WellRithms™

LEVELING THE PAYING FIELD

2024 PRESS KIT

WELCOME TO THE WELLRITHMS PRESS KIT

Our press kit includes:

1. **Company overview** articulates our vision, brand promise and identifies key market differentiators

2. **Press Releases** on recent newsworthy announcements

3. **White Papers** recently published

4. **Blogs** covering industry news

5. **Multimedia Assets** including hi-resolution logos

6. **Contact information** including mailing address, e-mail addresses of company media contacts, social media handles and other easy-to-access information

COMPANY OVERVIEW

NAME: WellRithms

FOUNDED: 2016

CEO: Merrit Quarum, MD

VISION STATEMENT: Boldly transforming a broken system for the benefit of all.

BRAND PROMISE: Level the Paying Field™.

ABOUT WELLRITHMS

WellRithms saves money for health plan sponsors by Leveling the Paying Field™ between healthcare purchasers and providers. The company serves group health and workers' compensation payors who seek the most advanced medical bill review system available, the most precise repricing, and unsurpassed plan savings. WellRithms Shield Indemnification™, backed by our insurance captive, sets WellRithms apart by transferring full financial liability from the payor and participant to WellRithms, rendering balance billing tactics, collections, and pressures to overpay ineffective and unenforceable. Visit www.wellrithms.com.

WellRithms has been recognized in the top quartile of the Inc.-5000 Fastest Growth Companies in the U.S., 2021, 2022, and 2023. The Portland, OR Business Journal has recognized WellRithms as the only company among the 10 fastest growing companies in Oregon for 2021, 2022, and 2023.

KEY OFFERINGS

GROUP HEALTH

- In-Network Claims Review
- Itemized Inpatient Bill Review
- Out-of-network Review & Repricing
- Air & Ground Ambulance Review & Repricing

WORKERS' COMPENSATION

- UCR Repricing
- Stop Loss Outlier Inpatient Physician Review
- Air & Ground Ambulance Review & Repricing
- Complex Clinical Edits and Physician Review

SHIELD INDEMNIFICATION

- Group Health Claims
- Workers' Compensation

VALUE PROPOSITION AND KEY DIFFERENTIATORS

U.S. health care purchasers desperately need help containing costs.

- Health insurance premiums in **2023 average $23,968 for family coverage, up 7% this year and 47% from 2013.**
- Million-dollar claims **rose 45% from 2019 to 2022.**
- Nearly one third of employer health plans in 2019 **reported a claim exceeding $1 million.**

WellRithms helps purchasers by "scrubbing" bills for abuses and repricing them. The company operates on a shared-savings pricing model in which groups pay only a percentage of what we save them.

This includes the option to have WellRithms assume 100% of the financial risk of disputed, high-cost claims by indemnifying the client. WellRithms is alone in offering this option, and it is being recognized as a compelling differentiator.

OUR PROPRIETARY BILL REVIEW SYSTEM IS MEDICALLY ACCURATE, TECHNICALLY SCALABLE, MARKET TRANSCENDENT, AND LEGALLY DEFENSIBLE. COMPETITIVE DISTINCTIONS INCLUDE:

1. **We serve workers' compensation and group plans,** while competitors typically serve only the group or workers compensation market.

2. **We review and reprice bills prior to payment,** while many competitors seek to claw back overpayments by a plan after they have paid a claim.

3. **We review bills line-by-line, and base our reimbursements on actual provider costs,** while providing a fair profit, making them strongly defensible if litigated.

4. **We maintain a proprietary cost database for every U.S. hospital, grounding our reimbursements in crucial data.** We and our clients do not negotiate payments based upon obsolete Reference Based Pricing methods, which leave payors at a disadvantage.

5. **We use physicians and surgeons to review high-cost flagged items,** not nurses, billing, or coding personnel. Our physicians have a deeper understanding of medical procedures, and do not buckle under pushback from hospitals and surgeons.

6. **We can fully indemnify clients through our own captive, to guarantee our pricing.** Our rigor allows us to do this with full confidence. Our work has been pressure tested in courtrooms across America and the courts continue to rule that our reimbursement methodology is fair and reasonable.

BRIEF BIOGRAPHIES OF KEY LEADERS

Merrit Quarum, MD, CEO & Founder. Founding CEO of Qmedtrix, successful 2016 exit with sale to Mitchell Int'l / KKR. Growth and sale of Columbia Medical Consultants, 2012. Serves as visionary guiding company / product strategy, sales.

Anna Quarum, President & Co-Founder. General business background, successful launch of insurance captive, medical chaplaincy, educator. Accountable for guiding several rapidly growing parts of the company including compliance issues, administrative functions, HR, Audxguard.

Ira Weintraub, MD, CMO. Orthopedic surgeon for 38 years, founder of successful surgery center. Leads clinical bill review team of physicians and surgeons.

Meghan Cerotsky, CPA, CFO. 12 years finance, accounting, auditing experience in health care and public accounting. Provides stewardship over finances and reporting.

Glen Pitruzello, COO. 30 years in workers compensation including A.I.M. Mutual, The Hartford, AmTrust. Manages day-to-day operations and business functions.

