Reference Based Pricing

Leveling the Playing Field in Healthcare Cost and Quality

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What's Top of Mind?

As employers look forward to 2017 and beyond, they continue to focus on some key issues:

1) Controlling cost, dealing with escalating large claimant costs
2) Engaging employees to be better consumers by providing them with the tools they need to succeed in navigating the health care system; using tools like navigators and transparency
3) Ensuring employees have access to good quality health care through centers of excellence, tiered networks, ACOs and other value-based supply-side initiatives
4) Finding solutions to the growing challenge of skyrocketing specialty pharmacy costs
5) How will the Trump administration deal with the ACA and when will there be relief for employers on simplification and changes

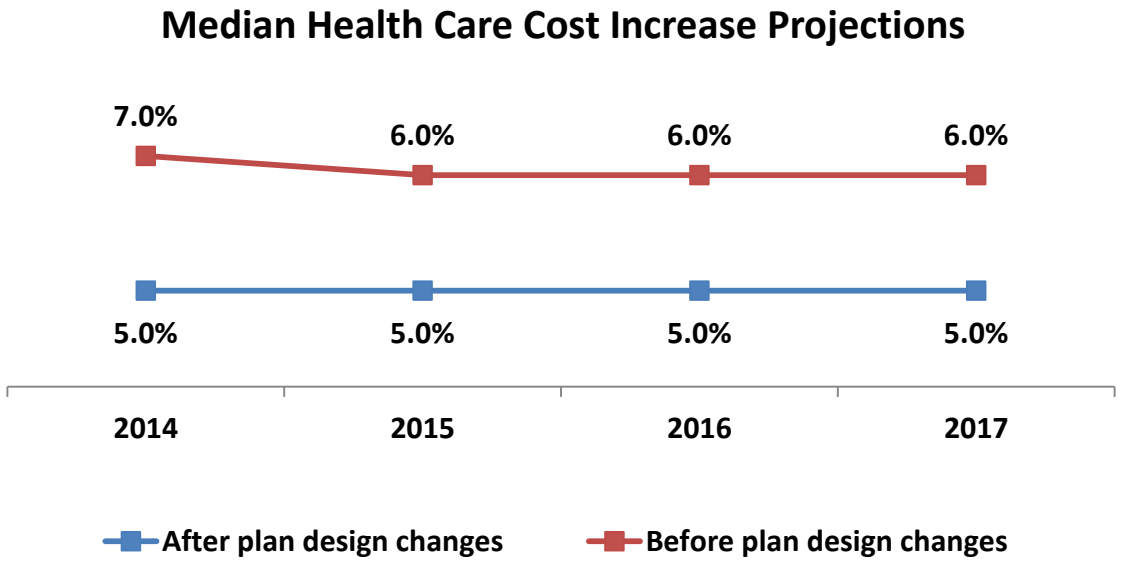
Look what's happened in 25 Years

	1992	2017	The Future
Annual cost to provide coverage for a family	$4,000	$26,000	Trends continue to escalate as does access to new and more costly care
Average employer share of premium	76%	78% - 80%	Attempting to sustain cost sharing to remain competitive
Health spending as % of GDP	11%	17%	20% by 2020
Number of Americans with a chronic condition	118 million	131 million or 45% of the population	164 million in 2025

Costs Continue to be *the Issue*

- The majority of employers expect costs will continue to increase by an average of 5.0% in 2017

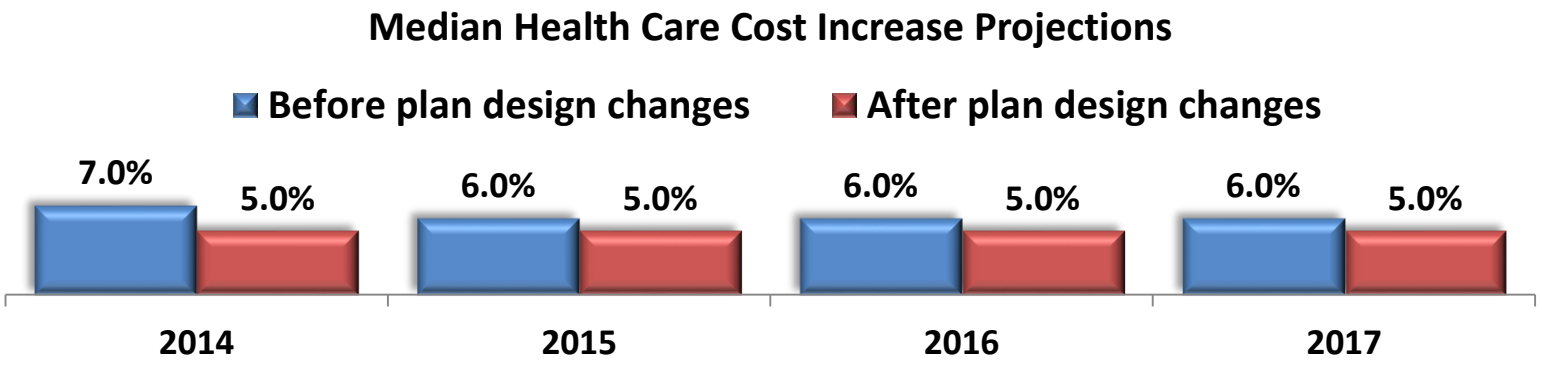
- While this increase is consistently stable, especially when compared to premium increases found in the public exchanges, it continues to exceed general inflation and general wage increases threatening the affordability of health care



