AVOID THESE THREE COSTLY MISTAKES WHEN IMPLEMENTING A PPO REPLACEMENT STRATEGY
Using reference based reimbursement (RBR) or cost plus services to replace the failed PPO system is increasingly growing in popularity. Unfortunately, the difference between applying RBR/Cost Plus correctly, or incorrectly, can often lead to a significant number of employer/employee issues.

RBR/Cost Plus offers employers the opportunity to lower healthcare charges by 25% or more and will soon dominate the healthcare landscape replacing the current PPO system that often grossly overpays hospitals and facilities. However, as with self-funding, there are correct and incorrect applications of this type of program that will definitively lead to an employers’ success or failure. Below is a list of three key mistakes to avoid when implementing this cost management strategy.

MISTAKE: SINGULAR BENCHMARK FOR REPRICING

Many administrators assume that a singular benchmark like Medicare is in and of itself a sufficient mechanism for a commercial claim. While Medicare, as the largest payer of health provider services in the US, can be one reasonable benchmark within a cadre of benchmarks, it often will not result in fair and just reimbursement to providers when used alone. Medicare is not intended to always reimburse a provider reasonably in all cases for a variety of reasons. It instead is meant to compensate the hospital or facility reasonably in aggregate over the course of a given period of time (as evidenced by quarterly true ups, and other adjustment mechanisms). Using a “greater of” methodology and applying the greater of several data points helps insure fair reimbursement for the hospital, plan and member. Demonstrating to the hospital that the plan is going the extra mile to insure reasonability paves the way for reasonable access to quality care. Facilitating this type of environment has proven to lead to the best possible end result, a direct contract between the group and the hospital.

MISTAKE: NO NAMED FIDUCIARY WITHIN PLAN DOCUMENT

For RBR/Cost Plus to function effectively there needs to be a named fiduciary within the ERISA plan document with sole pricing discretion on hospital and facility claims. The buck stops for all decisions. For all practical purposes, that fiduciary is “the plan” on those claims. If multiple parties involved in a plan have the ability to override decisions or exercise discretion, it will create “chinks in the armor” of the program that will be susceptible to attack and the possibility of failure will increase dramatically.

The move away from PPO plans to RBR/Cost Plus involves a paradigm shift in the way a health plan is managed and applied, so a significant amount of education for employers, employees, and dependents is absolutely essential. Employees at all levels of education would be appalled at how PPOs allow charges for toothbrushes of $1,000 or more or extra bed pillows at $400.
If employees were shown how to apply the same kind of prudence and logic that they apply when buying a flat screen TV or car - they would become eager participants in the purchase of healthcare services. A quality RBR/Cost Plus system will offer tools and member support to educate employees, in addition to very proactive member advocacy to address any issues related to specific hospital bills.

A members employee benefits are confusing. We are members, not “students” of the game since we are generally healthy and don’t need to know all the fine print in the SPD.

**MISTAKE: NOT HAVING A PROCESS IN PLACE TO EFFECTIVELY MANAGE AN RBR/COST PLUS PLAN**

It is not a clerical process and thus requires significant acumen with regard to many state and federal laws and regulations as well as provider services and finance. Your company should carefully consider altering your group health-plan to an RBR/Cost Plus solution, as it is the only way you will receive fair value for the healthcare dollars you spend. Many solutions are geared towards solely saving money and focus on paying the provider as little as possible. This “scorched earth” approach can lead to a contentious and extremely litigious environment. We want the hospital to make a fair and reasonable profit when one plan or family member is receiving care. It is extremely important to look beyond the possible dollar savings and choose a partner that is has validated processes to help your firm manage the change that comes with this paradigm shift so that the immediate impact to your entities operating income is not lost by member dissatisfaction.

**THE AMPS DIFFERENCE**

Since 2005 Advanced Medical Pricing Solutions (AMPS) has worked to provide premium healthcare cost management services to the self-funded payer community. We specialize in physician led, technology driven, and facility claim review.

AMPS has become the preeminent supplier of healthcare claim review and verification services over the past eight years. Our charge of excellence has now expanded to wellness, dependent verifications, direct contracts with hospitals, and progressive re-pricing models. Our direction is to bring the same level of professionalism and leadership within these segments of cost management that we have delivered previously with our established claim services.

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