# Reference-Based Pricing Fundamentals – "The Right Road for You?"

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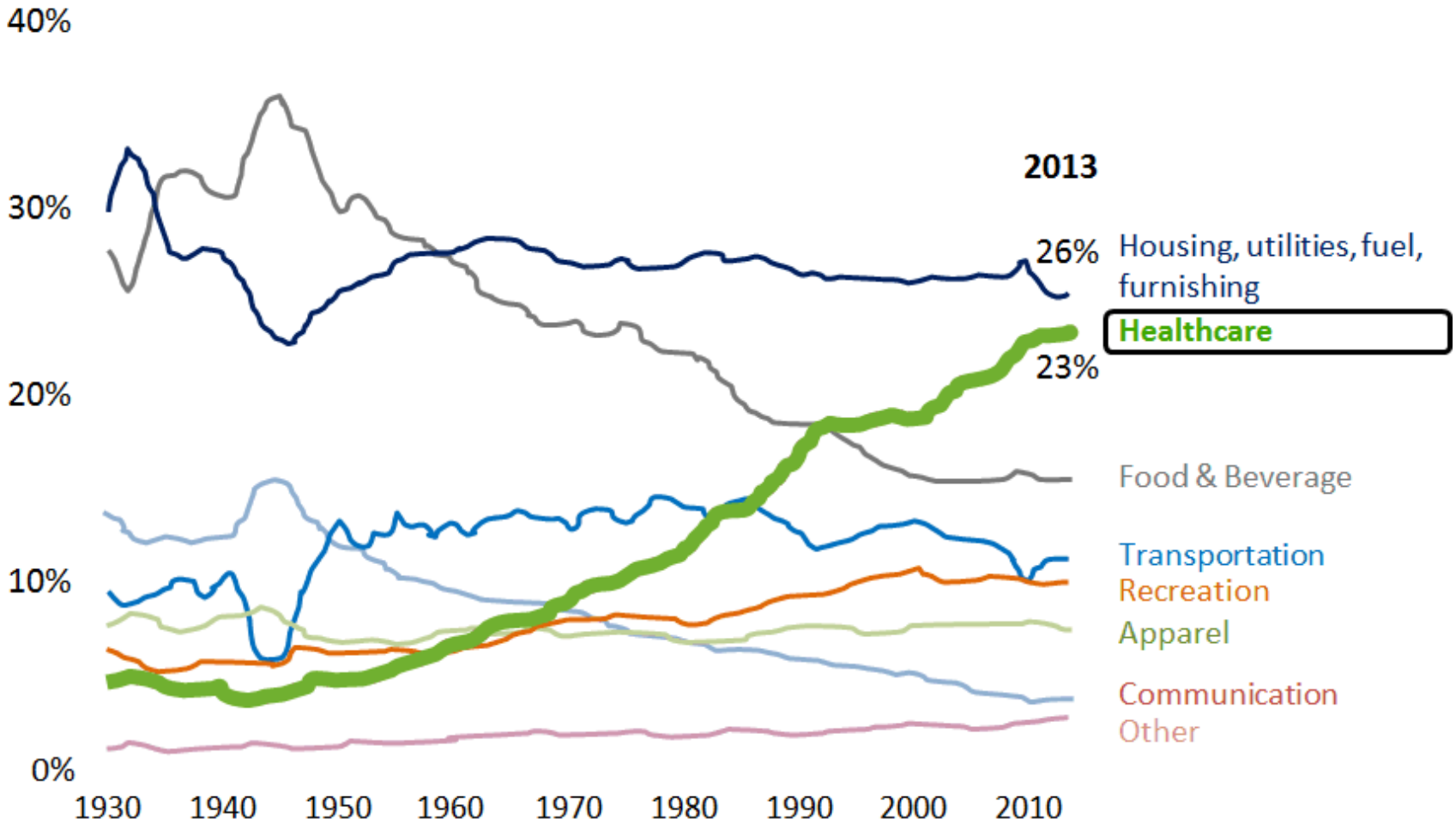
# Why we are having this discussion?

