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Reference Based Pricing for Employee Healthcare Needs

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Abstract

Agencies that provide supports and services to individuals who have intellectual and/or developmental disabilities operate within a system in which governmental agencies typically control the price to be paid for the provision of these supports and services. One consequence of the imposition of these fixed prices is a chronic shortage of those staff who provide direct supports and services to people who have disabilities. Because agencies have no control over the prices they can charge for the provision of supports and services, they are unable to raise staff wages sufficiently to create an equilibrium between supply of and demand for staff. Instead, equilibrium must be sought by cost reduction measures. Strategies to reduce costs are essential to the continuation of this service model as substantial increases in governmental funding are unlikely. Reference based pricing for employee health insurance is described and proposed as a cost reduction strategy within the intellectual and developmental disability community. An example of the adoption of this strategy within the intellectual disability field is provided.

Keywords: Intellectual disability; workforce crisis; reference based pricing

1.0 Introduction – Workforce Crisis

A chronic workforce shortage characterizes the operation of community based residential programs for people who have intellectual and/or developmental disabilities Recent reports (Spreat, Davis, & Gruber, 2022) suggest that turnover of those staff who work directly with people who have intellectual disability/autism (called Direct Support Professionals) exceeds 50% in some areas of the United States. The same study (Spreat, Davis, & Gruber, 2022) revealed that almost one out of every 4 Direct Support Professional positions was vacant (unfilled). These two factors drive excessive use of overtime as well as exceptional recruitment and training costs. These factors jeopardize program quality by creating a revolving staff door in programs, jeopardizing the development of essential interpersonal relationships with the individuals being supported.

Although many factors contribute to the ongoing workforce crisis, it is clear that Direct Support Professionals are not being paid enough to create an equilibrium between the demand for and supply of Direct Support Professionals. Complicating the workforce crisis is the growing number of people who are receiving residential services (Braddock, Hemp, Tanis, Wu, & Haffer, 2017),

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the longer lifetimes enjoyed by people who have intellectual disability (Dolan, Lane, Hillis, & Delanty, 2019) and the higher staffing demands within typical group homes, the dominant residential model. Spreat (2021) has suggested that the government practice of fixing prices for ID/A services is clearly a primary maintaining factor of the workforce crisis. Because provider agencies have such narrow operating margins (Spreat, 2019a) they have no room to increase pay for Direct Support Professionals in an effort to affect the equilibrium between supply and demand.

A serious question exists as to whether the community based residential support system in the United States can continue to exist under current conditions. The anticipated introduction of managed care strategies to the Intellectual and/or developmental disabilities field hardly seems likely to improve matters, with Managed Care Organizations absorbing some portion of the funds allocated to assist individuals who have intellectual and/or developmental disabilities.

A number of provider associations and advocacy networks continue in their efforts to resolve the workforce crisis. Some (New Jersey Coalition for a DSP Living Wage, undated) call for Direct Support Professionals to be paid a "living wage," as defined by the MIT Living Wage calculator (MIT, undated). Others (Blumenthal, 2021) have called for Direct Support Professionals to be paid the same wages as are paid to Direct Support Professionals working in state hospitals. Spreat (2021) has argued for a more empirical approach in which wages were increased until vacancies are eliminated. All of these approaches essentially ask the government for more money, rather than demanding the freedom to operate business in a fiscally responsible manner. It is sometimes suggested that provider agencies, rather than acting as independent businesses, are really just an extension of government agencies. Asking for money, rather than demanding independence, only serves to highlight the weakness of the community based support system for individuals who have intellectual and/or developmental disabilities.

2.0 Achievable Economies

Establishment of a free market seems unlikely, particularly with the probability of managed care strategies soon to be imposed in many areas. Pleas for additional funding or higher rates need to be supplemented by sound business strategies. It is reasonable to anticipate that strategies such as these will be imposed by managed care organizations in the near future. It is essential to identify economies that can be incorporated to make additional funding available to pay for Direct Support Professionals and hopefully minimize the workforce crisis. The purpose of this paper is to suggest and describe one narrow area in which economies might be achieved within the intellectual and developmental disabilities field. Whether these economies will substantially impact the workforce crisis will remain an empirical question.

Let us consider employee health insurance as one area in which there might be savings. In Pennsylvania, 95% of intellectual disability/autism providers offer some form of health insurance for Direct Support Professionals (Spreat, 2019b). This percentage may vary from state to state, but ever since the Stabilization Act of 1942 (Fox & Kongstvedt, 2013), employee health care benefits have become entrenched as an integral part of compensation packages.