Source: NBGH Annual Employer Survey

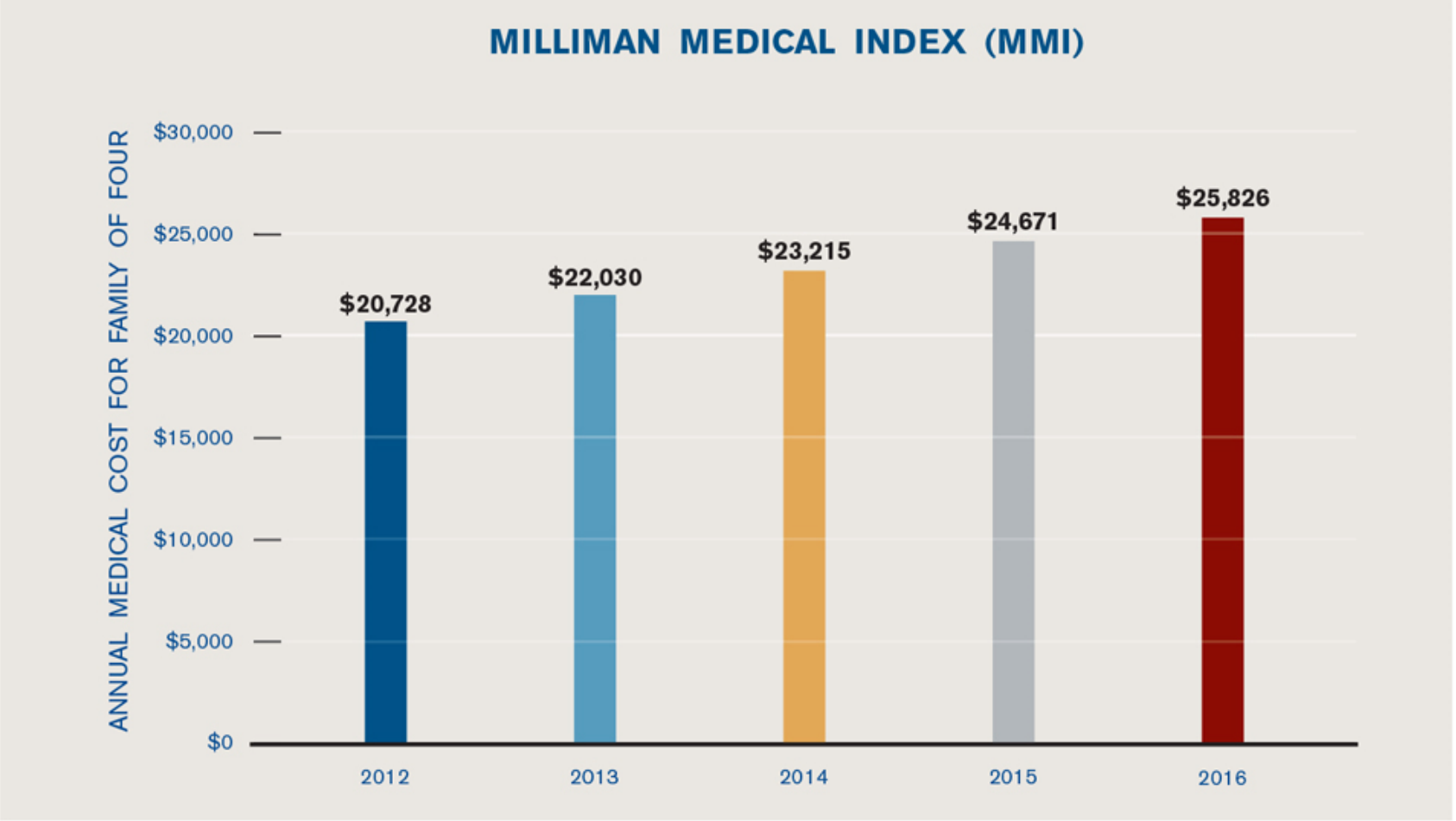
Cost Trend

- For 2017, employers are predicting that health care costs would increase by 6.0% over the course of the year, if no steps were taken to mitigate rising costs.
- Based on plan design changes, they expect that cost increases will be kept to 5.0%.

