5 criteria to evaluate when considering reference-based pricing

While reference-based pricing is gaining popularity as a tool to help control the increasing cost of health care, the cost of health care is not an easy puzzle to solve and each solution creates a different challenge.

Reference-based pricing is no exception. The design of many reference-based pricing plans creates compliance challenges when it comes to the Affordable Care Act's maximum cost sharing rules on out of pocket limits.

Reference-based pricing programs are designed to reimburse health care providers a maximum price per service or procedure. The maximum price is called the "reference price." The idea is that employees are directed to providers that accept the reference price based on reduced cost-sharing or out-of-pocket expenses.

Employees who seek care from a provider that does not accept the reference price can be billed and responsible to pay any charges over the reference price. For example, the reference price for a knee replacement (for purposes of example) is $15,000. An employee who sees a provider that charges $20,000 for a knee replacement will be held responsible for the additional $5,000.

The ACA issue is what amount must be applied to the out- of-pocket-maximum – only the employee's cost sharing based on the underlying plan design, or the employee's cost sharing plus any billed charges over the reference price? The answer based on guidance from the Departments in ACA FAQ XXI is that it depends on whether or not the plan is deemed to have taken reasonable measures to ensure adequate access to providers at the reference price.

In a traditional network-based plan, only cost sharing applicable to providers that are "in-network" are required to be applied to the out-of-pocket maximum.

Guidance applies similar logic to reference-based plans. If reasonable measures are adopted ensuring adequate access to providers that accept the reference price, those providers may be treated as "in-network" and only those charges must be applied to the out of pocket maximum.

1. Type of service – Plans must not be a subterfuge for placing limitations on coverage. They should have a method to ensure that there are high quality providers who accept the reference price and that reference pricing applies only in situations where employees have the opportunity to evaluate their choice of providers before receiving care.
2. Reasonable access – Plans must have methods to make sure that there are enough providers available that accept the reference price. It is recommended that plans use similar methods that apply to state insurance carriers and consider distance to providers, patient wait times, and other similarly measures.
3. Quality standards – Plans should have a process for determining whether enough providers accepting the reference price meet reasonable quality standards.
4. Exceptions process – The plan must include an exception process and services should be considered provided at the reference price if a service is unavailable at the reference price or if a provider of reasonable quality is not available.

5. Disclosure – The plan must disclose information to plan participants about the pricing structure, the services available at the reference price, and the exception process automatically. Additionally, plans should provide a list of providers accepting the reference price.

If a plan cannot or does not meet the above criteria, a plan must include charges in excess of the reference-based price in an employee's out-of-pocket maximum. Failure to comply with the ACA's maximum cost sharing requirements applicable to maximum out-of-pocket limits could face an excise tax of $100 per day per person for violations of the ACA's group health plan mandates in addition to other potential civil and monetary penalties.

Employers considering a reference-based pricing program should ask their claims administrator or insurer to describe and/or illustrate how the plan meets the criteria outlined in the ACA guidance. A plan that does not meet the ACA criteria provides limited incentive for participants to receive services from providers accepting the reference price and prevents a plan from achieving its cost containment goals.

Employers should also consult with their legal counsel to properly weigh the compliance risks and whether the steps taken by the claims administrator may be deemed to meet each of the criteria.

For information on reference-based pricing contact Cheryl Mueller, vice president of HORAN at 614-376-0901 or cherylm@horanassoc.com.

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