MEEKO HEALTH'S:

Cost Containment Strategies Guide

Approaches to Managing Healthcare Costs and Improving Employee Outcomes in the Modern Benefits Landscape

Meeko Health

Reference Based Pricing 101

What is Reference Based Pricing?

Reference Based Pricing (RBP) is a healthcare cost containment strategy that establishes payment for medical services based on an objective, transparent pricing benchmark rather than arbitrary hospital chargemaster rates. Instead of accepting traditional network discounts off inflated prices, RBP uses a defined reference point—typically Medicare rates plus a percentage—to determine fair payment for services.

Why is RBP needed?

Reference Based Pricing helps ensure that employers aren't charged inflated prices for common procedures.

What you need to know about RBP

Reference Based Pricing is effective when patients can make informed comparisons for procedures and aren't adversely impacted financially. For RBP to be successful the following conditions must be met:

- **Shoppable Procedures**: The patient has the time and ability to compare on price and performance.
- **Measurable Quality**: The procedure is reasonably standardized (labs, colonoscopy, etc...) or it can easily be compared (cataract removal, joint replacement, etc...).
- **Awareness**: Initiatives must be in place to point patients toward low-price and high-quality procedures and providers.
- **Out-of-Pocket Cost**: Patients don't have to pay more out of pocket.

Reference Based Pricing is not good for emergency services or a complex treatment plan because the patient doesn't have the time or ability to compare on price and performance.

Interested in implementing Reference Based Pricing?

Learn how Meeko Health empowers organizations to reduce healthcare cost with Reference Based Pricing. Contact Us

KEY BENEFIT

20% savings on common procedures compared to a traditional PPO arrangement.

(Reference Pricing Changes The 'Choice Architecture' Of Health Care For Consumers)

EXAMPLE

In traditional healthcare pricing models, hospitals and providers often start with their "chargemaster" rates, which are essentially their list prices for services. These chargemaster rates are typically highly inflated - sometimes 300-800% above actual costs - with the understanding that no one actually pays these rates.

Insurance carriers then negotiate "discounts" off these inflated prices, often advertising things like "we secured a 50% discount!" However, a 50% discount off an artificially inflated price may still result in a payment that's much higher than what's reasonable or what the service actually costs.

Example procedure:
- $10,000 Artifically inflated hospital chargemaster rate
- 50% Traditional PPO network discount
- $5,000 Final paid amount

This appears to be a good deal because of the "50% discount," but the actual cost of providing the service might only be $2,000.

RBP takes a fundamentally different approach by ignoring these inflated chargemaster rates entirely. Instead, it uses Medicare rates (which are generally based on the actual cost of providing services plus a small margin) as the reference point, and then pays a fair percentage above that (typically 140-180% of Medicare).

So in the same scenario with RBP:
- $2200 Medicare rate for the procedure
- $3520 Final paid amount (160% of Medicare)
- $1,480 Actual savings compared to PPO network (30%)

High-Performance Networks 101

What is a High-Performance Network?

High-Performance Networks (HPNs) are healthcare cost containment strategies that selectively contract with providers who demonstrate superior clinical outcomes and cost efficiency. Unlike traditional broad networks, HPNs include only providers who meet specific quality and cost benchmarks, creating a narrower but higher-value network of hospitals, physicians, and other healthcare services.

Why are HPNs needed?

High-Performance Networks help employers avoid unnecessary spending by connecting employees with providers who consistently deliver quality care at reasonable costs.

What you need to know about HPNs

High-Performance Networks are effective when properly implemented with strong provider partnerships and appropriate plan design. For HPNs to be successful they need:

- **Sophisticated Data Analytics**: Provider selection must be based on rigorous quality and cost metrics rather than arbitrary factors or network size.
- **Balanced Geographic Access**: Network must maintain adequate access to care across required specialties and locations.
- **Member Education**: Employees need clear communication about network benefits, provider options, and the rationale behind the narrower network.
- **Financial Incentives**: Plan design should include meaningful incentives for using in-network providers, such as lower copays or coinsurance.

High-Performance Networks are not ideal for organizations with widely dispersed employees in rural areas or for specialized care where options are limited.

Interested in implementing HPNs?

Learn how Meeko Health empowers organizations to reduce healthcare costs with carefully curated High-Performance Networks. Contact Us

KEY BENEFIT

36% cost savings for members enrolled in a High Performance Network plan

(Commonwealth of Masschusetts Group Insurance HPN enrollees)

EXAMPLE

In traditional networks, insurers contract with many providers without considering cost or quality differences.

Traditional broad networks generally include:
- Providers with widely varying costs for identical services
- Significant quality differences between in-network providers
- Limited incentive for providers to improve value

Example scenario with a traditional broad network:
- $10,000 Average knee replacement cost
- Wide variation in quality outcomes (infection rates, re-admissions, etc...)
- $10,000 Final paid amount + indirect costs

This offers broad access but with high costs and inconsistent quality.

HPNs take a fundamentally different approach by carefully evaluating providers on both quality and cost metrics. They only include those meeting specific performance thresholds, then incentivize members to use these high-value providers.

Same scenario with HPN:
- $7,500 Average knee replacement cost
- Better quality outcomes (fewer complications)
- $7,500 Final paid amount
- $2,500 Actual savings (25%)
- Additional indirect savings from improved outcomes

Transparent PBM Pricing 101

What is Transparent PBM Pricing?

