In 2014, a midsize employer in rural Missouri hit a crossroads . . . or perhaps a brick wall.

After several years of battling increased taxes, government-mandated changes, and double-digit increases in medical costs, the company’s medical plan costs were expected to increase again . . . this time by $1 million.

Even if the employer increased its contributions to the plan by $700,000, employee contributions would still have to increase by 23 percent.

Twenty-three percent.

With the help of Lockton’s Kansas City Benefits team, the employer made a bold decision, moving all of its 1,350 employees from a traditional PPO health insurance plan to a reference-based pricing model.

The switch was not easy.

Employees were scared. Company leaders were apprehensive.

But they were also determined. And, ultimately, successful.
But they were also determined. And, ultimately, successful.

In the first year of the reference-based pricing model, the company promised—and delivered—incredible results:

- Deductibles stayed the same.
- Coinsurance rates stayed the same.
- And instead of a 23 percent hike, premiums did not increase at all.

Here is the story of how one employer fought back against rising healthcare costs, the status quo, and that law known as health reform . . . and won.

A company in crisis

It did not take long after the implementation of the Affordable Care Act (ACA) for company leaders to realize that change was imminent. In addition to increased taxes and reporting burdens, discounts promised under the traditional PPO health insurance plan weren’t working.

An example the company shared with employees illustrates their experiences well.

**Medical Provider Joe:** “I sell MRIs. If you join a PPO network, I will give you a 50 percent discount.”

**Patient Mary (or health plan):** “What is your normal price?”

**Medical Provider Joe:** “Sorry, I don’t know.” And/or “Sorry, that’s confidential.”

Then, there were the network fees charged every month for every enrolled employee.

The true deal breaker was the $1 million increase in medical plan costs that would have resulted in the retailer increasing employee contributions by 23 percent.

“Could employees even afford a 23 percent contribution hike?” company leaders asked.

**Employees answered with a resounding “No.”**

Making the move

In a bold move, the company removed the PPO network entirely and replaced it with reference-based pricing.

The plan was to reprice all billed claims, regardless of provider type, at an average of 25 percent above Medicare’s allowed price.

In each and every communication, they stressed the importance of employee cooperation.
It was understood that primary care physicians would cooperate, but specialists, particularly anesthesiologists and radiologists, and hospitals would be more likely to put up a fight.

In addition to the challenge of winning over providers, company leaders knew that they would need to campaign for employee support as well.

Company leaders met with employees face-to-face and utilized all available communication channels—printed materials, the company Intranet, email, break room posters, and more.

In each and every communication, they stressed the importance of employee cooperation.

Under the new health insurance model, employees would have to:

- Open their mail.
- Read every single Explanation of Benefits (EOB).
- Keep an evergreen HIPAA release on file with their employer to allow discussion of medical bills.
- Notify the benefits team of any balance bills received.
- Work with the benefits team to respond to and resolve all balance bills.

In addition to employees, the company needed the support of its key partners—the third-party administrator (TPA), repricing firm, legal counsel, and reinsurance carrier.

With everyone on board, company leaders took one final deep breath … and jumped.

The results

In a presentation to employees, company leaders summed up the success of the new plan:

“You stopped the always upward increasing costs. It took all of us working together. It was scary. Balance bills are scary. It was stressful. Collection threats are stressful. But by working together, we replaced and continued to replace unfair overcharges for healthcare with reasonable fair market prices.”

Two years after implementing the reference-based pricing health plan, the company is happy to share:

- Premiums have stayed the same for two years running.
- Coinsurance has not increased either.
- Deductibles decreased for 2016.

By reading EOBs and comparing them to their bills, employees have uncovered several billing errors, including:

- $10,000 overcharge for a knee surgery.
- $6,000 overcharge for a colonoscopy.
- $4,000 overcharge for cancer treatments.
- Charges by providers for procedures not received (charges for an outpatient surgery on a day the employee was at work, charges for MRIs not received, etc.).
- Duplicate charges by providers.
Despite successes, the transition was not without its struggles.