Bill Mattecheck, Chief Sales Officer, National Director of Broker Relations. 45 years health benefits industry experience. Former owner of benefits brokerage. Builds relationships with broker channel and leads sales team.

Kelvin Yip, Chief Data Scientist. 20 years in strategy, insights, and product management. Responsible for leveraging data to inform strategic decisions and foster digital transformation.

Matthew Jacobs, Chief Business Development Officer. 15+ years in health care strategy, product development, cost containment across insurance markets.

Ron Saxton, JD, Executive Board Chair. Past EVP, General Counsel of PeaceHealth. Former partner at Schwabe, Williamson & Wyatt. EVP and CAO, JELD-WYN. Leads governance, company fund raising.

Jeff Jahnke, VP and Director, Bill Review. 28 years in healthcare, managed care, bill review. Past executive director, Bunch & Associates. Oversees growing bill review team.

Kevin Renner, Chief Marketing Officer. Marketing and product leadership across 8 Inc.5000 and 3 global public companies. Manages brand, go-to-market strategy and execution.

PRESS RELEASES

Media:
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WellRithms, Pioneer in Payment Integrity, Joins Industry Leaders at SIIA Healthcare Price Transparency Forum

PORTLAND, Ore. – February 13, 2024 – WellRithms, the industry leading payment integrity firm, today announces its attendance at the upcoming SIIA Healthcare Price Transparency Forum, February 26-27, 2024, in Charlotte, NC. Bringing together self-insured employers, plan sponsors, TPAs, benefits consultants, captives, stop loss companies and insurance carriers, the Forum provides an ideal setting for WellRithms to demonstrate its commitment to transparent and fair healthcare reimbursement.

"As a SIIA member, WellRithms is dedicated to transforming healthcare pricing transparency and reducing the cost of care for group health and workers' compensation payors," says Anna Quarum, WellRithms COO, who invites attendees to meet personally at the Forum. "Our unique approach to bill review and repricing is led by experienced physicians and surgeons – not simply coders or ancillary personnel – who are powered by proven algorithms, extensive data and AI."

She points to another key WellRithms differentiator: Shield Indemnification™, which is backed by a captive insurance company and transfers all legal and financial liability from the payor to WellRithms. "Fully shielding payors through risk transfer, WellRithms guarantees the recommended payment amount, protecting carriers, plans and members from litigation expenses and balance billing tactics," she adds.

Savannah Quarum, managing director of Audxguard, a health plan compliance consultancy and WellRithms subsidiary, also will be attending. "As pricing transparency takes center stage in policy and regulatory discussions," she notes, "WellRithms and AudxGuard are at the forefront, providing tailored solutions that meet market expectations for cost savings. Our commitment aligns seamlessly with the theme of the Forum, where industry leaders converge to address the challenges and opportunities in the evolving landscape of healthcare pricing transparency."

To arrange a meeting with WellRithms or Audxguard during the Forum, contact aquarum@wellrithms.com or squarum@audxguard.com.

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WellRithms Subsidiary, Audxguard, Verifies Gag-Clause Prohibition Compliance for Health Plans

PORTLAND, Ore. – March 12, 2024 – WellRithms, the industry leading payment integrity firm, today announces the launch of Audxguard, a medical claims review service and wholly owned subsidiary developed around the growing demand for transparent pricing within the healthcare industry.

“Leveraging the robust infrastructure and data analytics prowess of WellRithms, Audxguard specializes in aiding health plans to navigate the complex landscape of payment terms and regulatory compliance,” says Savannah Quarum, managing director, Audxguard. “With the emerging data transparency landscape, health plan sponsors are now entrusted with the responsibility of understanding and managing their data effectively.”

Since December 2020, the Consolidated Appropriations Act (CAA) has mandated that ERISA health plans cannot be in contractual agreements that include gag clauses, effectively codifying plans’ unrestricted access to their claims data. Failure to comply with the CAA, which mandates annual affirmation, can lead to significant fines and legal consequences, including breach of fiduciary duty.

Audxguard stands at the forefront of facilitating compliance with these regulations offering a suite of services aimed at safeguarding health plans from regulatory pitfalls. Its historical medical claims review product, Audx-C, employs proprietary technology and rule engines to detect overpayments and billing discrepancies, thereby assisting plans in adhering to correct billing and coding standards.

“In today's evolving healthcare landscape, transparency and compliance are paramount,” explains Merrit Quarum, M.D., CEO, WellRithms. “By ensuring compliance with regulatory standards and promoting transparency in billing practices, Audxguard reinforces our mission of Leveling the Paying Field™ for all stakeholders in healthcare.”

Savannah Quarum adds, "Our mission extends beyond mere compliance-- it endeavors to uphold the duties of health plan fiduciaries by ensuring transparency, protecting against financial liabilities and

prioritizing the interests of plan participants. The Audxguard team is committed to ensuring that every aspect of healthcare management is conducted with integrity and accountability."

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About Audxguard
Audxguard, a WellRithms wholly owned subsidiary, is a medical claims review service uncovering overpayments, waste and potential fraud in how claims have been paid. The company delivers savings and helps plans step into proactive compliance by verifying gag-clause prohibition compliance, protecting health plans from DOL fines and legal liability, eliminating doubt about provider performance and prioritizing members by protecting the plan. Visit https://www.audxguard.com.

