Understanding the evolution of reference-based pricing and considerations for employers evaluating the approach

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As employers explore ways to control rising healthcare costs for their organizations and their employees, reference-based pricing (RBP) continues to be discussed as a potential solution. RBP has evolved since its origins in the 1990s, and has gained more exposure in recent years. Employers continue to evaluate its viability, drawn by the allure of "reduc[ing] health care claims spending by 20 percent to 30 percent."[1]

Surveys indicate that approximately 2% to 3% of employers were already using some form of RBP within their healthcare programs in 2019, and 7% to 11% were considering it for 2021 and beyond.[2] It is critical that employers understand how these programs work and the potential risks associated with them before transitioning to RBP. We address these risks in the following sections, along with an overview of the various approaches to RBP, examples of existing arrangements, and key considerations for employers when evaluating RBP programs.

Overview

RBP refers to a benefit design or reimbursement structure under which a self-funded employer establishes a maximum amount it will pay for a product or service.[3] While RBP originated as a single concept focused on shoppable services with wide price variations in a covered region, it has evolved over the years into several different variants, all of which are referred to as "reference-based pricing." A useful framework for understanding these different approaches distinguishes them under two broad categories—reference-based benefits versus reference-based reimbursement.[4]

REFERENCE-BASED BENEFITS

The first evolution of RBP was centered on a reference-based benefits (RBB) approach. RBB typically focuses on services like MRIs and joint replacement surgery where the market has a variety of providers, the service is not time-dependent, and the consumer can reasonably be expected to shop around. Under RBB, an employer determines a defined maximum benefit amount—the "reference price"—that it is willing to reimburse for that specific service. For example, an employer might set a reference price of $750 for an MRI based on an analysis of MRI costs in the local market. RBB aims to encourage the plan participant to seek providers who charge at or below the reference price, as the amount is established based on local market contracted reimbursement rates. Members typically are provided with a list of providers who have agreed to accept reimbursement at or below the reference price. As such, the participant is not exposed to balance-billing for the excess cost unless they affirmatively decide those excess costs are justified by other considerations, such as location, perceived provider quality, or other personal preferences.

REFERENCE-BASED REIMBURSEMENT

Because RBB approaches are limited by the number of services to which reference prices can reasonably be applied, employers have sought to extend the benefits of reference prices to broader portfolios of services—not just the consumer-focused services of RBB. Under this reference-based reimbursement (RBR) structure, plan administrators still establish reference prices based on contracted reimbursement rates in the local market. While this reimbursement can be structured as a flat dollar amount, it is more frequently indexed against a fixed fee schedule (often Medicare reimbursement rates) to enable coverage of a greater volume of potential services without having to develop prices for each distinct service. Plan administrators still provide members with lists of providers who agree to accept the mutually negotiated and agreed-upon reference prices so that members are still protected from balance-bills except through their own choice, in effect creating a plan network.

UNILATERAL REFERENCE-BASED REIMBURSEMENT

The most recent evolution of RBP is a *unilateral* reference-based reimbursement (URBR) approach. Under this approach, the plan administrator unilaterally determines what it believes to be a reasonable reimbursement rate, typically focused on generating

employer savings rather than aligning with prevailing rates in the local market. The unilaterally determined reimbursement is based on a "reference price"—in most cases Medicare reimbursements are used to develop these prices, as in RBR, though other approaches may apply for services that are not covered by Medicare, such as reimbursing providers at cost plus some fixed margin. The reimbursement rate determined unilaterally by the plan administrator is generally some multiple of this reference fee schedule (e.g., 125% of the Medicare rate), and represents what the plan administrator deems an acceptable reimbursement for the medical care provided. The choice of reference price and reimbursement multiple may or may not account for regional differences, providers' operating expenses associated with delivery of services, provider quality, or other factors.