- The burden on the benefits team was overwhelming. A very small staff was responsible for following up on balance bills and working with partners to ensure employees were not left with additional costs.
- While paying 25 percent above Medicare on average and relying on the assignment of benefits language was the goal, many providers sent balance bills to employees.
- Overall, 10 percent of all claims were questioned.
- Employees and family members were threatened with collections.
- Some preventive care claims were not considered paid at 100 percent, which is a requirement of the ACA and had to be negotiated on a case-by-case basis.

In addition, the original EOB language was confusing to providers, and immediate updating was needed. On the EOB, the third-party administrator included dollars over the reference-based pricing amount in the “Excluded” column. A change was made in the second quarter of the new plan to use a column labeled “Excess” rather than “Excluded,” alerting providers that the “Excess” amount was the reduction to the agreed to reference-based pricing amount.

**Once changes were made, the number of disputed claims was cut in half.**

In addition to the struggles, reference-based pricing came with surprises:

- Discussions with some providers led to direct contracting—an unexpected and disappointing turn of events.
- Some providers really wanted the company’s business … and others did not.
- While some providers were open to transparent pricing, others were reluctant to change.
- The company’s partnership with the TPA, HealthSCOPE Benefits, was critical. HealthSCOPE Benefits contacted many providers to explain reference-based pricing and to resolve balance billing issues. The TPA also handled a large amount of claims reprocessing based on final pricing agreements with providers.

“At the end of the day, despite it all, company leaders and 99 percent of employees are happy,” said Deena Schaffer, Vice President and Director of Client Services for Lockton Kansas City Benefits.
Looking ahead

There's truly no rest for the weary.

To keep costs down, company leaders and employees must remain vigilant by:

- Reading all EOBs.
- Insisting on generic and less expensive therapeutic equivalent drugs (in which case reference-based pricing does not apply).
- Assigning plan benefits to medical providers.
- Contacting the company benefits coordinator immediately if a balance bill is received.
- Taking advantage of preventive care, which is covered at 100 percent.
- Utilizing all on-site and off-site clinics and screenings.
- Adhering to a list created by the company that shows providers that are willing to cooperate with reference-based pricing and those who are not. (Employees who seek care from providers on the “unwilling list” are on their own when they are overcharged or balance-billed.)

Company leaders are even leveraging quarterly prize drawings to encourage employees to research best pricing on prescription drugs and medical procedures and sharing new cost-saving ideas.

“Company leaders are very aggressive and innovative in their healthcare management,” said Schaffer. “It’s most certainly paid off.”

What is reference-based pricing?

Reference-based pricing allows employers to set a pricing cap on the maximum amount they will cover for certain medical services that have wide cost variations, such as knee and hip replacement surgery.

According to a report by the nonprofit Robert Wood Johnson Foundation, reference-based pricing may be a promising cost-control strategy when applied to frequently performed nonemergency tests and procedures for which the prices charged vary widely across providers but the quality of results remains largely similar.

Knee Replacement

<table>
<thead>
<tr>
<th>Billed Amount</th>
<th>$14,210.44</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Paid</td>
<td>$700.13</td>
</tr>
<tr>
<td>Plan Paid</td>
<td>$2,800.50</td>
</tr>
<tr>
<td>Billed</td>
<td>$14,210.44</td>
</tr>
<tr>
<td>Reasonable Fair Market Value</td>
<td>$3,500.63</td>
</tr>
<tr>
<td>Overcharge</td>
<td>$10,709.81</td>
</tr>
</tbody>
</table>

Colonoscopy

<table>
<thead>
<tr>
<th>Billed Amount</th>
<th>$7,588.82</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Paid</td>
<td>$-</td>
</tr>
<tr>
<td>Plan Paid</td>
<td>$1,102.81</td>
</tr>
<tr>
<td>Billed</td>
<td>$7,588.82</td>
</tr>
<tr>
<td>Reasonable Fair Market Value</td>
<td>$1,102.81</td>
</tr>
<tr>
<td>Overcharge</td>
<td>$6,486.01</td>
</tr>
</tbody>
</table>

Learn more

To learn more about reference-based pricing and other options for your employee benefits plan, please contact your Lockton account team.
Our Mission

To be the worldwide value and service leader in insurance brokerage, risk management, employee benefits, and retirement services

Our Goal

To be the best place to do business and to work