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WellRithms Publishes E-Book Exposing Abusive Medical Billing Practices

PORTLAND, Ore. – March 19, 2024 – Three industry veterans with WellRithms-- a surgeon, a benefits broker, and a former health care manager -- have pulled back the curtain on systematic billing abuses in the company's latest e-book, "An Insider's Guide to Medical Overbilling, and How to Protect Your Group Plan."

"Our mission in publishing this e-book is to help shield more health plan sponsors from these outrageous practices by offering a unique blend of the market's most advanced payment-integrity capabilities and medical expertise to best decipher egregious billing," says Ira Weintraub, M.D., WellRithms' Chief Medical Officer and one of the authors.

The publication exposes common abuses in hospital and physician billing that cost a typical union or employer health benefit plan millions of dollars every year. Moreover, 62% of the two million personal bankruptcies filed each year are the result of medical debt, according to the American Bankruptcy Institute.

The e-book details 10 case studies of egregious billing practices that turn common procedures into episodes costing more than $100,000 – offering guidance on how to fight back and pay only what's fair. JAMA Open Network research estimates that medical pricing irregularities, fraud and abuse cost between $289 billion and $324 billion per year, or more than three times the entire budget of the state of Florida.

"In the realm of healthcare billing, it's essential to distinguish between legitimate costs and those inflated beyond reason," Dr. Weintraub continues. "Our team's surgical experience is crucial in differentiating between genuine complexity and falsified complexity when we review bills line by line."

Billing gimmicks that are usually overlooked by health insurers can quickly generate a mountain of overpayments by patients, unions, and employers. After reviewing and repricing bills, WellRithms

typically finds savings of 70% or more while ensuring that providers still earn a fair profit.

“Just as the past decade created a need for protection from online data breaches, identity theft and ransomware, the prevalence of medical overbilling has paved the way for the unique medical bill review and repricing that WellRithms performs,” concludes Dr. Weintraub. “As this guide documents, WellRithms provides health plan sponsors a comprehensive, legally defensible protection that is second to none.”

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WellRithms Publishes White Paper Exposing Flaws in Reference-Based Pricing and Introduces Superior Alternative

PORTLAND, Ore. – April 9, 2024 – WellRithms, the industry leading payment integrity firm, today released a provocative white paper, revealing the startling, inherent flaws of reference-based pricing (RBP) and introducing Sustainable Claims Pricing™ (SCP) as a superior alternative. *"Why Reference-Based Pricing has been Leapfrogged"* unwraps the failures of RBP to deliver on its promise for transparent and predictable healthcare costs.

"Once hailed as a viable market solution for providing fair-market value for medical services, RBP has not only proven to be unsustainable and ineffective, it has also resulted in inconsistencies, underpayments and regional complexities that hinder provider negotiations," says Ira Weintraub, M.D., CMO, WellRithms. "Readers will discover the inherent weaknesses in RBP's arbitrary methodology, understand why RBP has fallen short of its initial promise and learn how it has become a source of friction, litigation and dissatisfaction among both payors and providers."

Recognizing the urgent need for a more effective approach, WellRithms developed SCP to address these shortcomings and deliver greater payment integrity. SCP utilizes a proprietary medical pricing database to reprice medical bills line-by-line, incorporating factors such as hospital cost-to-charge ratios, geographical cost variations and inflationary adjustments. By leveraging the expertise of physicians and surgeons – not simply coders or ancillary personnel – the WellRithms proprietary SCP ensures precision in claims payment accuracy, prevents overbilling and eliminates fraud, waste and abuse.

"SCP offers payors a solution that guarantees savings while promoting transparency and reducing the risk of litigation," continues Dr. Weintraub. "This white paper advances greater appreciation of the historical roots of RBP, its limitations and the evolving landscape of healthcare payment strategies. Detailed analyses and case studies shed light on the challenges facing self-insured plan sponsors and explore the pressing need for a more sustainable, equitable reimbursement model."

About WellRithms

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WellRithms Publishes Groundbreaking White Paper: The Wait is Over - Guaranteed Protection from Balance Billing

PORTLAND, Ore. – May 9, 2024 – WellRithms, the industry leading payment integrity firm, today released a white paper revealing the ongoing challenges of balance billing in healthcare and introducing a revolutionary captive solution to shield health plan sponsors and members from financial liability. "The Wait is Over: Guaranteed Protection from Balance Billing" unpacks the attributes of a first-of-its-kind captive insurance for group health and workers' compensation plans that is designed to transfer the risk exposure for excessive claims away from payors and members.

"WellRithms' Shield Indemnification™, backed by AMI Indemnity, sets in place a legally defensible strategy to reprice individual medical bills and fully absorb that risk," says Ira Weintraub, M.D., CMO, WellRithms. "Readers will learn the incredible value of guaranteed protection from balance billing, relieving payors and patients from the clutches of collection agencies and relentless harassment."

While captives have long been used for managing risk in various industries, traditional captives do not effectively manage the risk of individual medical bills, leaving payors and patients vulnerable to balance billing. Attempts at indemnification against egregious billing practices, such as Contractor Liability Insurance Programs (CLIPs) and reference-based pricing (RBP), fall short in protecting payors and members from financial liability.