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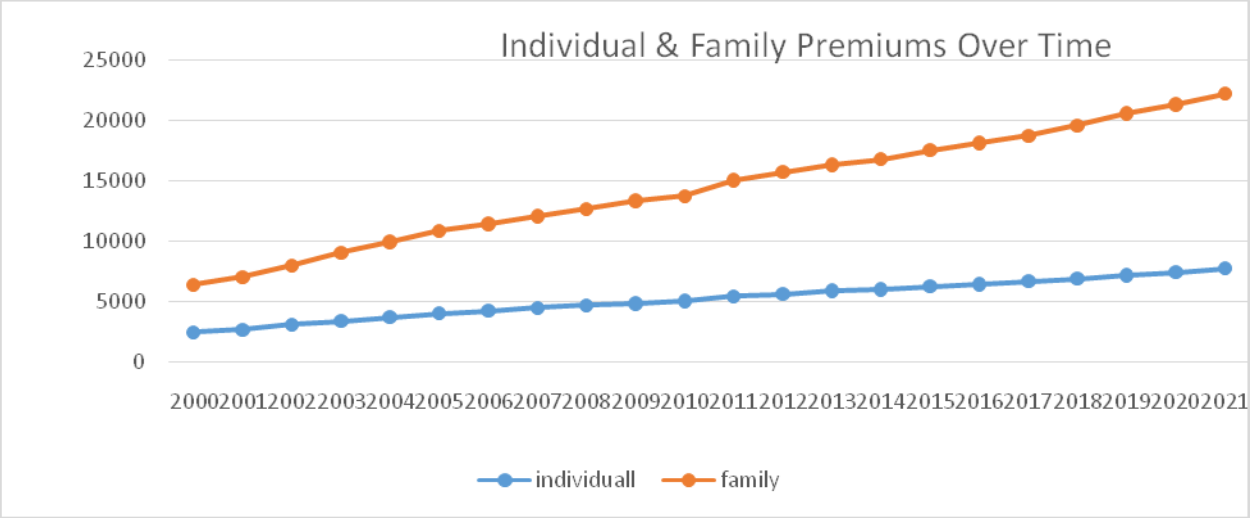
The provision of employee healthcare is expensive. KFF (2021) reports that in 2021, the average annual USA healthcare premium for individual employees was about $8000. For a family insurance package, the average annual price was about $22,000. Tracing these costs from 2000 forward, KFF (2021) reported that healthcare insurance costs increase by 10-11% on an annual basis, with minimal deviations from that trend. These data, obtained from the KFF report, are presented in the figure below. There is nothing to suggest that this 21 year trend will improve over the next 5-10 years.



Contrasting with the 10-11% increase in health insurance premiums, national expenditures for IDD (Braddock, Hemp, Tanis, Wu, & Haffer, 2017), have increased an average of 8% per year since 1977. Perhaps the 2% differentiation between health care premiums and revenue could be handled, but it must be recognized that the IDD system has increased its residential census by 6% per year over the same time period (Braddock, Hemp, Tanis, Wu, & Haffer, 2017), effectively making the absolute increase in funding just 2%. These data suggest an unsustainable situation.

2.0 Discussion

If a small business was faced with this level of annual insurance increase, it would probably have to raise their prices to cover the increased expense. This is not an option for intellectual disability/autism providers because they do not control their prices; prices are typically set by the purchaser of services and supports (i.e., the government). Instead, providers must search for less expensive means with which to insure their employees. One such approach would be the adoption of self-insurance with reference based pricing rather than a continuation of purchasing insurance through insurance agencies. Let us consider traditional forms of employee health insurance and referenced based pricing for employee healthcare.

The traditional approach to providing employee health insurance involves purchasing an insurance policy through a broker. The employer then typically pays a per employee fee for that

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insurance. The insurance company, in turn, negotiates a price with health care providers and pays that rate for healthcare services rendered. In reference based pricing, a third party administrator pays a rate based on some already established reference price. This reference is usually the Medicare rate, with the third party administrator paying the Medicare rate plus some additional percentage.