Transparent Pricing with Pharmacy Benefit Managers (PBMs) is a healthcare cost containment strategy that eliminates hidden fees, spread pricing, and undisclosed rebates in prescription drug programs. Unlike traditional PBM models, transparent PBMs disclose all revenue sources, pass through 100% of manufacturer rebates, and charge a flat administrative fee for services, creating complete visibility into prescription drug costs and eliminating conflicts of interest.

Why Transparent PBM Pricing needed?

Transparent Pricing with PBMs helps ensure that employers aren't paying hidden markups or losing manufacturer rebates that should be used to offset prescription drug costs.

What you need to know about Transparent PBM Pricing

Transparent PBM arrangements are effective when properly structured with clear contract terms and ongoing oversight. For transparent pricing to be successful the following conditions must be met:

- **Full Contract Transparency**: PBM contracts must explicitly prohibit spread pricing, clarify all revenue sources, and guarantee pass-through of all rebates and discounts.
- **Independent Auditing**: Employers need rights to conduct regular, detailed audits of claims data, rebate contracts, and network reimbursements.
- **Fiduciary Responsibility**: The PBM should contractually agree to act as a fiduciary, putting the employer's financial interests first in all negotiations and formulary decisions.
- **Data Ownership**: Employers must maintain ownership of their prescription claims data to enable independent analysis and program optimization.

Interested in making your PBM arrangement transparent?

Learn how Meeko Health empowers organizations to reduce prescription drug costs with Transparent PBM arrangements. Contact Us

KEY BENEFIT

20% savings on prescription drugs by using a transparent PBM

(Alliance of Community Health Plans)

EXAMPLE

In traditional PBM models, the PBM often generates revenue in multiple ways that aren't visible to employers:

- Spread pricing between what they charge employers and pay pharmacies
- Manufacturer rebates that aren't fully disclosed or passed through
- Administrative fees from pharmacies and drug manufacturers

Example scenario with a traditional PBM:

- $100 Employer charged for a prescription
- $70 PBM pays to the pharmacy
- $30 Spread kept by the PBM
- $20 Manufacturer rebate (only $5 passed to employer)
- $95 Final employer cost after partial rebate
- $45 Hidden revenue for the PBM

This appears to offer prescription coverage, but with significant hidden costs that inflate premiums.

Transparent PBMs take a fundamentally different approach by eliminating all hidden revenue sources and operating on a clear, flat administrative fee.

Same scenario with a Transparent PBM:

- $70 Employer charged for a prescription (true cost)
- $70 PBM pays to the pharmacy (no spread)
- $20 Manufacturer rebate (100% passed to employer)
- $50 Final employer cost after full rebate + $3 Administrative fee (transparent and pre-negotiated)
- $42 Actual savings compared to traditional PBM (47%)

Value Based Care Models 101

What are Value Based Care Models?

Value-Based Care Models (VBCMs) are healthcare cost containment strategies that align provider payment with patient outcomes rather than service volume. Unlike traditional fee-for-service approaches, VBCMs tie reimbursement to quality measures, patient experience, and cost efficiency, creating incentives for providers to deliver high-quality care, reduce unnecessary services, and better manage chronic conditions.

Why are VBCMs needed?

Value-Based Care Models help employers avoid the misaligned incentives of fee-for-service healthcare, which rewards volume over patient outcomes.

What you need to know about VBCMs

Value-Based Care Models are effective when properly structured with meaningful quality metrics and appropriate risk-sharing. For VBCMs to be successful the following conditions must be met:

- **Robust Data Infrastructure**: Requires comprehensive data collection and analytics to accurately measure quality outcomes and cost efficiency.
- **Provider Readiness**: Providers must have the clinical integration, team-based care approaches, and technology to succeed in value-based arrangements.
- **Meaningful Metrics**: Quality measures must be clinically meaningful, evidence-based, and focused on outcomes that matter to patients.
- **Balanced Risk-Sharing**: Financial models should share risk appropriately between employers and providers, with risk levels matching provider capabilities.

VBCMs are not ideal for episodic or emergency care where patient outcomes are unpredictable or dependent on factors outside provider control.

Interested in exploring a Value Based Care Model?

Learn how Meeko Health empowers organizations to reduce healthcare costs with carefully designed Value-Based Care arrangements. Contact Us

KEY BENEFIT

26% reduction in medical costs for patients participating in a VBC plan compared to those on a traditional fee-for-service plan.

(Humana: Value Based Care Report)

EXAMPLE

In traditional fee-for-service models, providers earn more by delivering more services regardless of outcomes:

- Revenue increases with service volume
- No penalties for complications or poor outcomes
- Fragmented care with minimal coordination
- Redundant services and inefficiencies

Example with fee-for-service diabetes care:

- $450 Quarterly visits
- $1,200 Lab tests
- $2,800 Specialist referrals
- $4,300 ER visits (preventable)
- $8,750 Total annual cost
- Poor disease management outcomes

This system treats illness rather than promoting health, with continually rising costs. Value-Based Care Models instead align payment with meaningful outcomes.

Same scenario with VBCM for diabetes:

- $6,000 Annual care budget per patient
- Performance bonuses for:
  - A1C control
  - Fewer hospitalizations
  - Patient satisfaction
  - Preventive care
- $6,750 Total cost (with bonuses)
- $2,000 Savings (23%)
- Better outcomes with improved disease management
- Additional indirect savings from reduced absenteeism and disability