"WellRithms substantially raises the bar on precision by layering Shield Indemnification™ on top of its proprietary repricing system, Sustainable Claims Pricing™," continues Dr. Weintraub. "This methodology ensures claims payment accuracy by repricing medical bills line-by-line based upon various factors, including hospital cost-to-charge ratios, geographical cost variations and inflationary adjustments."

WellRithms is the only payment integrity solution that successfully tackles the ongoing tug of war between payors and providers, extracting patients from the crosshairs of provider attempts to increase reimbursements for medical services, ensuring that providers have been paid appropriately.

Download the white paper here.

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WHITE PAPERS

WHY $$$$$$$$$ → $ REFERENCE-BASED PRICING HAS BEEN LEAPFROGGED

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Winter / 2024

Despite the best of intentions, RBP (reference-based pricing) is inherently flawed and not a sustainable solution. But a meaningful replacement that avoids RBP limitations and represents greater payment integrity is available.

Sustainable Claims Pricing™ reprices with greater accuracy and transparency, reducing the threat of litigation and eliminating balance bills along the way to indemnifying health plan sponsors and participants from financial and legal liability.

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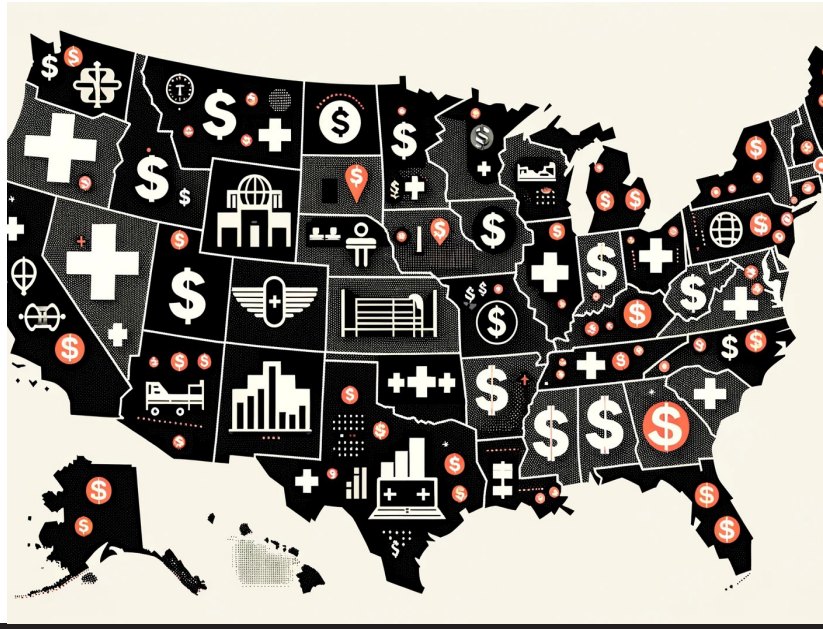
INTRODUCTION

With roughly 7,900 hospitals across the U.S., each with approximately 900 revenue codes that fit into about 30 revenue centers, group health plans need deep expertise to procure accurate prices on costly medical procedures for their members. One such strategy involves RBP.



What is RBP?

Under this approach, self-insured health plans establish a reference price for medical procedures, usually a multiplier of Medicare reimbursement in the 140% to 180% range, to keep their costs affordable and predictable. The reference price serves as an alternative to discounts from billed charges that traditional networks use to price claims based on usual, customary, and reasonable (UCR) pricing in their particular market.[1]

RBP may be offered in conjunction with a traditional PPO network or replace it entirely, frequently promoting usage of medical services "with or without a network." Claims reimbursement is occasionally negotiated with providers before services are rendered.

In other cases, a third-party administrator (TPA) or other vendor acting on behalf of an employer pays a set price for each service. The problem, of course, is that if a hospital or provider isn't satisfied with the payment, they can bill the patient for any unpaid portion of the claim – a practice known as balance billing. Most payors use RBP for out-of-network emergency and laboratory claims, while self-insured health plans regulated under the Employee Retirement Income Security Act are allowed to use RBP as a comprehensive payment strategy.[2]

HISTORY

RBP's roots can be traced to 2011 when the California Public Employees' Retirement System (CalPERS) sought to reduce the cost of hip and knee replacements. What prompted this bold move was a seven-fold difference in price for these procedures without any correlation to quality of care. CalPERS identified 46 hospitals statewide that were willing to accept a reference price of $30,000 or less, with health plan members that selected a higher-cost hospital paying the difference out-of-pocket. Several hospitals that charged more than that amount later voluntarily renegotiated their contracts to win the favor of what was then called reference-based "benefits."

Another variation of the model took shape in 2016 when the Montana State Employee Health Plan renegotiated hospital contracts by tying payment amounts to a multiple not exceeding 230% of Medicare rates. With strength in numbers (i.e. 33,000 covered members), Montana made an offer that every hospital in the state had no choice but to accept as part of an arrangement called reference-based "contracting."