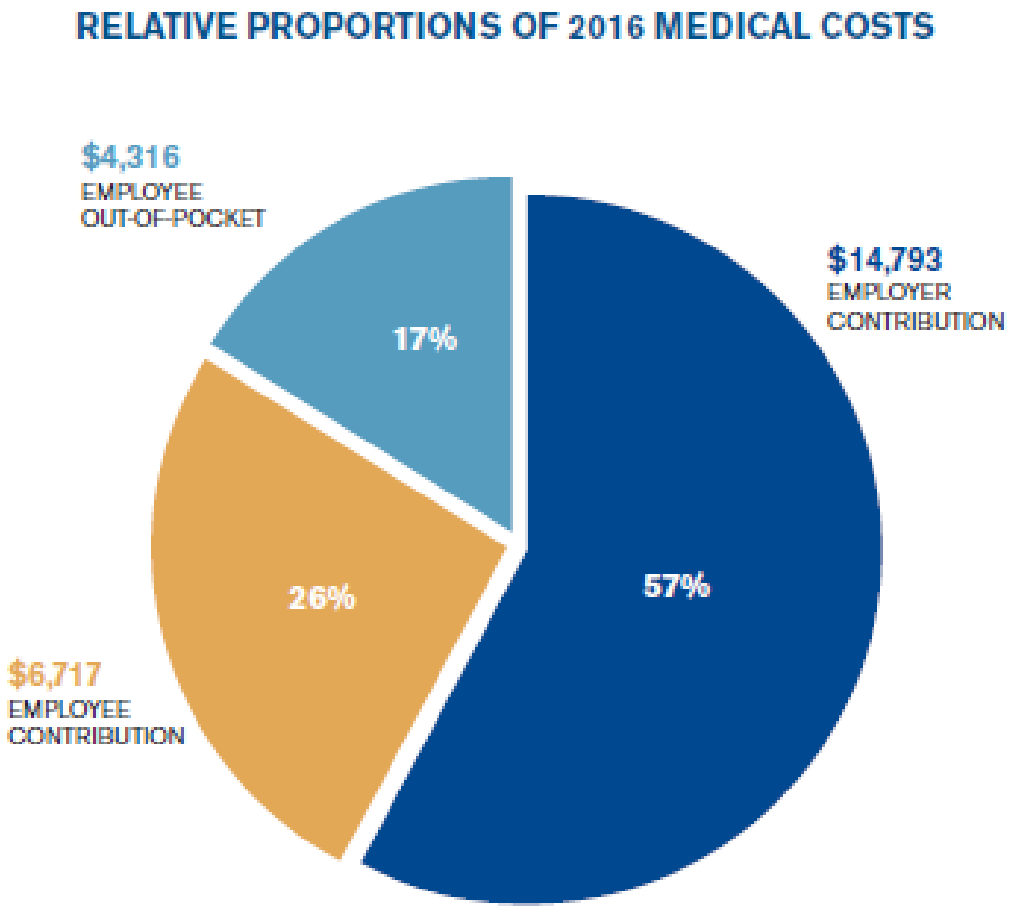


Source: NBGH Annual Employer Survey

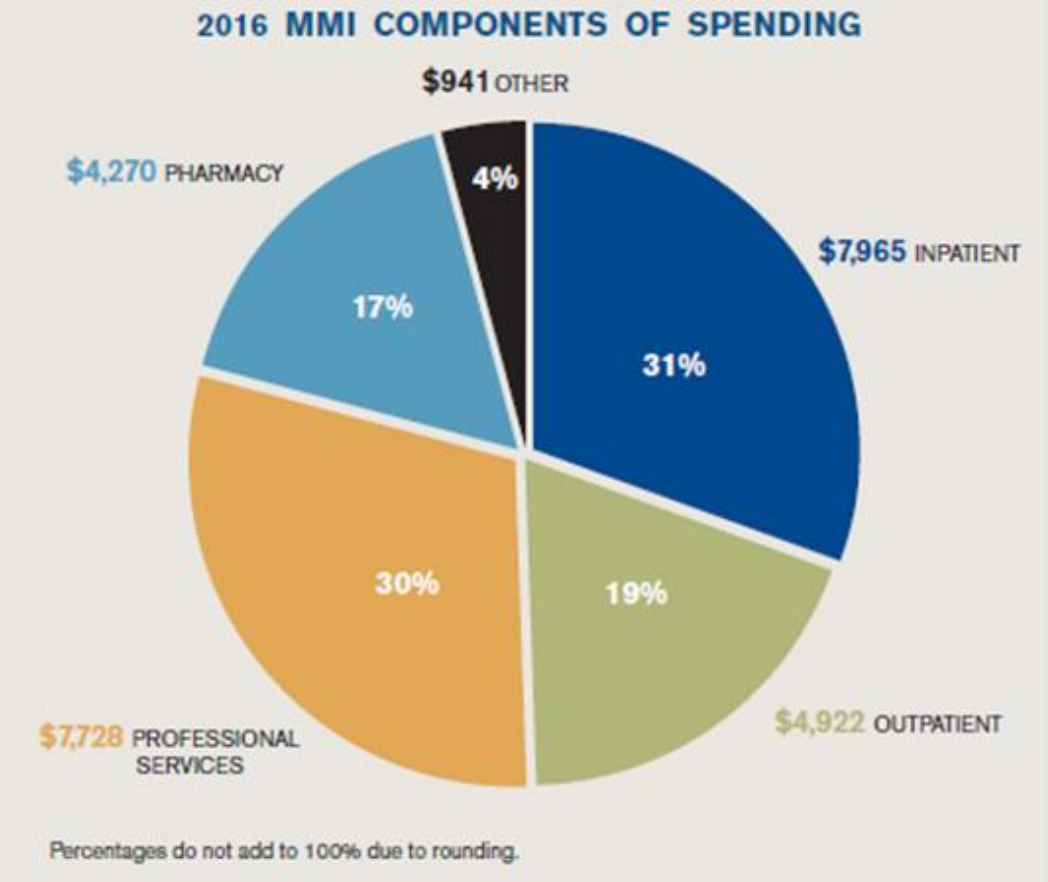
Annual Medical Cost for Family of Four



Relative Proportions of 2017Medical Costs



2017 Components of Spending

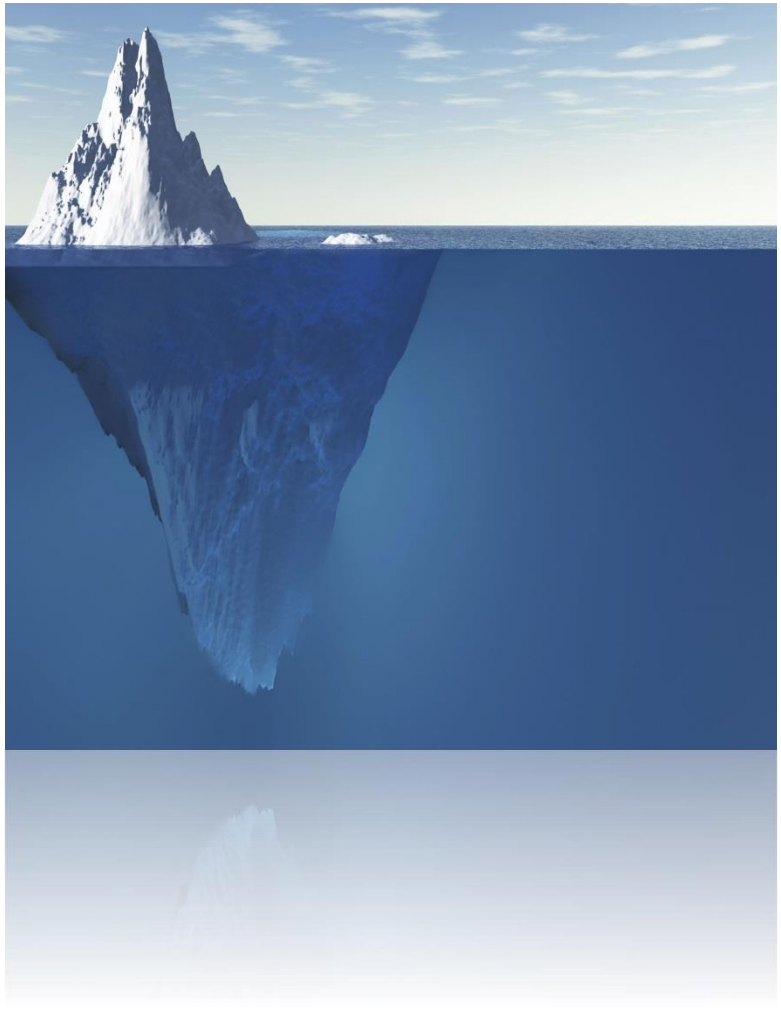


Broad Ecosystem of Solutions

- Price and Quality Transparency Tools
- Narrow and Tiered network products
- Narrow Pharmacy Network and tighter management controls
- Consumer Directed Health plans
- Defined Contribution and Private Exchange solutions
- High Octane population health and wellness plans
- Tele-Medicine
- Personalized care navigation and concierge services
- On-site or near-site health centers to improve quality, productivity and cost
- Funding strategies
- Use of Captives
- Cutting edge communication services. Technology and apps

But there's a bigger issue lurking…..

