American Hospital Association™
Advancing Health in America

Reference-based Pricing

Background: What is reference-based pricing?

- Some employers are moving away from offering traditional coverage with a provider network and instead are using reference-based pricing for some or all of services they cover. Under reference-based pricing, the employer (supported by a third party administrator [TPA] or other vendor) pays a set a price for each health care service instead of negotiating prices with providers. When a provider bills for the service, the payer remits the set amount. If the provider is dissatisfied with the payment, they can bill the patient for the unpaid portion of the claim.
- Some payers use reference-based pricing software to determine the price they will pay for a health care service. Although reference-based pricing software programs vary, the methodology includes collecting data on prevailing costs for medical services from CMS's HCRIS (Healthcare Provider Cost Reporting Information System), benchmarking it against relevant types of hospitals and settings, further calibrating by severity level, and applying a margin factor.
- Federal and state law permit most payers to use reference-based pricing for out-of-network claims. However, any plan subject to network adequacy rules may not use this as a comprehensive payment strategy (e.g., Medicaid managed care, Medicare Advantage, and fully-insured individual and group products). Only employer-based plans regulated under ERISA may use reference-based pricing as a comprehensive payment strategy.

Adoption of Reference-based Pricing

- To date, most payers that have used reference-based pricing have limited it to out-of-network emergency and laboratory claims.
- Increasingly, some payers are looking to replace the traditional provider network model with reference-based pricing for some or all of their medical spending.
  - A 2016 survey on employer benefits found that only 5 percent of employers utilized reference-based pricing in 2016, however, 60 percent of those surveyed planned to use reference-based pricing in the next 3 to 5 years.[1]
- The number of employers offering self-insured plans is growing, which increases the number of individuals covered under plans that are able to implement reference-based pricing.
  - The percent of employers offering self-insured plans rose from 28.5 percent in 1996 to 40.7 percent in 2016, including 78.5 percent of large employers, 29.2 percent of midsized employers, and 17.4 percent of small employers.
  - In 2016, 57.8 percent of employees were covered under self-insured plans.[2]
- Smaller employers have shown greater interest than larger employers in reference-based pricing. There is a growing industry of third-party administrators targeting small businesses for reference-based pricing solutions.

© 2018 American Hospital Association | November 2018

- Large employers that use benefits to compete for workforce talent have shown less interest in this payment model, as it creates pain-points for their employees (balance billing and subsequent adjudication). However, some larger employers are using reference-based pricing for discreet services, such as knee and hip replacements.
- Recent changes to federal rules that expand access to association health plans could increase the number of individuals enrolled in plans that use this reimbursement strategy.

AHA Position

Reference-based pricing is bad for patients and the hospitals and health systems that serve them because it:

- Is a **cost-containment strategy** that simply pushes more of the cost of care away from the payer and onto patients and providers.
- Often leaves patients **unaware that they may be subject to additional costs**, making them financially vulnerable.
- Does **not consider quality in the equation**, as the reference price does not help direct patients to higher-quality providers.
- Creates **"pain points" for consumers** by leaving them stuck with unexpected bills and greater costs.
- **Increases bad debt** for providers, making it more difficult for hospitals to meet their mission of caring for communities.
- Undermines **broader health care planning**, as providers have less ability to predict their patient mix and volume and their health care needs.
- Increases consumer demand for price and quality transparency, and **reliable tools are not yet widely available.**
- **Ignores one of the largest drivers of growth in health care spending:** prescription drugs – by excluding them from reference-based pricing programs.
- Will favor lower-cost alternatives and further erode society's **ability to finance social good activities, such as**:
  - training the future workforce;
  - conducting research;
  - caring for the uninsured and underinsured; and
  - maintaining emergency stand-by capacity in every community.

Sources

1. *http://images.respond.aonhewitt.com/Web/AonHewitt/%7B4eef02b6-ab2a-4fb7-958f-bade4f99ee0d%7D_00353_Health_Survey_2016_Report_v6.pdf?utm_source=eloqua&utm_medium=email_&utm_campaign=&utm_source=confirmation&utm_campaign=2016-health-care-survey&utm_medium=lp&elqTrackId=70ea94373075434a96ff9fe4aaa3e703&elqaid=5956&elqat=2*
2. *https://www.ebri.org/pdf/briefspdf/EBRI_IB_442.pdf*

© 2018 American Hospital Association | November 2018
www.aha.org