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REFERENCE PRICING: STIMULATING COST-CONSCIOUS PURCHASING AND COUNTERING PROVIDER MARKET POWER

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Researchers and the mainstream media are documenting what health insurers long have known: prices for similar services vary dramatically within as well as across markets, with little discernable difference in quality.¹ Because insurance shields patients from the full cost of their care, providers are able to price aggressively without fear of losing business. This phenomenon is especially evident in the market for hospital services and has been reinforced by ongoing consolidation among hospitals, which stymies payers' efforts to contract selectively on the basis of price as well as quality. The highest prices are charged by the hospitals that are part of a dominant regional system or simply have the strongest nerves and the thickest skin when negotiating.²

In an effort to make health care consumers more sensitive to provider price differences, employers and insurers have been increasing cost sharing requirements, with much of the exposure coming through higher deductibles. Forcing more first-dollar cost sharing moderates demand for small-ticket items such as preventive and primary care and encourages choice of generic over branded drugs, but it does little to influence demand for expensive services like inpatient care, advanced imaging and outpatient surgery. When admitted to a hospital, for example, most patients reach their deductible before they reach the elevator. Yet it is precisely among these expensive services where choice of a higher-cost provider generates especially high spending.

REFERENCE PRICING CHANGES THE INCENTIVES

Reference pricing is an alternative cost sharing structure that is designed to make patients more sensitive to price differences across service providers. Under this benefit design, the employer or insurer establishes a maximum payment it will make for a specific service. The price limit is set high enough to ensure that sufficient numbers of providers are available with prices below the limit, yet low enough to restrict reimbursement to the most expensive providers. Enrollees may use any provider but must pay the full difference between the allowed charges of high-cost providers and the reference price limit established by the employer or insurer.

Reference pricing creates stronger incentives for consumers than do conventional cost sharing structures. Coinsurance requires the enrollee to pay only a percent of the difference between high-price and low-price providers, while copayments are fixed regardless of which provider is selected. Reference pricing also sets the standard insurance deductible on its head. Under a standard deductible, the enrollee pays the first part of the provider's negotiated fee, up to the deductible limit, and the insurer pays the rest. Under reference pricing, the insurer pays the first part of the negotiated fee, up to the contribution limit, and the enrollee pays the rest. This reversal makes all the difference.

REFERENCE PRICING IN USE

Reference pricing has been employed most commonly in Europe for pharmaceuticals, with insurers grouping drugs into therapeutic classes and limiting payment to the average or lowest price in the class. More recently the concept has migrated to the U.S. and been applied to a wider range of clinical services. The two most prominent examples to date come from Safeway and CalPERS.

Safeway, a national food retailer, distributor and manufacturer with 40,000 employees in its self-insured health plan, pioneered the use of reference pricing for diagnostic radiology in response to dramatic differences in colonoscopy prices across and within its markets.³ After a pilot test of the concept in 2009, it expanded the initiative using a uniform reference price of \$1,250 for all markets. Safeway has since applied reference pricing to laboratory tests, pharmaceuticals, other imaging modalities, and ambulatory surgery procedures.

The second prominent application of reference pricing comes from CalPERS, the health insurance purchasing alliance that serves public-sector employees in California. In 2009 CalPERS noted a \$20,000-to-\$120,000 variation in the allowed charges its self-insured PPO plan had been paying to different hospitals for knee and hip replacements, with no apparent differences in quality. Working with Anthem Blue Cross, the administrator of its PPO plan, CalPERS established a reference price limit of \$30,000

for these two procedures and identified 41 hospitals as “value-based purchasing design” (VBP) facilities. The designated hospitals charged no more than the \$30,000 reference price, were sufficiently dispersed to provide adequate geographic coverage for plan members, and scored at or above the statewide average on available measures of quality.

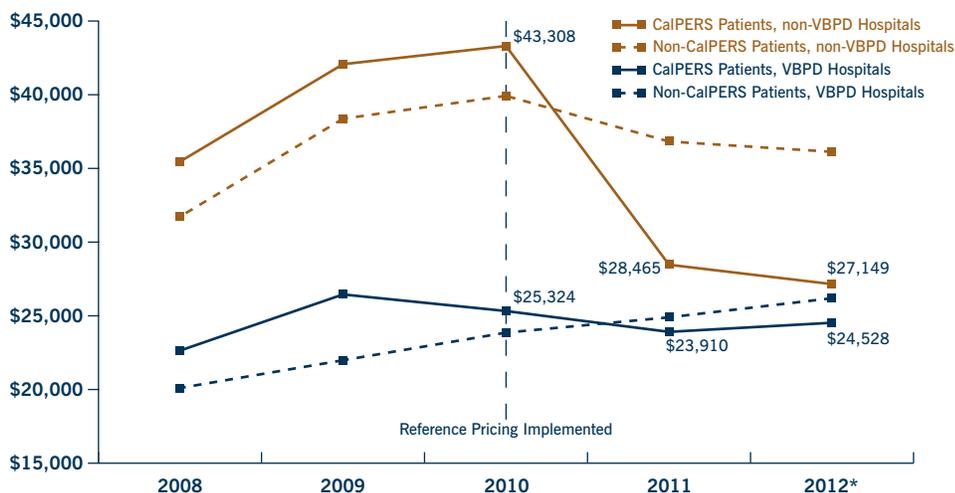
CalPERS enrollees maintained access to all available orthopedic providers in the state but, starting in January 2011, were required to pay all allowed charges above \$30,000 if they opted to use a non-VBP hospital. Members were also required to pay the normal 20 percent coinsurance, up to a maximum of \$3,000, regardless of where they obtained care. Anthem PPO members not enrolled through CalPERS were not subject to reference pricing and served as a control group for measuring the program’s impact.⁴