There are two major differences between the approaches. The first difference has to do with transparency. Under reference based pricing, the prices of healthcare services are transparent and clearly established, while the traditional approach relies on back room negotiation. The second major difference has to do with what is called the 80/20 rule (sanabenefits, undated). Under the Affordable Care Act (healthcare.gov, undated), insurance companies must pay 80% of their premiums for the provision of actual healthcare Operational support and profit come from the remaining 20%. An unintended consequence of this rule is that the easiest way for an insurance company to increase its profit margin is to support their contracted providers' increase in billing practices, raising the total cost of care, and making their 20% far more profitable. Evidence of this practice is inferred from the report that inpatient and outpatient costs have been rising 15-25% while provider costs have remained flat (Statista, undated). This would appear to be a significant conflict of interest, although perhaps mitigated somewhat by the need to remain competitive with other insurance companies.

To compare reference based pricing approach with the more traditional healthcare insurance approach, consider the example of knee replacement surgery. An individual without any form of healthcare insurance might anticipate costs in the neighborhood of $60,000 for the operation. Most insurance companies will have negotiated this price down to approximately $30,000. Medicare pays about $10,000. If reference based pricing uses Medicare plus 50%, it would pay $15,000 for the same surgery, a savings of approximately $15,000 on a single case. It should also be noted that for many hospitals, Medicare is the top payer, followed by the aggregate of all other payers. These hospital systems accept $10,000 as full payment for that knee replacement more often than they receive $30,000. They rarely receive the $60,000 figure.

Clearly, reference based pricing has the potential to save considerable financial resources for employers. In addition, it introduces transparency to healthcare costs, and it bypasses the profit incentive for insurance companies, replacing it with a Third Party Administrator fee. This Third Party Administrator fee is usually less than 4%, considerably less than the 20% administrative fee allowed under ACA.

Despite the clear advantages, reference based pricing is not without risks. Consider the following:

- Doctors/hospitals can bill for the difference between their charge and the reference based payment. This does not appear to be a significant problem at this time, but challenges may emerge if reference based pricing takes on a larger portion of the market. This problem can be addressed by paying either Medicare plus a percentage or by paying a percentage above the facility's reported cost to charge ratio.

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- It is not clear that Medicare fully covers the cost of all procedures. This has been one of the arguments against Medicare for all plans. Will Medicare plus a percentage sufficiently compensate health care providers?
- Healthcare providers may elect to not accept Reference Based Pricing. It should be noted, however, that most healthcare providers do accept Medicare, and reference based pricing typically pays the Medicare rate plus some additional percentage.

Does it Work? - Empirical research on reference based pricing has been limited and generally focused on a small number of discrete healthcare services, however, Jackson, Novak, and Ucello (2018), in an analysis for the American Academy of Actuaries estimated the potential for savings to be significant. Zhang, Cowling, & Facer (2017) reported that the adoption of a reference based pricing approach was responsible for a 27% reduction in costs for knee/hip replacements in comparison with traditional approaches. Both absolute medication costs (Schneeweiss, Soumerai, Glynn, Maclure, Dormuth, & Walker, 2002) and rate of growth in medication costs (Narine, Senathirajah & Smith, 1999) were reported to decline under a reference based pricing model.

In Pennsylvania (United States), a large healthcare organization offering a continuum of care for people with various disabilities and challenges instituted a self-insurance model using reference based pricing for its over 2000 employees. Data collected (Homestead, undated) suggest a savings of approximately $950 per employee per year. This was almost a $2 million saving that was diverted into increased pay and enhanced benefits for the employees. It has been estimated that there are over 55,000 Direct Support Professionals working in Pennsylvania's intellectual disability/autism system. If reference based pricing performed in a similar manner across these 55,000 employees, annual savings in excess of $52 million would be accrued.

Whose Ox Gets Gored? - Reference based pricing has demonstrated the ability to save money for employers. These savings, in turn, can be used to help address issues related to the ongoing workforce crisis. Employees may benefit in terms of increased compensation packages, but there appears to be a distant threat of being required to pay additional charges imposed by healthcare providers. Healthcare providers will make more money than received for Medicare patients, but less money than received from individuals with traditional forms of health insurance. One might anticipate some form of resistance should the reference based pricing approach become a significant funder of healthcare services. On the other hand, it seems likely that healthcare providers will save money because of enhanced speed of payment, reduced paperwork, and fewer payment denials. Obviously, the insurance companies will have the greatest risk from reference based pricing, losing market share and the profit associated with that market share. One would to wise to anticipate considerable resistance to any large scale shifts toward reference based pricing from any parties with vested interests in the existing model.

Conflict Statement: Dr. Spreat is involved in the administration of a program that provides supports and services to people with disabilities. Mr. Buchanan is involved in the development and provision of employee benefit plans, including reference based priced models.

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