Percent of household spending, 1930-2013




Source: BEA

# Personal observations of healthcare over time

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- Relative Value Schedules were in use to establish the reimbursement levels *paid to insureds*
  - Indemnity payments moved to various fee for service payment methods
- Narrow networks (PPOs and HMOs) formed throughout the country
  - Networks became broad access and fiscal value became less relevant
- Utilization strategies formed to address increased cost trends
  - Phantom savings and ROI clouded the discussion over true statistical validation
- Prescription Benefit Managers (PBM) emerged as specialized TPAs
  - Ability to create multiple revenue streams within the fiscal model artificially inflate the cost of drugs to consumers and health plans

# Personal observations of healthcare over time

- Care management for acute and chronically ill populations emerged
  - Episodic regression to the mean was not understood or properly measured leading to resource drain by managing the wrong risks
- Predictive modeling applications were developed and integrated into care management applications
  - Better identification of adverse risk was achieved, but actionable tasks and resource allocation to manage the risk prove to be lacking
- Wellness
  - Band-Aids on societal challenges but awareness is necessary because of a lack of personal accountability

# Personal observations of healthcare over time

- Transparency and pass through
  - Few take the time to actually review and validate through the use of valid statistical methods
    - Transparency is not synonymous with lower cost, but marketed as such
- White papers are suspect, at best
- Increasing member out of pocket costs as a measure to enhance consumerism

“The growth in health system accounts receivable attributable to cost shifting now exceeds the amount of uncompensated care prior to the Medicaid expansion.”

*—CFO of large integrated delivery system*

# Why are we having this discussion?

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- In the larger picture, traditional networks have failed to stem the rising costs of healthcare
  - This has the overall effect of reducing access to healthcare
  - Further, networks have encouraged a two-tiered pricing system where providers charge one thing for their services, but accept an entirely different payment from plans they contract with—usually based on some percentage of those charges

Source: Timothy D. Martin, LL.M, JD, Executive Vice President and General Counsel, Payer Compass, LLC

# Why are we having this discussion?

- There are differences in the pricing of healthcare services by market within the US
  - There are vast differences in pricing within close geographic regions between providers of healthcare services – city, state, county
- Prices are not tied to health care use or capacity to deliver
  - Certain markets are not only high priced but also have marked excess capacity to deliver services
- Price patterns are not consistent
  - Higher inpatient prices do not necessarily mean outpatient pricing is high
- No sense of the fair market value of medical services with consumers

# Why are we having this discussion?

- Ability for patients to compare total charges for procedure (e.g. hip replacement) or treatment of acute or chronic condition (e.g. breast cancer treatment; diabetes) is in its infancy
- While the current pricing environment for medical services is irrational and inconsistent, many evolving reimbursement methods may not serve to alter the short term cost basis of services
  - Patient centered medical homes
  - Value based purchasing
  - Accountable care organizations
  - Bundled payments
- Providers themselves don't always understand the basis for reimbursement

# Reference Based Pricing: Defined

# FAQ ACA Implementation (Parts XXI) – October 10, 2014

- Reference Based Pricing (RBP) is not specifically defined by statute or regulation
- The FAQ appears to address only plans that contain a gap between a reference price and a contractual allowed charge
- RBP as defined by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments)
- RBP is a term that generally describes a network design under which the plan pays a fixed amount for a particular procedure (for example, a knee replacement), which certain providers will accept as payment in full

# FAQ ACA Implementation (Parts XXI) – October 10, 2014

- Plans that employ RBP apply the practice only to a relatively small number of specified medical services that have traditionally been found to have wide cost variations
- Pending issuance of future guidance, the Departments will consider all the facts and circumstances when evaluating whether a plan's RBP design (or similar network design) that treats providers that accept the RBP as the only in-network providers and excludes or limits cost-sharing for services rendered by other providers is using a reasonable method to ensure adequate access to quality providers at the reference price

# Network requirement?

FAQ ACA Implementation (Parts XXI) – October 10, 2014

- The Affordable Care Act, provides that a non-grandfathered group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) of the Affordable Care Act. Section 1302(c)(1) limits an enrollee's out-of-pocket costs
  - $6,350 individual and $12,700 family in 2014
  - $6,600 individual and $13,200 family in 2015
  - $6,850 individual and $13,700 family in 2016

# Network standards

FAQ ACA Implementation (Parts XXI) – October 10, 2014

- Type of service
  - Must allow reasonable time for consumers to make informed choice of providers
  - Cannot be applied to emergency services
- Reasonable access
  - Assure adequate number of providers who accept RBP
    - Geographic distance
    - Waiting times
    - Specialty access

# Network standards

FAQ ACA Implementation (Parts XXI) – October 10, 2014

- Quality standards
  - Ensure that an adequate number of providers accepting the reference price meet reasonable quality standards
- Exceptions process
  - Plans should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the RBP to be treated as if the services were provided by a provider that accepts the reference price if:
    - Access to a provider that accepts the reference price is unavailable
    - The quality of services with respect to a particular individual could be compromised with the reference price provider

# Network standards

FAQ ACA Implementation (Parts XXI) – October 10, 2014

- Disclosure
  - Plans should provide the following to plan participants free of charge:
    - Information regarding the pricing structure, including a list of services to which the pricing structure applies and the exceptions process. (This should be provided automatically, without the need for the participant to request such information, for example through the plan's Summary Plan Description or similar document)
    - A list of providers that will accept the reference price for each service;
    - A list of providers that will accept a negotiated price above the reference price for each service; and
    - Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards

# Network standards

FAQ ACA Implementation (Parts XXI) – October 10, 2014

- Interpretation
  - FAQ XXI indicates that it targets plans that have contracted with providers but then impose on those same providers a lower, fixed, reference price for certain services such as full knee and full hip replacements
  - In this context, the Departments wanted to ensure that any gap between a negotiated in-network rate and a fixed, reference price counts toward a patient's max out-of-pocket (MOOP) expenditures under PHS Act § 2707(b)

# Broader definitions

- Layered Reference Based Pricing
  - Payer imposing fixed prices for certain high-cost services on in-network providers that, in effect, override the already-negotiated contractual rate or allowed amount
- Medicare Reference Based Pricing
  - Application of reference to Medicare pricing as basis for determining plan indemnification for claims
  - These plans offer a reference price to any willing provider
- Hybrid Reference Based Pricing
  - Combination of a professional (physician) PPO network with reference pricing for institutional claims

Source: Timothy D. Martin, LL.M, JD, Executive Vice President and General Counsel, Payer Compass, LLC

# Broader definitions

- Interpretation - Types of RBP business models
  - FAQ XXI addresses plans that negotiate rates with providers and then impose a reference price on those same providers (creating confusion and difficulty for members seeking in-network services)—not plans that use a consistent reference pricing method and have no contracts with providers
  - A competent patient advocacy process will ensure that an adequate number of quality providers will accept reference pricing;
    - If any exceptions process is needed for providers that do not accept the reference price, a comprehensive patient advocacy process will provide it; and
  - Plans that adopt best practices can easily satisfy FAQ XXI's disclosure requirements.

Source: Timothy D. Martin, LL.M, JD, Executive Vice President and General Counsel, Payer Compass, LLC

# *My* definition of Referenced Based Pricing

- The market based process of establishing the fair market value of healthcare goods and services
- Fair market value is established by leveraging areas of overcapacity within the healthcare delivery system and those suppliers willing to fill that capacity at competitive costs
- Networks are established through the on-going acceptance of this process as a standard of practice
- My opinion is the federal government is challenged to tell the marketplace that health plans must have provider networks in place

What does healthcare literacy have to do with Reference Based Pricing?

# Many healthcare issues in the US are directly related to illiteracy

- Populations most likely to experience low health literacy are:
  - Older adults
  - Racial and ethnic minorities
  - People with less than a high school degree or GED certificate
  - People with low income levels
  - Non-native speakers of English,
  - People with compromised health status
- Education, language, culture, access to resources, and age are all factors that affect a person's health literacy skills

Source: National Assessment of Adult Literacy

# Why is health literacy important?

- Only 12 percent of adults have Proficient health literacy
  - In other words, nearly nine out of ten adults may lack the skills needed to manage their health and prevent disease
  - Fourteen percent of adults (30 million people) have Below Basic health literacy
- Low literacy has been linked to poor health outcomes such as higher rates of hospitalization and less frequent use of preventive services

Source: National Assessment of Adult Literacy

# Example of the challenge

- Population size: 25,000 employees
- Average wage: $13.45 per hour
- 60% qualify for Medicaid, the balance qualify for exchange based insurance that is heavily subsidized
- We have identified 32 distinct languages within the overall population
  - Culturally, the population does not understand the American healthcare system – even those born and raised in the US struggle to understand
  - Most have limited English reading and comprehension levels

# Member communications

- Employee education of RBP process and value is critical to the success of the program – challenge, see Health Literacy
- Making scope of service and fiscal arrangements in advance of service delivery is critical to the success of RBP in addressing network and maximum out of pocket compliance
  - Consumers do not want to get stuck with out of network cost sharing that does not accumulate toward their out of pocket exposure
  - Claim types paid at RBP levels must be disclosed in the plan document
    - Not all RBP models are applied the same
    - Some are broad based across all service categories – mainly focused on facility claims
    - Others are limited and focus on specific surgical or general service categories
    - Carve-out transplants, ESRD, other unique occurrences

# Maximum out of pocket is a key issue

- Any member cost share of an RBP arrangement should count toward the satisfaction of the maximum out of pocket limitation due to the providers willingness to accept the pre-defined allowed amount in full
- Providers who accept RBP allowed, should be prohibited from balance billing the member after application of benefits
- In the event the provider does balance bill a member and the amount cannot be negotiated away, the amount of out of pocket exposure would not accumulate toward satisfaction of the maximum out of pocket limitation
  - Plan must demonstrate RBP allowed is based upon reasonable criteria
  - Plan must demonstrate RBP provides access to quality providers

