

## **Buyer Beware: Medicare Cost Plus**

As employers continue to explore alternative approaches towards reining in health care expenses, a handful of municipalities are considering Medicare Cost Plus (MCP) arrangements. Under the MCP approach, a municipality with a self-funded plan elects not to use a PPO network to obtain discounts from health care providers. Rather, the municipality sets its own price for medical procedures that is slightly higher than the amount that Medicare would pay for the same procedure.

At first blush, the MCP model is enticing – it has the potential to reduce health care costs for a municipality. However, all municipalities need to understand the political and legal risks associated with the MCP approach.

Here are the questions that all municipalities should ask when considering the MCP model:

### **1. Will our employees be balance billed by the health care providers?**

Under a traditional PPO network, employees are not balance billed when they use the services of an in-network medical provider. Each medical provider contractually agrees to accept the network reimbursement amounts when the medical provider enters into the network.

Conversely, under the MCP approach, there is not a contract. The medical providers are not obligated to accept the reimbursement as full payment for the services rendered. In some cases, the medical providers will accept the amount of the payment and move on. However, in a majority of situations, the medical providers will simply treat the MCP reimbursement as a partial payment and will seek recovery of the remainder from the patient.

Note that, under the MCP approach, there are not network discounts. Accordingly, full billed charges, minus any MCP payment, fall on the shoulders of the patient.

### **2. How will our employees respond to the MCP model?**

If the MCP model is successful in your community, it is likely that your employees will be pleased with potentially lower future increases. However, if the MCP model is not successful, employee discontent is likely to be high. As noted above, patients will be balance billed by medical providers when a municipality decides to use the MCP strategy. It is possible that the companies providing the MCP model may be able to negotiate and resolve the balance bills, but, if not, then the patients will be turned over to a collections company and may eventually face a lawsuit.

### **3. How will our community hospital partners respond to the MCP model?**

Very few, if any, Indiana community hospitals will accept payments under a MCP arrangement as full payment for services provided. Accordingly, in these situations, the

patients will be balance billed for the remainder of billed charges. Attached [here](#) are letters from Community Health Network, Franciscan Alliance, IU Health, St. Vincent Health & St. Vincent Medical Group, and the Suburban Health Organization that indicate that none of these organizations will accept the MCP model.

**4. Is the MCP approach permissible under federal law?**

The Departments of Labor, Health, and Human Services recently issued guidance on reference-based pricing, a variation of MCP. The federal guidance acknowledged concerns that reference-based pricing “may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers.” Specifically, because patients may be balance billed for services under reference-based pricing arrangements, these balance bills may violate the cost-sharing limits under the Affordable Care Act.

It is important to closely examine MCP and other reference-based pricing arrangements. The consequences may be significant if all community shareholders (elected officials, municipal employees and community hospitals) are not fully aligned on these issues.

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