Case Study

# Reference Based Medical Pricing


## Summary

Included herein is a summary chronology of a major medical procedure that was authorized and funded under an employer's self-insured reference-based medical benefit program. This study was extracted from an employee's daily journal. The journal covers the spectrum from the emotional to the financial and was designed to tell the story from both employee and employer prospective with a goal of improving the process for all. This document is an extract from the actual journal which contains many more details about the experience itself. Representatives of the employer and the individual involved are available upon request.


## The Players

- KR

  KR is the 52-year-old female Director of Human Resources at a public corporation. KR is the Company's single most influential person in the design and operation of employee benefit plans and policies.

-Employer

  Employer is a self-insured employer under ERISA with 800 employees, the majority of whom are truck drivers. Self-insured employers have wide flexibility in the design of employee benefits and on January 1, 2013, Employer implemented reference-based pricing for its employee medical benefit program.

-Benefit Captive Re (BCR)

  BCR is the medical insurance broker for Employer and its principal is Ben Krambeck. Employer was introduced to BCR through the pooled self-insured group that Employer utilizes for workers' compensation and automobile (truck) liability insurance. BCR introduced Employer to reference-based pricing for medical services. BCR also secures prescription drugs, medical stop-loss and transplant coverage insurance for Employer.

-TPA

  The TPA is a third party administrator contracted by employers to administer their employee medical insurance from initial open enrollment through the payment of claims.

-Claims Auditor

  The Claims Auditor is contracted by employers to audit individual medical claims and re-price medical provider billings based on the reference-based pricing approach.


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-Reference Based Pricing

Under Federal law, hospitals and other medical care providers must file their cost of service for various procedures with the Centers for Medicare and Medicaid Services. This is called the hospital's departmental "cost to charge" ratio. With this information the medical claims auditor is able to re-price a provider's billings at an equitable rate. Typically, reimbursements are made at the higher of 125% of the rate paid by Medicare or 120% of the provider's cost of service. The medical claims auditor also analyzes reasonable and customary provider fee data from various publishers including Fair Health Consumer. This data stratifies reimbursement rates into percentiles, allowing the claims auditor to determine the payment amount that is readily accepted by 90% of the hospitals in a given area for each procedure. Once payment is made at a credibly determined reasonable and customary amount, the burden then falls on the hospital to establish and petition for a higher rate of reimbursement.

## Chronological Summary

- May 27, 2015 – KR's well woman exam detected a lump in her right breast. Follow up testing was completed on June 15, 2015.

- June 17, 2015 – KR's staff informed her that her needle biopsy scheduled for the next day must be pre-certified to avoid a $500 personal charge. Although KR is the HR Director, she forgot about this particular pre-certification requirement. This is now a learning point for Employer to improve employee training. In any event KR called her TPA and the TPA made several attempts to contact the doctors with no luck. However, the TPA properly approved the procedure in the absence of the doctor input.

- June 22, 2015 – KR was informed by her family doctor that she had an invasive ductal carcinoma and ductal carcinoma in-situ.

- June 24, 2015 – KR visited a recommended surgeon in Houston, and discussed the risks and various options. She was comfortable with this doctor but wanted a second opinion and informed him of such. Since Employer's program does not utilize the network or gatekeeper concept, KR was free to work the problem to her fullest satisfaction.

- July 8, 2015 – KR traveled to San Antonio to see both a surgeon and a plastic surgeon. KR's daughter is an operating room nurse and had previous work experience with the San Antonio group. Note: under the reference-based pricing protocol utilized by Employer, the concept of "out-of-network" does not exist. Employees are free to choose facilities, second opinions etc. without restriction. KR's provider of choice was the San Antonio group although her employment is based in Houston.

# Case Study

- July 9, 2015 – KR was back in Houston and met with her oncologist, to further discuss the risks and problems associated with the double mastectomy and reconstruction versus lumpectomy and radiation options. After evaluating the choices, she opted for the former. KR and her doctors were able to make this medical decision based solely on the merits without interference from any mandated insurance cost restrictions.

- July 14, 2015 – KR confirmed her surgery was scheduled for July 28, 2015 in San Antonio. She also received a phone call from the TPA and was told the nurse case manager was working the pre-certification process.

- July 21, 2015 – The TPA confirmed approval of pre-certification.

- July 27, 2015 – KR traveled to San Antonio. She also received a call from a hospital facility seeking payment of $1,516 and gave them a credit card number. Two sentinel node injections at a hospital facility were also completed. The $1,526 payment required was subsequently determined to be an overcharge of $725 as KR had already met her deductibles/copay requirements.

- July 28, 2015 – Surgery took place. KR spent two nights in the hospital requesting a private room. This request necessitated a $270 upcharge which the hospital had been trying to collect following surgery. She paid the $270 at check out on July 30, 2015.

- July 28, 2015 – A hospital facility billed $93,547 which was received by the TPA.

- July 31, 2015 – KR returned home for recovery. She was contacted by the TPA appointed nurse case manager during this period, but does not remember much.

- August 11, 2015 – KR had an appointment with her plastic surgeon and was released to drive and to work from home part time.

- August 18, 2015 – The Claims Auditor audited the detail of the hospital facility's billing, repriced the billing and the TPA paid the hospital facility $17,309 against the July 28, 2015 invoice.