The final URBR payment is then used as the basis for health plan cost-sharing adjudication (i.e., determining plan participant cost sharing via deductibles, copayments, and coinsurance) and payment to the provider. Because URBR is not generally tied to prevailing local market considerations, plan administrators may not have a robust list of providers that agree to accept the URBR price, and members may be subject to balance-bills for any services received. While URBR approaches may still have a limited number of contracted providers, this approach is focused on cost control rather than typical provider network considerations, such as broad access to a vetted network of quality providers. As such, URBR plan administrators generally do not perform a thorough evaluation of provider quality or network breadth to ensure adequate access to quality care at the URBR price across all types of services. As a result, this approach exposes plan participants (or potentially plan sponsors) to the risk of balance-billing.

URBR approaches often seek to address the potential increased exposure to balance-bills through support services for plan participants who receive care from providers that do not accept the URBR price as payment in full. Plan administrators may offer appeals pathways that providers may use to seek higher reimbursements from the plan, assist members directly with negotiating lower reimbursement rates from these providers, or, in the most aggressive approach, engage lawyers to assist in balance-bill defense.

In practice

Although employers have yet to widely adopt URBR in the U.S., examples of more targeted RBB and RBR approaches can be seen in the U.S. and around the world. These approaches have been particularly prevalent in the prescription drug space. Germany, as well as several other European countries, for example, regularly establishes a reference price for drugs, on the conditions that there are therapeutically similar options available and wide price variation among those options.[5] Patients are charged a standard copayment for a given drug, and charged the copayment plus the difference between their drug's price and the reference price should they choose a more expensive alternative. When establishing reimbursement rates for new drugs, regulators consider the incremental benefit a drug has over therapeutically similar alternatives.

Some U.S.-based organizations have begun to mirror this approach. Researchers at the University of California Berkeley Center for Health Technology studied the impact of reference-based drug pricing on a large population of employer-sponsored healthcare plan participants. The researchers found that patient cost sharing increased in the first two years after implementing a reference price approach, but decreased over the five-year period following implementation as patients and physicians adapted to the new structure. Average prices paid by the employers in the study decreased as a result of the change.[6]

Success with RBP has been observed with medical benefits as well. A separate study evaluated the impact of reference pricing on specific nonemergency procedures including joint replacements, colonoscopies, and various laboratory and radiology services in large employer populations—the prototypical RBB concept. By the end of the second year following implementation of reference pricing for these services, the percentage of patients selecting facilities that charged below the reference price had increased between eight and 18 percentage points, depending on the procedure. In general, patients demonstrated increased levels of engagement and consumerism under the new reimbursement mechanism.[7]

Key considerations

Implementing RBP in any form can potentially yield plan savings for employers, but not without risk. Particular attention should be paid to the considerations outlined below.

EMPLOYER OBJECTIVES

A core consideration for employers contemplating RBP under any of the approaches we have outlined is what they hope to achieve and the associated trade-offs.

In a recent survey, 95% of employers indicated that the competitiveness of network access was "important or extremely important" when selecting a plan administrator. Additionally, 67% indicated that an administrator's ability to protect plan participants from surprising bills was an important consideration as well.[8] Employers should thoughtfully consider whether members will have sufficient access to providers willing to accept reference-based reimbursements.

However, some employers may have a primary goal to maximize savings. In this case, the employer needs to understand the tactics used by the plan administrator to generate those savings.

ESTABLISHING THE REFERENCE PRICE

As an employer evaluates its objectives, a primary decision is the level at which the reference price is set. If a plan administrator sets the reference price too high, plan expenditures increase, but the likelihood that plan participants may be exposed to excess charges and potential collection activities decreases.

However, if a plan administrator uses an unsustainably low reference price to maximize savings, there is a risk that plan participants won't have adequate access to high-quality providers willing to accept the reference price as full payment. These administrators may also seek to be more aggressive in collection defense activities in order to offset the risk of plan participants being exposed to excess charges.

Average hospital reimbursements paid by private health plans were approximately 247% of Medicare in 2018.[9] Based on this information and other market data, common URBR hospital reimbursement rates at 125% or even 150% of Medicare may not be deemed fair and/or reasonable by the private market at large, which creates significant risk for URBR plan participants and additional complications for providers.