North Carolina wasn't as lucky three years later when the state sought to mirror that strategy at 196% of Medicare. Now widely known as reference-based "pricing," the strategy boasts what one source cleverly described as a "reserve army of advocates and legal representatives" to negotiate on the patient's behalf until a settlement is reached or pursue litigation.[4]

Recognizing its shortcomings, an improved version of this model often referred to as RBP 2.0 sought to reduce or eliminate employee friction, litigation, and balance billing. But those efforts have fallen short of the mark.

Why RBP?

Reference-based pricing is a strategic response to the need for healthcare transparency in the face of significant price variations for medical procedures. It is an alternative to escalating costs associated with the traditional fee-for-service model, which have increased 31-fold over past four decades and 6.5 times on an inflation-adjusted basis.[3]

THE PROBLEM

While RBP allows employers more than one way to pay a medical bill without having to establish a provider network, thereby opening the marketplace, it has still failed to provide a methodology that is transparent and understandable. RBP's pure Medicare multiple is arbitrary and does not meet the definition of UCR pricing.

In short, it does not offer a fair-market value for medical services. Group plans that adopt RBP will invariably find themselves having to explain why they're willing to pay, say, 130% of Medicare instead of 142% or 152%. There's no escaping the arbitrary nature of the methodology involving these multipliers.

Medicare is an imperfect system that doesn't have an allowance for every medical procedure, making it impossible to reasonably price some claims. Other potential trouble spots may include a significant hospital stay that exceeds the typical diagnosis-related group (DRG) allowance or complex inpatient medical claims for which there is no DRG number for Medicare to reference and add a multiple. While uncommon, it is not possible to fairly price those claims.

Among its other limitations, RBP is highly inconsistent, with a tendency to underpay hospitals and overpay for laboratory services. There is also variation within hospitals, paying some areas too much and other areas too little – a pattern seen across some hospitals that have lower cost structures.

Moreover, regional acceptance or rejection of RBP complicates provider negotiations, especially for multi-state employers whose search for standardized pricing is foiled. For instance, there are many restrictive rules in Indiana, Illinois, Michigan, Missouri, California, and New Jersey that tie the hands of self-insured employers in states where Blues plans are familiar and popular among health plan members.

With providers under increasing pressure to claw back whatever reimbursement they can to make up for below-market rates, RBP creates acrimony that pits patients against providers, which results in balance billing and dissatisfaction among both parties. It is no wonder that employee friction is still an issue, with even savvy healthcare consumers lost in a confusing maze of complexity.

Legal battles persist over RBP's adversarial approach that critics dismiss as a shakedown of hospitals to procure below-market rates. In short, RBP is indefensible in court. The need for advocacy and legal assistance represents an admission that this method does not actually work. What would work far better for group plans, of course, is to offer a turnkey solution that removes payors and patients from the equation entirely, along with any friction, and indemnifies them from any financial and legal liability.

THE SOLUTION

While RBP served as an alternative to PPO discounts that employers eventually saw as inflated, the same is now true for RBP. Fortunately a far superior method has been developed: Sustainable Claims Pricing™ (SCP). SCP uses a proprietary medical pricing database to reprice medical bills line-by-line based on hospital cost-to-charge ratios reported quarterly to the Centers for Medicare & Medicaid Services, as well as geographical cost variations and quarterly inflationary adjustments from the U.S. Department of Labor.

Under the SCP approach, daily room rates are priced alongside medical services for inpatient claims. Once all these costs are determined, a profit margin is then calculated based on geography, medical inflation and other factors (i.e., adding a reasonable surcharge to manage an influx of COVID-19 cases).

WellRithms SCP, for example, utilizes the expertise of physicians and surgeons, rather than coders or administrative personnel, to manage a technically advanced bill review process. This guarantees precision in claims payment accuracy, prevents overbilling, and eliminates fraud, waste, and abuse. The only way to ensure that a medical bill is properly reviewed is to fully understand the medicine behind it. When medical professionals are the ones who scrub bills line-by-line, they are easily able to spot redundancies and items such as durable equipment that should never be separately billed or paid.

Accurate bill review and claims payment are predicated upon understanding the medicine behind the charges for medical procedures. Without that expertise, there is no true payment integrity. But paying providers fairly is also an important guiding principle of payment integrity. Hospitals appreciate having a more

thoughtful system in place and prefer engaging in constructive discussions rather than acrimonious exchanges that often mar RBP.

Between an ironclad repricing method and high level of medical expertise employed in the bill-review process, savings are actually guaranteed. SCP features the industry's only payment integrity solution bolted to a protective captive insurance program, WellRithms Shield™, which transfers risk exposure for excessive claims away from payors and members – avoiding financial and legal liability.

Relative to RBP, providers often will be paid more under SCP while health plan sponsors reap greater savings from more accurate reimbursement that prevents overbilling, promotes transparency, and reduces the chances of litigation.

CONCLUSION

At a time of rising healthcare costs and crackdown on medical pricing transparency, employers and their advisors looking for alternatives to inflated provider network discounts face a clear choice: continue rolling the dice on RBP at their own peril or adopt a defensible strategy in SCP that satisfies all major stakeholders.