- There is a bigger issue lurking that if not addressed, will place even greater pressure on the health care economic environment and further stress employers
- If not addressed, all of the other necessary tactics around effective EB management will ultimately prove ineffective



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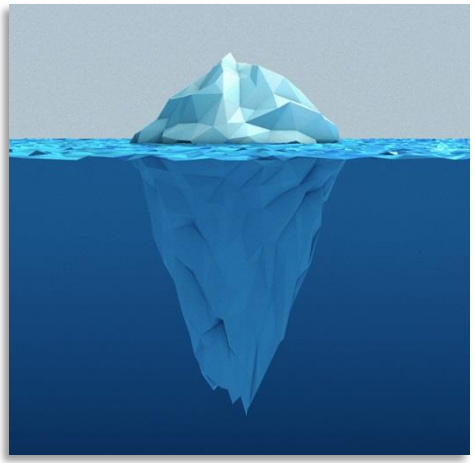
There is a bigger issue…

Growing Issue

- Healthcare is the only service people consume without knowing the cost in advance. Plus, healthcare defies the law of economics. Generally as prices increase, consumption decreases. This does not apply in healthcare
- Absent easy access to information on cost and quality, there is little competition or motivation to change
- And, there is *enormous disparity* in cost for the identical service or procedure from one health care provider to the next
- Providers in part negotiate “discounts” with the health plans as a percent off charges. To make more, they increase their charges

Growing Issue

- The cost disparity for the identical care can be 1000% in some market.
- In California, according to CalPERS, the state worker's benefit fund, the cost for knee and hip replacements varies between $15,000 and $110,000, without medical complications
- Hospitals generally have to make up for the reduced reimbursement they get on their government business (i.e., Medicare, Medicaid). So commercial plans are charged much more
- Even with carrier network discounts, in most cases hospitals are paid 200% to 230% of what Medicare pays
- Hospital care accounts for 50% of healthcare cost
- As this trend continues, employer plans bear the brunt



So What To Do About It?

- Drive for positive disruption. Current model is unsustainable and only transparency in cost and competition will provide the sustainable impact needed
- The disruption must start by impacting the cost of health care at the place where the costs are the greatest: healthcare facilities
- Force: Real consumer engagement, competition on cost and quality and transparency
- **Introducing Reference Based Pricing (“RBP”)**

What is Reference Based Pricing?

- RBP is a reimbursement method that uses Medicare and Cost Information to determine the prevailing price for medical services.
- RBP is the emerging payment standard for medical services due to the sheer continued year over year increase in costs
- RBP provides the ability to objectively value medical services and to budget for benefits with a huge degree of certainty are key features of RBP
  - In this discussion, RBP is focused on inpatient and outpatient hospital care

Is RBP like a Narrow Network?

- RBP is different than “narrow networks”
  - Narrow-network strategies offer full coverage at some providers and no coverage at others
- For hospital services it is open access to any facility for the member based on providers willingness to accept the RBP rates
- Reference Based Pricing is analogous to migrating to a defined contribution approach in plan design (i.e., setting a specific amount the employer will spend)

Designed to Deal with Cost Variation

- RBP pricing addresses the wide variation in the prices charged for similar services across the health care sector
- CalPERS, the CA state workers plan has begun to use RBP
- Prior to the implementation of RBP the prices CalPERS ranged widely:
  - $12,000 to $75,000 for Joint Replacement Surgery
  - $1,000 to $6,500 for Cataract removal
  - $1,250 to $15,500 for Arthroscopy of the knee
- And these are the “network discounted prices” paid to the providers, not the (much higher) list prices that providers impose on uninsured consumers who lack bargaining leverage
- This variation is due in part to market consolidation and to regulatory barriers to new provider entry and it is facilitated and enhanced by the consumer’s demand for convenient care at any price

Designed to Deal with Cost Variation

- Cost of an MRI in San Francisco, CA area, Zip 94016 - Charges

MRI of the Back without Dye	Cost
Health Diagnostics	$575
St. Mary's Medical Center	$875
Norcal Imaging	$1,024
Valley Radiology Medical Associates	$1,378
Nucrall Imaging	$1,076
CA Pacific Medical Center, Sutter Health	$2,607
University of CA Medical	$6,271
AVERAGE MEDICARE Reimbursement in zip code	**$614**