> Finding an appropriate balance between cost and access is the key factor in setting a reference price.

Assigning an appropriate value for services rendered is complicated. Private health insurance market dynamics establish prices for each provider and service. These rates are distinct from Medicare rates, and can vary significantly as a percentage of Medicare by service and geographic region, even when accounting for regional variation in Medicare rates. A uniform unilateral percentage of the Medicare fee schedule is unlikely to adequately align with how commercial markets value services from providers, and creates risk and exposure to plan participants that is very different from traditional contracted-network health insurance.

PROVIDER ACCEPTANCE

Another consideration for employers assessing an RBP approach is the degree of acceptance of the reference-based price among providers. Network plans typically must meet network adequacy standards that ensure sufficient provider access for plan participants such that plan participants can reasonably be expected to obtain all services from in-network providers. Network adequacy ensures all essential health benefits covered by the plan are able to be obtained under the protection of the annual limitation on cost sharing.

However, a health plan that uses a URBR approach typically does not have a hospital and facility network for those services that are reimbursed using reference prices, which could potentially expose members to out-of-pocket costs beyond the cost-sharing limits of the Patient Protection and Affordable Care Act (ACA). Providers may choose to accept a reference price to avoid losing patients to other lower-cost providers, or to avoid costly litigation, but plan administrators typically cannot ensure that outcome.[10]

Another access consideration, particularly for URBR plans, is how providers who do not accept the reference price respond when a member schedules treatment. Providers, and particularly facilities, may be hesitant to allow patients to accrue significant liabilities for care, and many health systems require payment in full of all known charges for nonelective care prior to receiving care under a noncontracted payer.[11] These practices can create service access issues for plan members when URBR rates are not in line with prevailing rates in the commercial markets, decreasing employee satisfaction and potentially leading to employee retention issues if health coverage proves unreliable.

Hospitals in North Carolina recently exemplified this issue when they refused to accept reference-based reimbursements from the state for its employee population of over 700,000 participants. The state's initial strategy was to reimburse providers at a fixed rate of Medicare reimbursements below prevailing commercial market rates, but it ultimately elected to prioritize access over cost after many hospitals declined to participate in the state's network.[12]

PRICE AND QUALITY TRANSPARENCY

A cornerstone of the early iterations of RBP was the consumer's ability to make an informed decision on the most appropriate provider or place of service based on cost and quality measures. Such data may be available for services included under an RBB or RBR arrangement, but is likely less accessible for a broader set of services under a URBR approach. The lack of both available complete electronic health records and price transparency in the U.S. creates barriers to achieving the level of consumerism and transparency desired. However, transparency and consumerism are not key factors under a URBR plan—cost is king. Additionally, quality can be difficult to measure.

Employers should consider the responsibility being passed onto plan participants under RBP arrangements to navigate the U.S. healthcare system given these limitations. Robust communication campaigns would need to be rolled out alongside these programs to ensure sufficient member education, which can add to an employer's administrative

burden. Employers should also be prepared for the possibility that members may reach out more frequently with questions or concerns than before RBP was implemented, especially if they inadvertently elect a physician who does not accept the reference price and they are balance-billed.

As the healthcare climate evolves and price and quality information become more accessible, RBP may become more viable for employers in the future.

LEGAL CONSIDERATIONS

Employers should also be aware of the liability exposure RBP arrangements create. Providers have taken legal action in recent years against plan administrators, employers, and patients in several instances, most notably in Colorado, Florida, Nebraska, Oregon, and Utah.[13] The outcomes of many of these cases have yet to be determined, furthering the risk to plan sponsors and participants as little precedent exists.

Several organizations that administer RBP programs include legal support in their offerings, which can mitigate some of this risk. Still, employers must consider the extent to which they are willing to transfer that risk to their members. Previous state action toward addressing unanticipated out-of-network bills[14] (referred to as "surprise bills") via legal resolution processes has generally been viewed as being provider-friendly.[15] This may suggest that providers have more leverage in payment disputes in a legal setting, which could increase the risk of additional costs to the plan or the member arising out of legal support offerings.