Footnotes

1 "Six Common Questions About Reference-Based Pricing Answered. MultiPlan. April 27, 2022. https://www.multiplan.us/six-common-questions-about-reference-based-pricing-answered/
2 "Fact Sheet: Reference-based Pricing." American Hospital Association. https://www.aha.org/fact-sheets/2021-06-08-fact-sheet-reference-based-pricing
3 McGough, Matthew, Winger, Aubrey, Rakshit, Shameek, and Amin, Krutika. "How has U.S. spending on healthcare changed over time?" Kaiser Family Foundation Health System Tracker. December 15, 2023. https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/
4 "Reference-Based Pricing Risks and Rewards of Playing Health Care Hardball." Catalyst Payment Reform. April 2021. https://www.catalyze.org/wp-content/uploads/2021/04/RBP-Whitepaper_April-2021_Published.pdf
5 Soman, Nick. "What Is Reference Based Pricing (RBP) in Healthcare? Understanding Its Implications for the Digital Age." Decent. October 11, 2023. https://www.decent.com/post/what-is-reference-based-pricing-rbp-in-healthcare-understanding-its-implications-for-the-digital-age#:~:text=It's%20the%20percentage%20of%20the,Is%20RBP%20insurance%20good%3F
6 "Fact Sheet: Reference-based Pricing." American Hospital Association. https://www.aha.org/fact-sheets/2021-06-08-fact-sheet-reference-based-pricing

FOR MORE INFORMATION ON HOW WELLRITHMS CAN GET YOU RESULTS, CONTACT US TODAY

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In other cases, a third-party administrator (TPA) or other vendor acting on behalf of an employer pays a set price for each service. The problem, of course, is that if a hospital or provider isn't satisfied with the payment, they can bill the patient for any unpaid portion of the claim – a practice known as balance billing. Most payors use RBP for out-of-network emergency and laboratory claims, while self-insured health plans regulated under the Employee Retirement Income Security Act are allowed to use RBP as a comprehensive payment strategy.[2]

HISTORY

RBP's roots can be traced to 2011 when the California Public Employees' Retirement System (CalPERS) sought to reduce the cost of hip and knee replacements. What prompted this bold move was a seven-fold difference in price for these procedures without any correlation to quality of care. CalPERS identified 46 hospitals statewide that were willing to accept a reference price of $30,000 or less, with health plan members that selected a higher-cost hospital paying the difference out-of-pocket. Several hospitals that charged more than that amount later voluntarily renegotiated their contracts to win the favor of what was then called reference-based "benefits."

Another variation of the model took shape in 2016 when the Montana State Employee Health Plan renegotiated hospital contracts by tying payment amounts to a multiple not exceeding 230% of Medicare rates. With strength in numbers (i.e. 33,000 covered members), Montana made an offer that every hospital in the state had no choice but to accept as part of an arrangement called reference-based "contracting."

North Carolina wasn't as lucky three years later when the state sought to mirror that strategy at 196% of Medicare. Now widely known as reference-based "pricing," the strategy boasts what one source cleverly described as a "reserve army of advocates and legal representatives" to negotiate on the patient's behalf until a settlement is reached or pursue litigation.[4]

Recognizing its shortcomings, an improved version of this model often referred to as RBP 2.0 sought to reduce or eliminate employee friction, litigation, and balance billing. But those efforts have fallen short of the mark.

Why RBP?

Reference-based pricing is a strategic response to the need for healthcare transparency in the face of significant price variations for medical procedures. It is an alternative to escalating costs associated with the traditional fee-for-service model, which have increased 31-fold over past four decades and 6.5 times on an inflation-adjusted basis.[3]

THE PROBLEM

While RBP allows employers more than one way to pay a medical bill without having to establish a provider network, thereby opening the marketplace, it has still failed to provide a methodology that is transparent and understandable. RBP's pure Medicare multiple is arbitrary and does not meet the definition of UCR pricing.

In short, it does not offer a fair-market value for medical services. Group plans that adopt RBP will invariably find themselves having to explain why they're willing to pay, say, 130% of Medicare instead of 142% or 152%. There's no escaping the arbitrary nature of the methodology involving these multipliers.

Medicare is an imperfect system that doesn't have an allowance for every medical procedure, making it impossible to reasonably price some claims. Other potential trouble spots may include a significant hospital stay that exceeds the typical diagnosis-related group (DRG) allowance or complex inpatient medical claims for which there is no DRG number for Medicare to reference and add a multiple. While uncommon, it is not possible to fairly price those claims.

Among its other limitations, RBP is highly inconsistent, with a tendency to underpay hospitals and overpay for laboratory services. There is also variation within hospitals, paying some areas too much and other areas too little – a pattern seen across some hospitals that have lower cost structures.

Moreover, regional acceptance or rejection of RBP complicates provider negotiations, especially for multi-state employers whose search for standardized pricing is foiled. For instance, there are many restrictive rules in Indiana, Illinois, Michigan, Missouri, California, and New Jersey that tie the hands of self-insured employers in states where Blues plans are familiar and popular among health plan members.

With providers under increasing pressure to claw back whatever reimbursement they can to make up for below-market rates, RBP creates acrimony that pits patients against providers, which results in balance billing and dissatisfaction among both parties. It is no wonder that employee friction is still an issue, with even savvy healthcare consumers lost in a confusing maze of complexity.