Source: Clear Health Cost

Designed to Deal with Cost Variation

- Variations in Cost in Washington DC Area - Charges

Provider	Procedure/Service	Cost
George Washington Univ. Hospital	Ventilator	$15,000
Provident Health	Ventilator	$53,000
George Washington Univ. Hospital	Lower Joint Replacement	$69,000
Silby Memorial	Lower Joint Replacement	$30,000

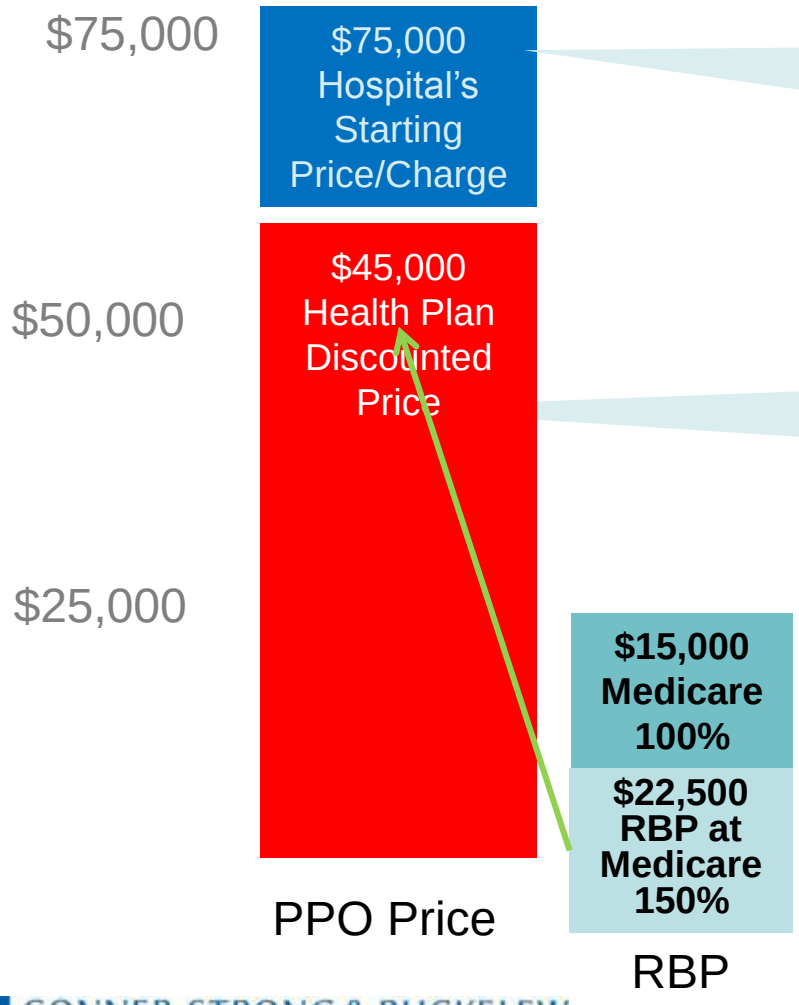
Impact

- According to a 2014 study by the Employee Benefits Research Institute ("EBRI"), RBP would have a profound impact on the cost of healthcare in the group based market
- They predict potential aggregate savings could reach $9.4 billion or nearly 2% of employer based healthcare spending
- RBP for knee and hip replacement alone would save $10,300 per service
- Savings comes from:
  1) The health plan applying the "reference based price" which is much lower than usual carrier network discounts
  2) Offering the member options if a hospital is charging excessively.

So What's the Reference Base?

- The RBP must be set on a reasonable and fair, market based metric that can be uniformly used in all markets and deal with cost differences across the USA
- The RBP is usually set as a percentage of Medicare. Medicare has a universally accepted reimbursement model that accounts for complexity of the service, geography and other factors
- The RBP becomes disconnected from the volatility of the provider's "charge" and has an inherent inflationary protection built-in
  - Provides immediate savings
  - Slows the rate of healthcare inflation

How RBP Compares to Today's Model



In a traditional PPO plan, the hospital sets their own price for a service.

