges.

With appropriate participant protections in place, this novel approach has lowered both the employee point-of-purchase cost sharing in the form of annual deductibles, copayments and coinsurance, as well as the cost of benefits. Over time, it lowers the cost of coverage by reducing both employee and employer contributions.

RBP is one of many effective strategies for addressing today's economic challenges, ensuring the health and wealth of benefit plan participants. Related initiatives include adequate participant protections against balance billing, participant advocacy and litigation support, as well as acquisition cost-based pharmacy pricing and Health Savings Account-capable coverage.

While RBP designs have long been part of self-insured health plans and established a meaningful track record in reducing health spend, there hasn't been meaningful adoption of these plans amid provider resistance, a litigious climate and employee friction. However, with pure RBP and other improvements, more employers are expected to embrace this approach.

When implemented in the right way, RBP proactively anticipates the challenge of balance billing and provides participant representation. And at a time of rising healthcare costs, the pure model is the best approach for avoiding the medical overbilling epidemic, which erodes not only benefits coverage and wages, but also employee well-being, morale and productivity.

About the author: Christine Cooper is the CEO of aequum LLC and the Co-Managing Member of Koehler Fitzgerald LLC, a law firm with a national practice. Christine leads the firm's health care practice and is dedicated to assisting and defending plans and patients.