Legal battles persist over RBP's adversarial approach that critics dismiss as a shakedown of hospitals to procure below-market rates. In short, RBP is indefensible in court. The need for advocacy and legal assistance represents an admission that this method does not actually work. What would work far better for group plans, of course, is to offer a turnkey solution that removes payors and patients from the equation entirely, along with any friction, and indemnifies them from any financial and legal liability.

THE SOLUTION

While RBP served as an alternative to PPO discounts that employers eventually saw as inflated, the same is now true for RBP. Fortunately a far superior method has been developed: Sustainable Claims Pricing™ (SCP). SCP uses a proprietary medical pricing database to reprice medical bills line-by-line based on hospital cost-to-charge ratios reported quarterly to the Centers for Medicare & Medicaid Services, as well as geographical cost variations and quarterly inflationary adjustments from the U.S. Department of Labor.

Under the SCP approach, daily room rates are priced alongside medical services for inpatient claims. Once all these costs are determined, a profit margin is then calculated based on geography, medical inflation and other factors (i.e., adding a reasonable surcharge to manage an influx of COVID-19 cases).

WellRithms SCP, for example, utilizes the expertise of physicians and surgeons, rather than coders or administrative personnel, to manage a technically advanced bill review process. This guarantees precision in claims payment accuracy, prevents overbilling, and eliminates fraud, waste, and abuse. The only way to ensure that a medical bill is properly reviewed is to fully understand the medicine behind it. When medical professionals are the ones who scrub bills line-by-line, they are easily able to spot redundancies and items such as durable equipment that should never be separately billed or paid.

Accurate bill review and claims payment are predicated upon understanding the medicine behind the charges for medical procedures. Without that expertise, there is no true payment integrity. But paying providers fairly is also an important guiding principle of payment integrity. Hospitals appreciate having a more

thoughtful system in place and prefer engaging in constructive discussions rather than acrimonious exchanges that often mar RBP.

Between an ironclad repricing method and high level of medical expertise employed in the bill-review process, savings are actually guaranteed. SCP features the industry's only payment integrity solution bolted to a protective captive insurance program, WellRithms Shield™, which transfers risk exposure for excessive claims away from payors and members – avoiding financial and legal liability.

Relative to RBP, providers often will be paid more under SCP while health plan sponsors reap greater savings from more accurate reimbursement that prevents overbilling, promotes transparency, and reduces the chances of litigation.

CONCLUSION

At a time of rising healthcare costs and crackdown on medical pricing transparency, employers and their advisors looking for alternatives to inflated provider network discounts face a clear choice: continue rolling the dice on RBP at their own peril or adopt a defensible strategy in SCP that satisfies all major stakeholders.

Footnotes

1 "Six Common Questions About Reference-Based Pricing Answered. MultiPlan. April 27, 2022. https://www.multiplan.us/six-common-questions-about-reference-based-pricing-answered/
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THE WAIT IS OVER

INTRODUCTION

As long as egregious medical overbilling continues it will be impossible to eliminate balance billing. A never-ending tug of war between payors and providers, along with network restrictions and reference-based pricing (RBP) strategies, place patients in the crosshairs of provider attempts to increase reimbursements for medical services.

However, there is finally a way to shield health plan sponsors and members from any financial liability associated with balance billing: A first-of-its-kind captive insurance solution for group health and workers' compensation plans. This captive transfers the risk exposure for excessive claims away from payors and members. By indemnifying group plans and members from risks involving high-cost claims, the captive establishing a legally defensible strategy to reprice individual medical bills and fully absorb that risk.

This novel approach differs from a single or group captive program, which insures risk on claims that haven't yet occurred. It is a major disruptor to medical overbilling, providing greater savings to group health and workers' compensation plans than a medical stop-loss or property and casualty captive.

More importantly, it provides peace of mind to payors and patients alike by protecting them from any financial liability from balance bills. It is the relief that the marketplace has been waiting for.

UNDERSTANDING THE LIMITATIONS OF CAPTIVE INSURANCE

Captives are a form of self-insurance that manage a wide range of specialized risk that the traditional commercial insurance market does not cover. They provide companies an additional layer of protection through a wholly owned subsidiary that the insured entity creates. There are many types of these vehicles:

A single-parent or pure captive that underwrites risk for just one owner

Group captives that underwrite the risks of a homogenous or heterogeneous group of unrelated businesses

Protected cell captives that separate their assets and liabilities from core corporate assets

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While captives have long been used for workers' compensation insurance, much of their recent growth has been in the medical stop-loss market as a hedge against high-cost claims.

AM Best Captive Center estimates that there are now more than 7,000 captives worldwide, which represents a seven-fold increase since 1980. As many as 90% of Fortune 500 companies have formed captive subsidiaries.

While captives can be highly effective tools for managing risk, this additional layer of protection only goes so far when it comes to shielding payors and patients from egregious billing. Captives that pool covered lives in group health and workers' comp plans do not manage the risk of individual bills.

Captives are not set up to indemnify health plan members from balance billing when a large claim becomes problematic, and there is no agreement on a fair payment to the provider. Healthcare payors have skirted this issue by hiring attorneys to challenge overbilling in court, which is no guarantee that they – or their participants – will escape financial liability.