Then, the health applies a network discount, say 60%

In RBP, the price starts at a fair reference point, set at 140% of what by Medicare would pay

In the end, a final RBP is set at between 140% and 200% of Medicare based on hospitals' negotiated settlements

Favorable Member Impact

A member's costs will be different for each procedure and each hospital, but here is the example further:

Sample Procedure	Traditional PPO	RBP Plan
Starting Price:	$75,000 (What the hospital wants to bill)	$15,000 (What Medicare would pay for the same procedure)
Plan Price:	$45,000 (Hospital agrees to a 60% discount off of the bill)	$22,500 (Hospital agrees to 150% of the standard Medicare price)
Coinsurance:	Member Pays 20%	Member Pays 20%
Member's Bill:	$9,000	$4,500

RBP payments can save thousands of dollars per procedure. Members are responsible for the deductible and coinsurance, up to the annual out-of-pocket maximum just as they are today

What will it Save?

- By migration to a RBP system, employers can expect to see a 10% to 15% savings in their medical costs in the first year (varies group to group)
- The savings is largely related to the move from paying billed charges for “network discounts” to hospitals that are between 225% and 500% of Medicare to 140% of Medicare
- The RBP model also flattens the year over year trend curve as “charges” increase

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So how does it work?

The RBP Process for Hospital Care

1. 

Provider calls for pre-certification

2. 

Provider is notified of pre-priced amount for the service

3. 

Medical treatment or services are received by you or your family member

4. 

The provider submits a bill for services to TPA for payment

5. 

TPA remits payment to the provider based upon the pre-priced amount

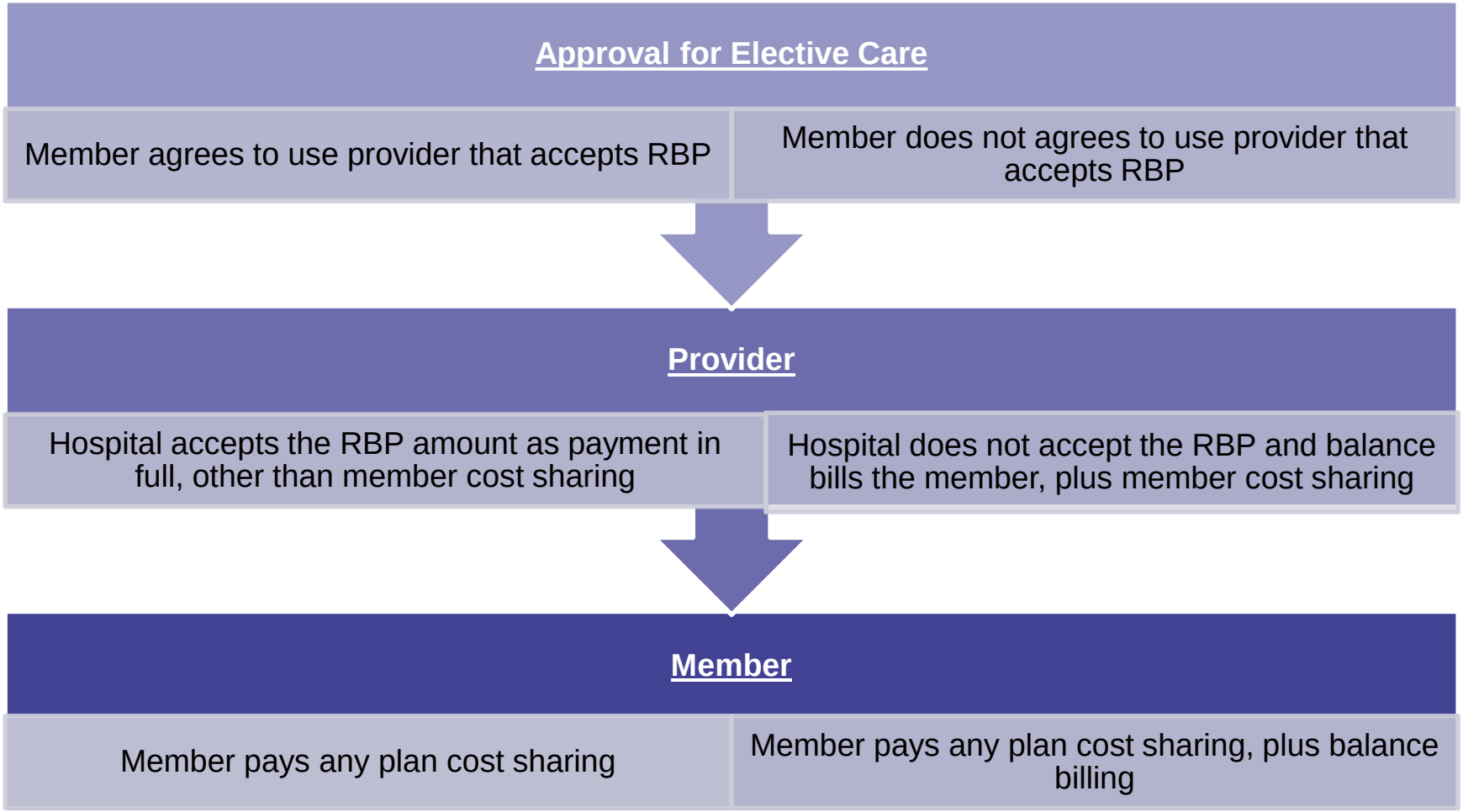
6. 