- August 27, 2015 – KR visited her oncologist to determine if further treatment in the form of chemotherapy was needed. She was informed that this would depend on her genetic predisposition and that the results of an Oncotype DX test would be needed. This test is performed by a third party test firm and over the next few days, two types of confusion ensued. First, it was uncertain whether the test had been ordered and if the required specimen had been sent to the test firm. Second, it was unclear if Employer's plan, as designed, covered the $4,000 cost of the test. Consistent with general insurance practices, Employer's plan contains certain exclusions for genetic testing as it frequently is not used for medical purposes.

# Case Study

- August 28, 2015 – KR determined that her test had been ordered and pushed for the hospital facility to release the required specimen to the test firm. This is a learning point since ideally the nurse case manager assigned through the TPA would have been more pro-active to work on this problem in advance of KR doing it herself.

- September 2, 2015 – The third party test firm called KR to inform her they required $4,000 in advance before releasing her test result. She told them she would contact the TPA.

- September 11, 2015 – After several days of confusion over the payment to the test firm, KR confirmed that the nurse case manager had the documentation and was recommending insurance approval.

- September 14, 2015 – The TPA approved payment of the $4,000 charge after consulting with BCR. Unlike the traditional insurance program, the Employer's plan is flexible and can be amended to accommodate the unexpected.

- September 16, 2015 – The oncologist's office called KR to inform her that the genetic tests were favorable and she would not need chemotherapy. She was also informed that the TPA had approved her next reconstructive surgery which was scheduled for November 6, 2015.

- October 12, 2015 – KR received a balance bill from the hospital facility for the $74,451 difference between the original bill on July 28, 2015 and the amount paid by the TPA on August 18, 2015.

- October 13, 2015 – KR sent the hospital facility's bill to the Claims Auditor.

- October 14, 2015 – The Claims Auditor notified KR that their attorney would be representing her and provided an Attorney-Client Agreement and a HIPPA Form for signature.

- November 2, 2015 – KR confirmed with the nurse case manager that her revision (reconstructive) surgery was approved for pre-certification.
- November 6, 2015 – Revision surgery was completed at the hospital facility in San Antonio.

- November 10, 2015 – KR received a collection call from National Patient Account Services (NPAS) seeking payment of the $74,451.73 balance bill. She told NPAS to call the Claims Auditor or the TPA. NPAS said they would not do that and that KR needs to call the TPA. There was no further contact from NPAS.

- December 15, 2015 – KR had a follow up with the oncologist and all looked good.

- January 7, 2016 – KR received a $24,219 balance bill from the hospital facility for her revision surgery back on November 6, 2015. She forwarded this invoice to the Claims Auditor. Also in mid-January 2016, KR received a collection call on a separate $522 balance bill from the hospital facility and KR informed the caller that under her plan, the hospital facility had been paid what they were supposed to be paid for this invoice. The response was "Ok, I will note the account".

- March 7, 2016 – Employer received notice from the Claims Auditor that a vendor acting on behalf of the hospital facility had contacted the Claims Auditor offering to settle the $24,219 revision surgery invoice for $18,164. Employer rejected this settlement offer. There was no mention of the $74,451 billing that occurred six months earlier on October 12, 2015.

## Financial Summary

Total charges and payments to all hospital facilities, medical test facilities, doctors and staff billings, and including the fees paid to the Claims Auditor summarize as follows:

| | | |
|---|---|---|
| Total Billings | $ 204,383.47 | 100.0% |
| Paid by Employer | (72,988.56) | 35.7% |
| Paid by Stop-loss policy | - | 0.0% |
| Paid by KR | (3,871.55) | 1.9% |
| | | |
| Saving off billed amounts | $ 127,523.36 | 62.4% |
| | | |

During the course of this treatment, twenty-one medical service providers were paid under the Employer's program.

Importantly, in those situations where the employee receives a "balance bill" from a provider, the employee is only responsible for their standard deductible and co-pays. The attorney for the claims auditor will instruct bill collectors that all further correspondence is to go through the attorney and not the employee. Employers must communicate this to employees so there is no undue concern on the part of the employee. The claims auditor is responsible for dispute resolution costs. The employer and its stop loss carrier remain responsible for the claim in the event a resolution with the provider is not reached.

## Study Conclusions

1. KR has now experienced the program first hand and also fields the calls from employees dealing with similar concerns. In the course of her experience, she accessed the doctors, facilities and treatment options of her choice without insurance company network restrictions or coverage limitations.

2. While it continues to be necessary, the pre-certification process can be a burden for all parties involved. In large part, this is a matter of improved training and monitoring for both the employee user group and the selected nurse case manager.

3. The coverage provision of the insurance contract needs constant monitoring and updates with rapidly changing medical technology, so the employee group continues to receive affordable high quality care. Note: the underlying self-insured contract rolls up to the employer's stop-loss policy where the employer has pure third party insurance coverage so the preferred approach is to amend the plan where changes occur.

4. Continued success of the reference-based pricing methodology requires continued focus on the needs of both the employer and employee. Ideally the determination of the reference-based pricing methodology would be accelerated forward to the time of precertification or before. Once a pricing methodology is established with a provider, three improvements occur:

   i. The hospital receives prompt payment of the agreed amount absent the myriad and complexity of big insurance company discounts, costs, broker fees and profits.

   ii. The employee may seek the best quality care within the confines of their normal co-pays and deductibles, free from the collection call process.

   iii. The Claims Auditor avoids incurring dispute resolution costs and will therefore reduce its fee structure to the benefit of the employer.

By eliminating the middle man insurance company, hospitals are fairly compensated while employees have a significantly improved range of options all at a lower cost to the employer.

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