As a nation, we spent $3.2 trillion on healthcare in 2016. The total medical expenditure per person was $10,345 – the first year in which it surpassed $10,000.¹ U.S. employers that self-insure their medical benefits face added exposure to these mounting costs. They have become increasingly frustrated with the constant surge in healthcare expenses and also with the lack of price transparency. EBCG has helped numerous self-insured organizations uncover ways to reduce their financial exposure by developing plans to address these concerns. This summary outlines three alternative methods that we have recommended to our partner companies in an effort to manage their employees’ care in a cost-effective manner.

**Cash-Based/Fixed Cost Pricing Models**

In recent years, cash-based hospitals and surgery centers have been emerging throughout the country. These unique providers stand out from the typical healthcare market for two reasons: cost transparency and no insurance company involvement. Clinics that offer cash-based medical services designate fixed, up-front prices for their procedures, often posting them on their websites. This way, prospective patients and their employers know ahead of time what their financial exposure will be. Fixed costs for services represent a welcomed change from the characteristic uncertainty that persists in insurance-network affiliated hospitals and surgery centers. For companies that self-insure their employee benefits, cash-based facilities can be a viable cost-saving alternative. If an employee requires a specific procedure, the employer can check their nearest cash-based provider’s price and compare it to what their insurance company would presumably charge at a local hospital or surgery center. It is not uncommon for the cash-based price for an identical procedure to be $5,000 to even $25,000 lower, depending on the procedure.

In 2017, cash based medical centers are beginning to receive increased media coverage. TIME Magazine published an article in January highlighting the efforts of a surgery center in Oklahoma City that is disrupting the healthcare market by offering complete cost transparency and lower prices without sacrificing quality of care. The article begins with a real-life example of a 68 year-old patient in need of a knee replacement surgery. His local hospital would have charged roughly $40,000 to perform the procedure. After hearing about the Surgery Center of Oklahoma, he checked their website and calculated that it would cost only $19,000 (including airfare, medications and physical therapy) to address his knee replacement operation². He opted for the surgery center in OK City.
Without the bureaucracy and administrative costs imposed by insurance companies and hospital management systems, the Surgery Center of OK and similar facilities are able to offer an identical level of care for a fraction of the price. The quality of these procedures are guaranteed by the providers. For self-insured employers, cash-based providers might be a solution to their employees’ healthcare needs that result in high dollar claims. The ease of administration associated with these providers also makes them an attractive option. There are no hoops to jump through - simply schedule the procedure, pay the packaged price and the employee is treated.

**Reference-Based Pricing**

With reference-based pricing, employers designate maximum amounts that they will reimburse for specific medical services. The services subjected to RBP are typically ones that experience wide cost variation in the marketplace, like the knee replacement surgery discussed earlier or any other high dollar procedure. While traditional health insurance network agreements are centered around a discount off of billed charges from the provider, the RBP model restructures claims using the average wholesale or MSRP. Repricing claims in this manner allows for a less arbitrary reimbursement process than those under a contractual agreement with an insurance network, which often have an unsubstantiated relationship to the actual cost of the procedure.

Reference-based pricing follows the industry trend towards shifting healthcare costs and consumer responsibility to employees from employers. It also delivers a higher level of cost transparency from medical providers and gives the employer more control over their fixed and expected claim costs. In an RBP model, the employee/patient not only chooses their provider at the reference price, but also pays the difference between the reference price and the allowed charge via cost sharing. While this pricing model has obvious financial benefits for the self-insured employer, it becomes crucial for the employee to understand the ramifications of their provider selection. Plan enrollees are supposed to be actively driven to use providers who have agreed to accept the reference-based price as full payment. However, if the contractual arrangement with designated providers has not been effectively communicated to employees, it will likely result in the employee choosing a more expensive healthcare provider and being forced to pay the difference out of pocket.

Self insured employers looking to implement RBP into their benefits program need to be especially careful that they maintain ACA compliance to avoid any reporting issues. Because the Affordable Care Act designates specific out of pocket maximums for individual and family coverages, groups that utilize RBP must not allow the plan to count costs that exceed the reference based price against the employees’ annual out of pocket maximum. In addition, the ACA requires RBP plans to include a reasonable number of providers that meet a criteria of quality standards to ensure the patient has proper access to healthcare within the RBP model. There are also a number of disclosures regarding the pricing structure, the exceptions process and a list of acceptable services that are required to be communicated to employees when a RBP plan is initiated (and at annual renewals for as long as the plan is effective).
Centers of Excellence

Centers of excellence (COEs) in the healthcare realm are more than just top tier medical providers, as their title might suggest. For large self-insured employers, a COE represents an exclusive hospital or hospital system that they have partnered with to receive bundled pricing for medical services. Similar to the cash-based and reference-based models, COEs are typically designated for expensive procedures that are relatively common within a large employee population. By establishing up-front payment arrangements with hospitals and surgery centers, employers are able to limit their financial exposure to high-cost claims. Retail giants like Walmart and Lowe’s began contracting with hospitals back in 2012 and based on the success of their partnerships, hundreds of other companies have followed suit. According to a 2016 Willis Towers Watson survey of 600 employers (each with over 1,000 employees), 45% had made access to COEs available to their workforce. According to the same survey, in 2015 only 37% of employers had partnered with a center of excellence — marking a significant increase in the span of just one year ⁴.

Though still a moderately new player in the self-funded employer space, centers of excellence have provided a seemingly win-win-win scenario for companies and their employees as well as the medical providers. The employers win because they save substantially on their claim costs while providing healthcare for their employees at hospitals with excellent reputations. Employees win for the same reasons – name brand hospital care at reduced prices. And the contracted hospitals benefit from the partnership because they are able to circumvent payments from insurance companies which might take months to process completely.

Self-insured organizations contemplating a COE integration into their health plan need to select their providers using outcomes-based quality standards. What makes a COE efficient is that they have better medical outcomes. Partnering with a name brand hospital system specifically for cardiac procedures might sound great, in theory. However, just because a hospital is reputable does not mean that it’s long-term clinical outcomes for cardiac treatments score well on an objective outcome performance basis. In fact, when vetting providers to find a true center of excellence for specific high-dollar surgeries or procedures, employers are instructed to disregard reputation entirely. COE selection needs to be based solely on medical performance data using objective outcomes like complication rates or the rate of readmission or mortality⁵. Without statistical confirmation that a hospital has consistently performed at the top of the national rankings for cardiac surgeries, employers are severely missing the COE mark if they choose to partner with them for that purpose.

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May 10, 2017

EBCG has served as a consulting firm in the employee benefits industry for the last twenty years. They specialize in helping companies navigate through changes in healthcare reform.
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