There have been attempts at indemnification against egregious billing practices in the form of a Contractor Liability Insurance Program known as CLIP to help payors absorb risk much like reinsurance. However, there are inherent limitations to this approach. For example, public companies are limited in the types of risk they can assume. CLIPs also charge high administrative fees for their services that make them cost and risk prohibitive.

Reference-based pricing (RBP), which may be used in tandem with a medical stop-loss captive, is another failed attempt at protecting payors and members from balance billing. While RBP plans may refer patients to an attorney for negotiating large bills, they cannot erase the responsibility of group health plan sponsors or participants to pay those charges, nor can they require providers to behave appropriately. Doctors and hospitals continue to send balance bills to collection agencies and harass patients for payment, even in the face of greater government oversight.

While the self-insurance market has embraced RBP, which has no network for facilities, one inherent

"In my opinion, it's a game changer"

~John Capasso, President and CEO
of Captive Planning Associates LLC

limitation is the need to negotiate provider rates. For all of these reasons, WellRithms founder and CEO Merrit Quarum, M.D., brought to the market the company's innovative captive for assuming financial liability for individual claims.

"In my opinion, it's a game changer," says John Capasso, president and CEO of Captive Planning Associates LLC, of the WellRithms captive he helped establish.

"There are similar programs," he continues. "None of them, however, have a facility to guarantee the performance. WellRithms has more of a scientific approach that achieves deeper discounts by getting down into the weeds of each bill."

What's particularly significant about this arrangement, according to Capasso, is that it demonstrates "the financial strength to support the burden of risk associated with assuming certain medical and workers' compensation claims on a contractual basis."

THE INDEMNIFICATION ADVANTAGE

WellRithms is the only payment integrity company offering this unique protective captive insurance program called Shield Indemnification™. The program is backed by AMI Indemnity, a captive insurance company that is certified to absorb risk and shield patients from balance billing.

Featuring an incorporated captive cell for group health insurance and another for workers' compensation, AMI takes on the financial risk of high-dollar claims from any payor so that all parties are protected. Rather than insure risk on claims

that have not yet occurred, this captive specializes in indemnifying health plans and members. It sets in place a legally defensible strategy to reprice individual medical bills and fully absorb that risk.

With WellRithms contractually obligated to pay those claims, patients cannot be harassed or sent to collections, as the captive has assumed the bill.

Providing indemnification, not insurance, doesn't eliminate balance billing. However, it relieves payors and patients from financial liability and ensures that providers have been paid appropriately. Shield Indemnification™ represents the market's best solution for defanging balance-billing, a practice that occurs in no industry other than healthcare.

While traditional captives that aggregate risk across groups of covered lives are driven by volume, Shield Indemnification™ assumes the risk associated with individual medical bills. The captive can be added to WellRithms' bill review and repricing on a bill-by-bill basis with potential savings of 75% or more.

ADDING LAYERS OF PRECISION

This unique captive solution solves the balance-billing dilemma facing payors and patients by shielding them from liability associated with unreasonably high-cost claims. Armed with medical expertise for reviewing bills and advanced payment integrity technology, WellRithms offers ironclad protection against medical overbilling. This holistic approach allows WellRithms to review and reprice bills with more precision while also shielding plan sponsors and participants from balance billing like no one else.

WellRithms substantially raises the bar on precision by layering Shield Indemnification™ on top of the company's proprietary repricing system called Sustainable Claims Pricing.™ This methodology reprices medical bills line-by-line based upon hospital cost-to-charge ratios reported quarterly to the Centers for Medicare & Medicaid Services, as well as geographical cost variations and quarterly inflationary adjustments from the U.S. Department of Labor.

Another key differentiator is the use of physicians and surgeons, rather than coders or administrative personnel, to manage a technically advanced bill review process. Their medical expertise improves claims payment accuracy and reduces fraud, waste, and abuse. The only way to ensure that a medical bill is properly reviewed is to fully understand the medicine behind it. When medical professionals scrub suspect bills at the line-item level, they bring the expertise to spot redundancies and items that should never require separate billing.

Perhaps best of all, patients who are already struggling to navigate a complex healthcare system, and afford important treatment and medicine, can have peace of mind that they will never be at risk for a balance bill.

BLOGS

How WellRithms Kept One Customer from Footing an Egregious Podiatry Bill

J&J Lawsuit Over Rx Mismanagement a Bitter Pill for Employers

ER Bill Leaves Prominent Physician Exasperated

Down-and-Out in Beverly Hills: How a Hernia Repair Mirrors Larger Problems

Why Reference-Based Pricing is Unsustainable and What Will Replace It Employers are Losing Faith in Healthcare System's Billing Integrity

Significant Erosion of Wages From Rising Health Premiums Seen Over Decades

Escape From Balance Billing Purgatory: "Who Are You Guys?"

The End of Balance Billing: Introducing WellRithms' Shield Indemnification™

Leading the Way with Captive Indemnification and Other Key Differentiators

Egregious Charges Removed with Surgical Precision from Workers' Comp Bill

Revision Amputation Surgery on Finger Points Up Absurdity of Medical Bill Miscoding

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