So what happened? Once they were obligated to spend their own money, CalPERS enrollees voted with their feet for lower priced options. The VBP facilities experienced 21 percent higher volume of CalPERS patients in the year after reference pricing began, moving them to a collective market share of 63 percent for CalPERS patients (up from 48 percent). Non-VBP hospitals, on the other hand, saw their volume of CalPERS patients fall by 34 percent. This market share shift was sustained into the second year. In contrast, Anthem enrollees who were not subject to reference pricing did not change their use patterns during this time.

But by far the bigger and more astonishing response was in the prices charged by the hospitals. Half of the expensive hospitals reduced their prices for CalPERS patients, many by a substantial margin. Across all non-VBP hospitals, CalPERS prices fell by 34 percent in the first year (Figure 1). The shift in market share towards VBP facilities would certainly have been much larger without these price cuts. The lower-priced VBP facilities also reduced their prices slightly and, across all hospitals, prices for CalPERS patients fell by an average of 20 percent.

CalPERS saved almost \$6 million in two years from these two procedures alone, and members saved another \$600,000 in lower cost sharing. Approximately 15 percent of these savings were due to changes in market share favoring VBP facilities, with 85 percent due to price reductions at the most expensive hospitals. Overall, the program succeeded in maintaining member access to the state’s hospitals, but at more affordable prices. Based on these positive results, CalPERS and Anthem are now expanding reference pricing to ambulatory surgical procedures.

Figure 1. Average Prices for Knee and Hip Replacement Surgery Before and After the Implementation of Reference Pricing



All prices in 2011 dollars. VBP = Value-Based Purchasing Design. *Only through September of 2012. Source: Robinson JC and Brown TT. “Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery.” *Health Affairs*. 32(8):1-6, August 2013.

THE FUTURE POTENTIAL FOR REFERENCE PRICING

Reference pricing offers meaningful opportunities to employers and insurers seeking to counter the pricing leverage that hospitals can exert for their services. It may also produce savings when applied to smaller-ticket items, where even modest savings per service can add up to big dollars due to a high volume of use. But several challenges could limit use of this benefit design.

Reference pricing works best for products and services that exhibit wide variation in prices but only small differences in quality. Otherwise, patients will be understandably concerned that low price signals low quality. This is why reference pricing has been applied first to drugs and diagnostic testing, where quality is fairly standard. The extension of the CalPERS initiative to orthopedic surgery required attention to quality differences across hospitals. As applications proliferate, consumers will demand better data on quality at competing providers, pushing the quality measurement field well beyond its current state. Price transparency tools also must be improved so consumers can determine what they will pay for specific services before they select their providers.

Other operational challenges will multiply as reference pricing is applied more widely. Each new application will require determination of a reference price that is high enough to ensure an adequate number of service providers and protect patients from excessive out-of-pocket costs but low enough to send meaningful signals to providers and patients and generate savings. Likewise, each new application will

require efforts to educate plan enrollees about the benefit change.

The contemporary leaders in reference pricing are large, self-insured employers that are exempt from many state and federal insurance regulations. If the strategy spreads to smaller and fully insured employers, these regulations may pose impediments. Might state regulations about network adequacy, for example, require higher reference prices that trade off some savings potential? Could ACA requirements to cover preventive services without cost sharing inhibit use of reference pricing for these services?

Employers, payers and providers are working to improve the efficiency of our health care system using new methods of network contracting, pricing and payment, care coordination and disease management. But no durable changes can be achieved without also engaging consumers. By exposing patients to price differences that are not due to differences in quality, reference pricing can be an important tool in current efforts to achieve better value for our health spending.

ENDNOTES

- 1 Brill S. “Bitter Pill: Why Medical Bills Are Killing Us.” *Time*, March 4, 2013.
- 2 Berenson RA, Ginsburg PB and Kemper N. “Unchecked Provider Clout in California Forecasts Challenges to Health Reform.” *Health Affairs*, 29(4):1-7, April 2010.
- 3 Robinson JC and MacPherson K. “Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers.” *Health Affairs*, 31(9):2028-36, September 2012.
- 4 Robinson JC and Brown TT. “Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery.” *Health Affairs*, 32(8):1-6, August 2013.