MEDICARE PLUS PRICING GAINS TRACTION WITHIN THE SELF FUNDED BENEFITS COMMUNITY

"The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking."
— Albert Einstein

The health care industry continues to change at a swift pace; new treatments, regulations and soaring costs impose an obligation on all of us to thoughtfully approach those challenges and develop strategies to mitigate the impact.

The cost of health care is in the news practically every day. And why not? It remains one of the top concerns for individuals and businesses alike and will continue to be a focus for years to come.

Typically private insurers and self-funded plans pay for healthcare services on the basis of a negotiated rate. A natural result of these one-on-one negotiations is price discrimination, which means different prices for different payors.

Although healthcare price comparison tools are evolving, transparency in healthcare cost continues to be a challenge.

As such, you may be hearing about Medicare Plus Pricing and wonder, what is it and is this the right approach for my benefit plan? That depends on your way of thinking.

For many years, employers have contracted with Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs) and Point of Service (POS) plans, these are all managed care arrangements that provide medical services through a network of health care providers. Employers pay a fee and, in some instances, a percentage of savings to gain network access and receive discounts from the providers participating in the network.

In exchange, employers steer members to network providers by offering a higher level of benefits for the services they render. A network provider accepts a discounted amount along with the member-paid deductible, coinsurance and applicable co-pays as payment in full. Balance billing (billing the patient for the portion of the bill that the benefit plan does not pay) is eliminated. Is this a good thing? In this day of consumer driven health care, all of us should take a deeper look at the cost of services we receive.

Typically, **out-of-network** benefits are provided to members that choose not to receive services from a network provider. In this scenario, services are paid at a lower level of benefits (or not at all in the case of an HMO) and are subject to Usual, Customary and Reasonable charge (UCR). UCR is typically defined as the prevailing fee by geographic region and members may be balance billed for amounts above the UCR rate.

In recent years, Significa Benefit Services has encouraged employers to consider out-of-network reimbursements based on Medicare Plus Pricing, this may result in savings to the employer and is a non-discriminatory method for determining benefit reimbursement levels.

So what is Medicare Plus? As the title suggests, Medicare Plus is a reimbursement method which utilizes a Medicare fee schedule as a basis for payment to providers for healthcare services rendered, **plus** an additional percent, i.e. 160% of Medicare. In contrast to payments made using a discount off charges, Medicare fee schedules are based, in part, on the actual cost of providing care, adjusted for level of service, practice expenses and geographic region.

As Medicare Plus Pricing gains momentum, you may wish to examine the possibility of utilizing this reimbursement model. Whether you choose standard two or three tier PPO access, Exclusive Provider Organizations (EPOs) or Medicare Plus Pricing, by adopting robust employee education tools, coupled with concise plan document language, effective provider communications and a rigorous review and appeal process, Significa Benefit Services will advocate for you and your employees for fair and appropriate benefit reimbursements.

Please contact us if you would like to discuss this payment model and its implications for your benefit plan.