# What constitutes a network

- Most RBP plans pay a percentage of Medicare—usually somewhere between 120% and 180%[1]
- A very substantial percentage of Medicare patients (96%) report having ready access to physicians who accept Medicare[1]
- More than 4,800 hospitals around the country accept Medicare patients[2]

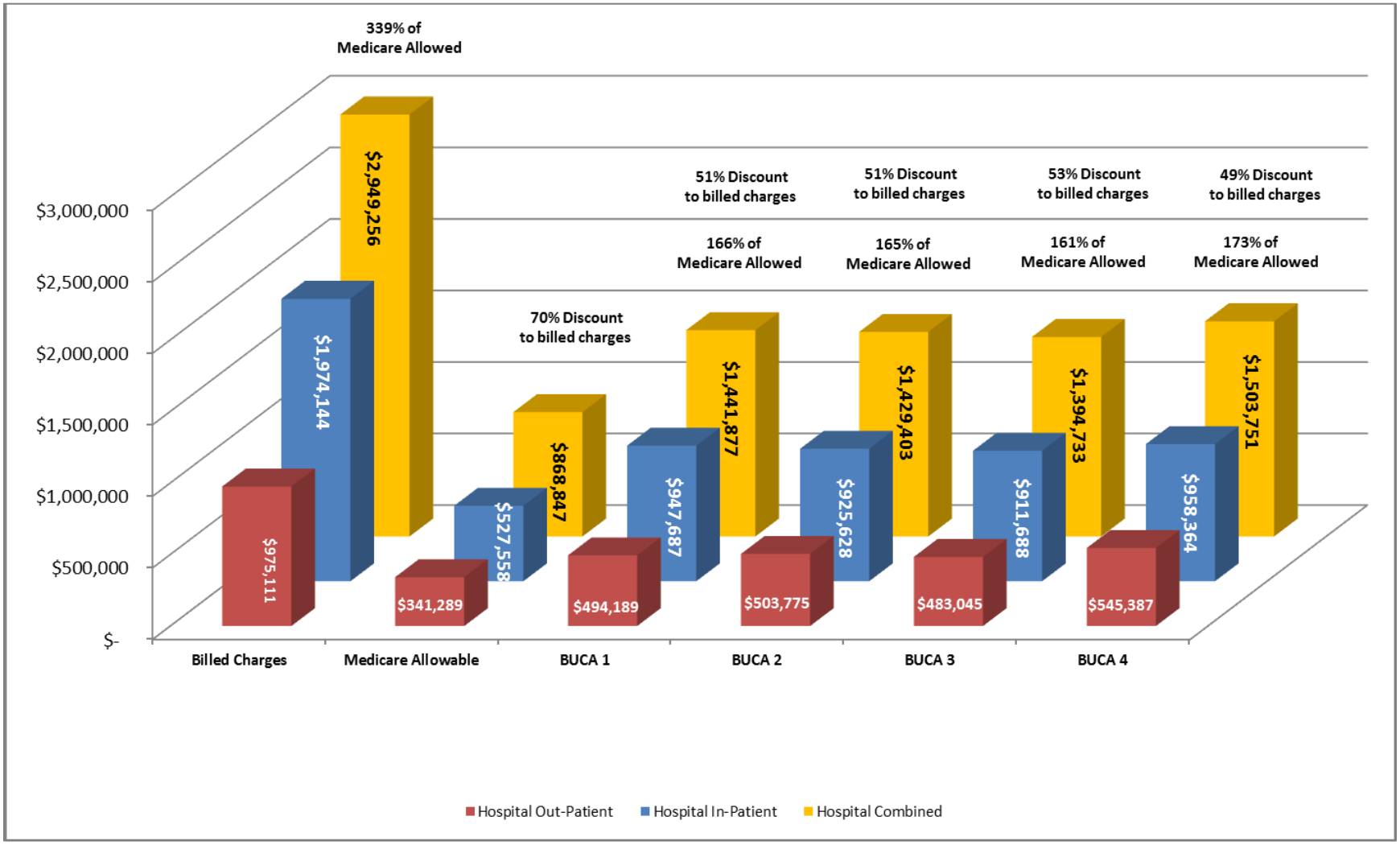
1 Source: The Henry J. Kaiser Family Foundation, Medicare Patients' Access to Physicians: A Synthesis of Evidence (Dec. 10, 2013), http://kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/ (last visited Oct. 19, 2014).
2 Source: Data.Medicare.gov, https://data.medicare.gov/Hospital-Compare/Hospital-General-Information/xubh-q36u (last visited Oct. 19, 2014)