You pay deductible and co-insurance

7. 

TPA issues an Explanation of Benefit (EOB) to you and the provider

The RBP Process for Hospital Care



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Different Approach

What's Different?

- Health plan must be self funded, which is a best practice regardless
- Members have skin in the game
- Real transparency and knowledge of healthcare costs
- Your plan has no "hospital" network
- Members can go to any hospital they choose for care and the RBP will be the amount paid. Plans can still have tiers around payment levels for providers deemed of a higher quality
- Custom safe harbor provider arrangements can ultimately be negotiated around hospitals that accept RBP

Need to Select a New TPA

- The “BUCA” organizations are unable to administer RBP due to the disruption it causes their network provider partners
- For RBP to work, employers need to partner with a Third Party Administrator (“TPA”) that has all the tools and attributes needed to manage a health plan and RBP:

  - Benefit design administration flexibility
  - Member and Employer Services
  - Care Management
  - Physician Network
  - Integration with a RBP technology platform

Need TPA Partner to have RBP Platform

- The selected TPA partner must have an integrated RBP technology model that:
  - Has the latest data from Medicare
  - Is synchronized with the claims and service adjudication process
  - Can deliver the “member service” experience around the new model

Other Aspects of Administration

- The best in class RBP model collaborates with the provider with the goal of paying a fair reimbursement and preserving plan assets
- For emergency room care and related admissions, the RBP can be negotiated and properly structured RBP plans are subject to ACA regulations for ER in 2017
- For teaching hospitals or centers of excellence, the RFP amount can again be negotiated to higher amounts as warranted

Why do Hospitals Accept the RBP Amount?

- Not all do but enough do to provide a robust set of agreeable hospitals in every major market
- They get a guaranteed set amount of payment. No ambiguity
- No hassles from the health plan around utilization management and denials, etc.
- It is still a small piece of their revenue stream

Health Plan Management Modifications

- The health plan must be modified to reflect the new provisions of the plan around RBP
- New communication for members to describe the process and RBP program
- Education related to the new Health Plan TPA, no hospital network and new physician network
- Longer term, potential RBP expansion around:
  - Select physician care
  - Non-hospital procedures
  - Build out of custom network using RBP

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Preferred Partners

Preferred TPA Partner

- **Health Plan Inc**. is the preferred Conner Strong & Buckelew (“CSB”) Health Plan TPA partner:
  - Subsidiary of Harvard Pilgrim, the number 1 ranked health plan in the USA
  - Flexible benefits administration and service platform
  - Strong care management services
  - Best in class member services
  - Integrated partnership with the PHCS PPO physician network nationally
  - Synchronized with CSB RBP technology platform for seamless administration
  - Comprehensive data reporting
  - Competitive fixed cost structure

HealthPlans
A HARVARD PILGRIM COMPANY

Preferred RBP Partner

- HST is the preferred CSB RBP technology platform delivering the pricing service behind the model:
  - HQ Irvine, CA with operations in Chicago; privately held company
  - Pioneer in RBP using collaborative approach
  - Access to national Medicare and other Cost data
  - Flexible process designed to secure best outcome with providers and least member disruption
  - Integrated with HPI for seamless administration

HST
Enabling Payment Technologies

Is RBP for Your EB Plan?

- Employer must be fed up with status quo and willing to try something different to address health care costs in the short and long term
- The health plan must be self funded
- Willing to leave current health plan carrier
- Ability to effectively communicate with plan members plainly about the need for change in health care delivery and engagement. Willingness to take re-educate employees
- Longer lead time for transition

Next Steps

- **CSB manages the evaluation, design and on-going management of a client's plan using RBP model**
  - Data analysis of benefit plan claims for RBP re-pricing analysis and evaluation
  - Physician network geo-access match and disruption analysis
  - HPI plan review and proposal
  - Cost comparison against current plan model
  - Planning and time line

Change Happens

"There's no chance that the iPhone is going to get any significant market share. No chance. It's a $500 subsidized item. They may make a lot of money. But if you actually take a look at the 1.3 billion phones that get sold, I'd prefer to have our software in 60% or 70% or 80% of them, than I would to have 2% or 3%, which is what Apple might get."

Microsoft CEO, Steve Ballmer, 2007

Questions & Answers