In December 2020, Congress included the elimination of surprise bills for consumers in the year-end federal budget bill.[16] However, these protections are tied to the concept of a median in-network rate for emergency services and services obtained at an in-network facility. It is unclear the extent to which these protections will ultimately apply to RBP approaches, as these plans do not have a provider network. Plan sponsors should monitor regulations that implement these surprise billing provisions to ensure that plan reimbursements and practices are in line with the new requirements.

REGULATORY COMPLIANCE

One of the requirements for health plans to be considered compliant under the ACA is that annual participant cost sharing imposed under the plan does not exceed a specified limit, or out-of-pocket maximum. However, balance-billing that can arise in plans that utilize RBP is not typically subject to these out-of-pocket maximums. The U.S. Departments of Labor, Treasury, and Health and Human Services provided feedback on this issue, stating that self-funded group health plans (i.e., employer-sponsored plans) that use RBP approaches must adhere to all of the following specific limitations to avoid running afoul of this requirement:[17]

- **Types of services**: Plans should only apply reference-based prices to services for which the period between identification of the need for care and provision of care is long enough for consumers to make an informed choice of provider (i.e., not emergency services).
- **Reasonable access**: Plans should ensure that an adequate number of providers that accept the reference price are available to employees and their dependents.
- **Quality standards**: Plans should ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.
- **Exceptions process**: If providers who accept the reference price are unavailable or cannot provide sufficient quality of care for a particular individual, there should be an easily accessible exceptions process where the patient can see a different provider (who does not accept the reference price) as if the provider will accept the reference price and that individual has no risk of balance-billing.
- **Disclosures**: Plans should automatically provide information on pricing to plan participants, and should provide on request for each service a list of providers that will accept the reference price, any providers that are contracted with the plan at rates higher than the reference price, and how the plan determined that an adequate number of these providers meet reasonable quality standards.

Collectively, these requirements are designed to ensure that plan participants in an employer-sponsored plan know in advance that they can receive care from providers of a reasonable quality without being exposed to balance-bills. This guidance suggests that a plan administrator cannot simply establish a reference price and automatically comply with the federal requirements. The guidance contemplates a situation in which high-quality providers are unwilling to accept what they deem to be unreasonable reimbursement. The guidance further suggests that, in these situations, it is incumbent on the plan administrator, not the provider, to ensure there are an adequate number of high-quality providers available at the reference price or otherwise under contracted rates, with an easily accessible exceptions process available to plan participants to seek care with providers that are unwilling to accept the reference price when care cannot otherwise be obtained under the plan.

The URBR approach may raise potential compliance issues, and employers considering any RBP approach should conduct a thorough legal review of the product to ensure it is compliant with cost-sharing requirements imposed by the ACA.

Conclusions

Employers exploring nontraditional approaches to their healthcare programs have found reference-based pricing arrangements to be an intriguing solution. In particular, for non-emergency, shoppable services with wide price variation among facilities and providers, establishing a reference price can benefit the employer as well as the patient. There has also been documented success with certain prescription drug programs. However, not all reference-based pricing approaches are created equal, and employers should carefully consider which approach, if any, is appropriate for their populations. Special attention should be paid to the risks associated with a unilateral reference-based reimbursement approach, which promises the highest savings, but certainly has the greatest potential risk for plan participants and plan sponsors.

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ENDNOTES

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[10] Robinson, James C. et al., Pricing Changes The "Choice Architecture" of Health Care For Consumers, op cit.

[11] According to data published by the Healthcare Financial Management Association, only 33% of providers do not attempt to seek any payment prior to service. See https://www.hfma.org/topics/hfm/2019/november/analyzing-pre-payment-and-point-of-service-collections-efforts.html.

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[14] Unanticipated out-of-network bills include those from out-of-network emergency care or care from an out-of-network provider at an in-network facility. While not a perfect analogue to balance-billing in a nonnetwork setting, the consumer experience can be similar to that under a URBR arrangement.

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