# What constitutes a network

- Most RBP plans pay a percentage of Medicare—usually somewhere between 120% and 180%
  - According to the American Hospital Association, Medicare payment, on average, covers 86% of actual costs in treating Medicare patients
    - This means that to cover costs, providers need to receive, on average, 116.3% of Medicare payment—an amount that most MRBP plans cover
  - If physicians were to receive only Medicare payment as compensation, they would realize a 12% reduction in overall compensation

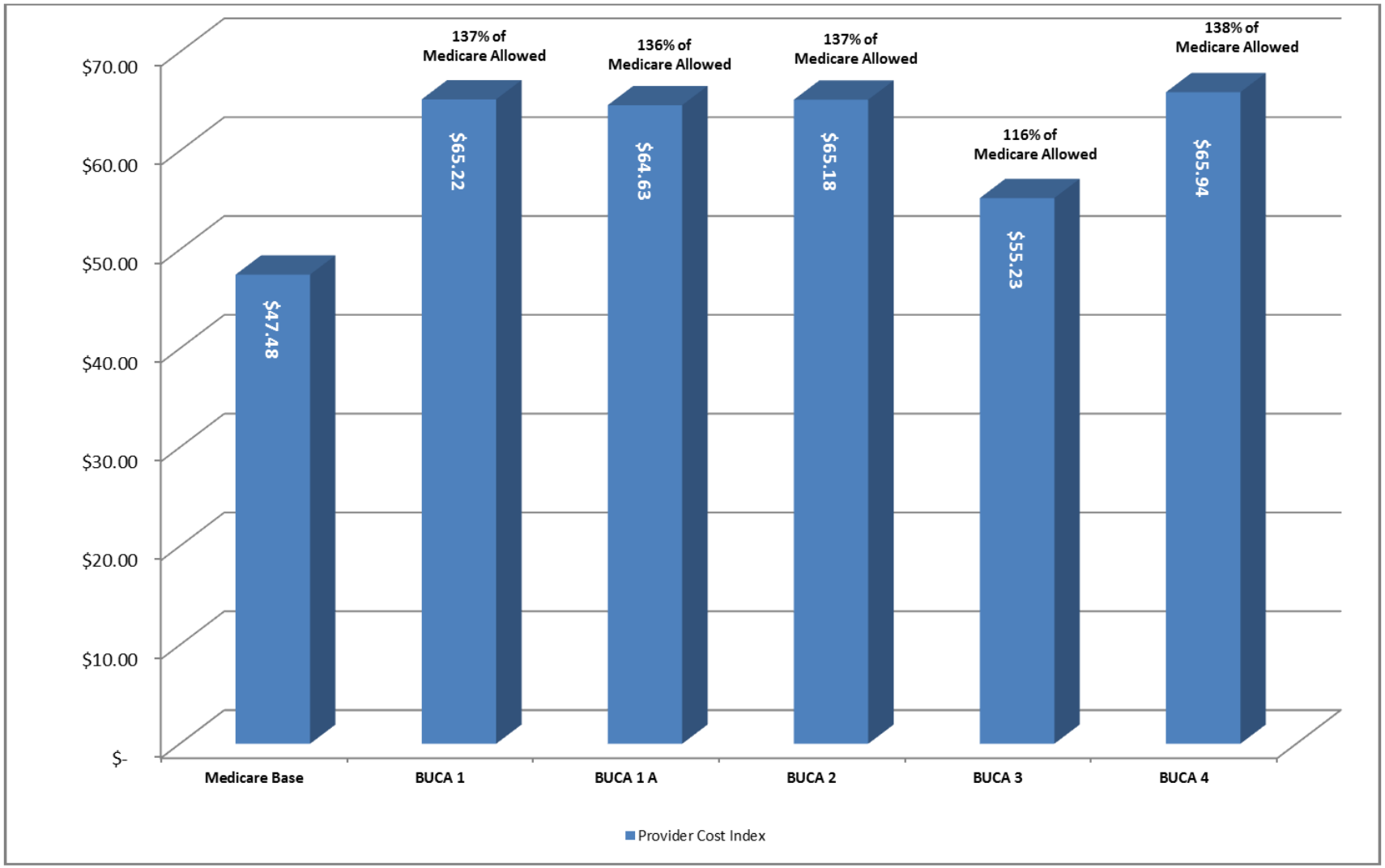
# Reference Based Pricing: The Math

# Lower value represents lower cost basis of contractual allowed



# Provider cost index

Lower value represents lower cost basis of contractual allowed



# Reference Based Pricing – The math

| category | Total Billed | Total Allowed | Network Discount |
|---|---|---|---|
| **Hip** | $ 42,925 | $ 28,747 | -33.0% |
| | $ 119,307 | $ 66,745 | -44.1% |
| **Knee** | $ 78,107 | $ 35,029 | -55.2% |
| | $ 45,987 | $ 35,686 | -22.4% |
| **Spine** | $ 131,417 | $ 80,908 | -38.4% |
| | $ 236,232 | $ 134,339 | -43.1% |
| **Grand Total** | **$ 653,974** | **$ 381,454** | -41.7% |

# Reference Based Pricing – The math

| category | Total Billed | Total Allowed | Medicare 2015Q3 Allowed | Network Discount | Network Allowed Relation to Medicare |
|---|---|---|---|---|---|
| **Hip** | $ 42,925 | $ 28,747 | $ 19,252 | -33.0% | **149.3%** |
| | $ 119,307 | $ 66,745 | $ 18,463 | -44.1% | **361.5%** |
| **Knee** | $ 78,107 | $ 35,029 | $ 14,563 | -55.2% | **240.5%** |
| | $ 45,987 | $ 35,686 | $ 15,513 | -22.4% | **230.0%** |
| **Spine** | $ 131,417 | $ 80,908 | $ 23,912 | -38.4% | **338.4%** |
| | $ 236,232 | $ 134,339 | $ 30,296 | -43.1% | **443.4%** |
| **Grand Total** | **$ 653,974** | **$ 381,454** | **$ 121,999** | -41.7% | **312.7%** |

# Reference Based Pricing – The math

| category | Total Billed | Total Allowed | Medicare 2015Q3 Allowed | Network Discount | Network Allowed Relation to Medicare | 140% of Medicare | Variance to Medicare Allowed | Variance to Network Allowed |
|---|---|---|---|---|---|---|---|---|
| **Hip** | $ 42,925 | $ 28,747 | $ 19,252 | -33.0% | **149.3%** | $ 26,953 | $ 7,701 | $ (1,794) |
| | $ 119,307 | $ 66,745 | $ 18,463 | -44.1% | **361.5%** | $ 25,848 | $ 7,385 | $ (40,897) |
| **Knee** | $ 78,107 | $ 35,029 | $ 14,563 | -55.2% | **240.5%** | $ 20,388 | $ 5,825 | $ (14,641) |
| | $ 45,987 | $ 35,686 | $ 15,513 | -22.4% | **230.0%** | $ 21,718 | $ 6,205 | $ (13,968) |
| **Spine** | $ 131,417 | $ 80,908 | $ 23,912 | -38.4% | **338.4%** | $ 33,477 | $ 9,565 | $ (47,431) |
| | $ 236,232 | $ 134,339 | $ 30,296 | -43.1% | **443.4%** | $ 42,414 | $ 12,118 | $ (91,925) |
| **Grand Total** | **$ 653,974** | **$ 381,454** | **$ 121,999** | -41.7% | **312.7%** | **$ 170,799** | **$ 48,800** | **$ (210,655)** |

# Reference Based Pricing – The math

| category | Total Billed | Total Allowed | Medicare 2015Q3 Allowed | Network Discount | Network Allowed Relation to Medicare | 180% of Medicare | Variance to Medicare Allowed | Variance to Network Allowed |
|---|---|---|---|---|---|---|---|---|
| **Hip** | $ 42,925 | $ 28,747 | $ 19,252 | -33.0% | **149.3%** | $ 34,654 | $ 15,402 | $ 5,907 |
| | $ 119,307 | $ 66,745 | $ 18,463 | -44.1% | **361.5%** | $ 33,233 | $ 14,770 | $ (33,512) |
| **Knee** | $ 78,107 | $ 35,029 | $ 14,563 | -55.2% | **240.5%** | $ 26,213 | $ 11,650 | $ (8,816) |
| | $ 45,987 | $ 35,686 | $ 15,513 | -22.4% | **230.0%** | $ 27,924 | $ 12,411 | $ (7,762) |
| **Spine** | $ 131,417 | $ 80,908 | $ 23,912 | -38.4% | **338.4%** | $ 43,042 | $ 19,130 | $ (37,866) |
| | $ 236,232 | $ 134,339 | $ 30,296 | -43.1% | **443.4%** | $ 54,533 | $ 24,237 | $ (79,806) |
| **Grand Total** | **$ 653,974** | **$ 381,454** | **$ 121,999** | -41.7% | **312.7%** | **$ 219,599** | **$ 97,600** | **$ (161,855)** |

# Reference Based Pricing – The math

| Description | LOS | Billed | Network Allowed | Discount |
|---|---|---|---|---|
| Septicemia | 11 | $ 177,263 | $ 83,160 | -53.1% |
| Cerebrovascular disorders | 8 | $ 314,250 | $ 60,480 | -80.8% |
| Hematologic/Immunologic | 10 | $ 105,131 | $ 55,330 | -47.4% |
| Septicemia | 5 | $ 77,016 | $ 43,340 | -43.7% |
| Esophagitis | 3 | $ 51,359 | $ 51,358 | 0.0% |
| Disorders of Pancreas | 12 | $ 70,737 | $ 70,737 | 0.0% |
| Bone diseases & Arthropathies | 2 | $ 49,506 | $ 40,223 | -18.8% |
| Cardiac Dysrhythmias | 0 | $ 125,461 | $ 72,188 | -42.5% |
| Chest Pain NOS | 0 | $ 44,557 | $ 31,725 | -28.8% |
| Radiation Therapy | 0 | $ 25,324 | $ 21,550 | -14.9% |
| Radiation Therapy | 0 | $ 24,385 | $ 20,751 | -14.9% |
| Radiation Therapy | 0 | $ 41,553 | $ 17,457 | -58.0% |
| **Total** | | **$ 1,106,543** | **$ 568,299** | **-48.6%** |

# Reference Based Pricing – The math

| Description | LOS | Billed | Network Allowed | Discount | Medicare Allowed | Netowrk Allowed Relation to Medicare |
|---|---|---|---|---|---|---|
| Septicemia | 11 | $ 177,263 | $ 83,160 | -53.1% | $ 53,307 | **156.0%** |
| Cerebrovascular disorders | 8 | $ 314,250 | $ 60,480 | -80.8% | $ 24,807 | **243.8%** |
| Hematologic/Immunologic | 10 | $ 105,131 | $ 55,330 | -47.4% | $ 16,657 | **332.2%** |
| Septicemia | 5 | $ 77,016 | $ 43,340 | -43.7% | $ 17,262 | **251.1%** |
| Esophagitis | 3 | $ 51,359 | $ 51,358 | 0.0% | $ 12,783 | **401.8%** |
| Disorders of Pancreas | 12 | $ 70,737 | $ 70,737 | 0.0% | $ 18,551 | **381.3%** |
| Bone diseases & Arthropathies | 2 | $ 49,506 | $ 40,223 | -18.8% | $ 7,903 | **508.9%** |
| Cardiac Dysrhythmias | 0 | $ 125,461 | $ 72,188 | -42.5% | $ 14,440 | **499.9%** |
| Chest Pain NOS | 0 | $ 44,557 | $ 31,725 | -28.8% | $ 2,449 | **1295.4%** |
| Radiation Therapy | 0 | $ 25,324 | $ 21,550 | -14.9% | $ 3,158 | **682.4%** |
| Radiation Therapy | 0 | $ 24,385 | $ 20,751 | -14.9% | $ 3,045 | **681.5%** |
| Radiation Therapy | 0 | $ 41,553 | $ 17,457 | -58.0% | $ 3,894 | **448.3%** |
| **Total** | | **$ 1,106,543** | **$ 568,299** | **-48.6%** | **$ 178,256** | **318.8%** |

# Reference Based Pricing – The math

| Description | LOS | Billed | Network Allowed | Discount | Medicare Allowed | Netowrk Allowed Relation to Medicare | 140% of Medicare Allowed | Variance to Medicare Allowed | Variance to Network Allowed |
|---|---|---|---|---|---|---|---|---|---|
| Septicemia | 11 | $ 177,263 | $ 83,160 | -53.1% | $ 53,307 | **156.0%** | $ 74,630 | $ 21,323 | $ (8,530) |
| Cerebrovascular disorders | 8 | $ 314,250 | $ 60,480 | -80.8% | $ 24,807 | **243.8%** | $ 34,729 | $ 9,923 | $ (25,751) |
| Hematologic/Immunologic | 10 | $ 105,131 | $ 55,330 | -47.4% | $ 16,657 | **332.2%** | $ 23,319 | $ 6,663 | $ (32,011) |
| Septicemia | 5 | $ 77,016 | $ 43,340 | -43.7% | $ 17,262 | **251.1%** | $ 24,166 | $ 6,905 | $ (19,174) |
| Esophagitis | 3 | $ 51,359 | $ 51,358 | 0.0% | $ 12,783 | **401.8%** | $ 17,897 | $ 5,113 | $ (33,461) |
| Disorders of Pancreas | 12 | $ 70,737 | $ 70,737 | 0.0% | $ 18,551 | **381.3%** | $ 25,972 | $ 7,420 | $ (44,765) |
| Bone diseases & Arthropathies | 2 | $ 49,506 | $ 40,223 | -18.8% | $ 7,903 | **508.9%** | $ 11,065 | $ 3,161 | $ (29,158) |
| Cardiac Dysrhythmias | 0 | $ 125,461 | $ 72,188 | -42.5% | $ 14,440 | **499.9%** | $ 20,216 | $ 5,776 | $ (51,972) |
| Chest Pain NOS | 0 | $ 44,557 | $ 31,725 | -28.8% | $ 2,449 | **1295.4%** | $ 3,429 | $ 980 | $ (28,296) |
| Radiation Therapy | 0 | $ 25,324 | $ 21,550 | -14.9% | $ 3,158 | **682.4%** | $ 4,421 | $ 1,263 | $ (17,129) |
| Radiation Therapy | 0 | $ 24,385 | $ 20,751 | -14.9% | $ 3,045 | **681.5%** | $ 4,263 | $ 1,218 | $ (16,488) |
| Radiation Therapy | 0 | $ 41,553 | $ 17,457 | -58.0% | $ 3,894 | **448.3%** | $ 5,452 | $ 1,558 | $ (12,005) |
| **Total** | | **$ 1,106,543** | **$ 568,299** | **-48.6%** | **$ 178,256** | **318.8%** | **$ 249,558** | **$ 71,302** | **$ (318,741)** |

# Reference Based Pricing – The math

| Description | LOS | Billed | Network Allowed | Discount | Medicare Allowed | Netowrk Allowed Relation to Medicare | 180% of Medicare Allowed | Variance to Medicare Allowed | Variance to Network Allowed |
|---|---|---|---|---|---|---|---|---|---|
| Septicemia | 11 | $ 177,263 | $ 83,160 | -53.1% | $ 53,307 | **156.0%** | $ 95,953 | $ 42,646 | $ 12,793 |
| Cerebrovascular disorders | 8 | $ 314,250 | $ 60,480 | -80.8% | $ 24,807 | **243.8%** | $ 44,652 | $ 19,845 | $ (15,828) |
| Hematologic/Immunologic | 10 | $ 105,131 | $ 55,330 | -47.4% | $ 16,657 | **332.2%** | $ 29,982 | $ 13,325 | $ (25,348) |
| Septicemia | 5 | $ 77,016 | $ 43,340 | -43.7% | $ 17,262 | **251.1%** | $ 31,071 | $ 13,809 | $ (12,269) |
| Esophagitis | 3 | $ 51,359 | $ 51,358 | 0.0% | $ 12,783 | **401.8%** | $ 23,010 | $ 10,227 | $ (28,348) |
| Disorders of Pancreas | 12 | $ 70,737 | $ 70,737 | 0.0% | $ 18,551 | **381.3%** | $ 33,392 | $ 14,841 | $ (37,345) |
| Bone diseases & Arthropathies | 2 | $ 49,506 | $ 40,223 | -18.8% | $ 7,903 | **508.9%** | $ 14,226 | $ 6,323 | $ (25,997) |
| Cardiac Dysrhythmias | 0 | $ 125,461 | $ 72,188 | -42.5% | $ 14,440 | **499.9%** | $ 25,992 | $ 11,552 | $ (46,196) |
| Chest Pain NOS | 0 | $ 44,557 | $ 31,725 | -28.8% | $ 2,449 | **1295.4%** | $ 4,408 | $ 1,959 | $ (27,317) |
| Radiation Therapy | 0 | $ 25,324 | $ 21,550 | -14.9% | $ 3,158 | **682.4%** | $ 5,684 | $ 2,526 | $ (15,866) |
| Radiation Therapy | 0 | $ 24,385 | $ 20,751 | -14.9% | $ 3,045 | **681.5%** | $ 5,481 | $ 2,436 | $ (15,270) |
| Radiation Therapy | 0 | $ 41,553 | $ 17,457 | -58.0% | $ 3,894 | **448.3%** | $ 7,009 | $ 3,115 | $ (10,448) |
| **Total** | | **$1,106,543** | **$568,299** | **-48.6%** | **$178,256** | **318.8%** | **$320,861** | **$142,605** | **$(247,438)** |

# Discussions with employer reinsurance carriers

- Conclusion: Overall, no one carrier seems to have enough volume to validate the impact to their books of business
  - "Experience is immature, but developing."
  - "Not a significant impact to the overall specific stop loss experience."
  - "Certain TPAs do a better job at managing RBP than others."
  - "There is strong outlier resistance by hospitals on resource intensive claims."
  - "Hospitals are beginning to push back on "train-wreck" claims. Neonate, burns, cancer claims."
  - "Makes sense intuitively, but doesn't address frequency of risk. Just the magnitude of the potential payout."
  - "Depending upon where the fixed price is set, not always lower than BUCA allowed."

# Conclusions

- The guidance makes it clear that the Departments are concerned about access, quality, and disclosure under alternative plan designs and payment methods
- Implementing best practices for patient advocacy, plan design, balance-bill escalation, access and quality monitoring, contingencies for unique circumstances, and member education and disclosure are imperative

# Thank you!