catalyst FOR PAYMENT REFORM

Action Brief
Reference Pricing

WHAT IS REFERENCE PRICING?

Reference pricing establishes a standard price that a purchaser will pay for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount. Reference pricing has been shown to lower the cost and increase value in prescription drug plans,[1] and is now expanding in the United States to selected medical and surgical services.

WHAT PROBLEMS DOES REFERENCE PRICING TRY TO SOLVE?

Paying for health care by "unit price" – a fee for each service or treatment delivered – is a major cause of health care cost inflation in the US. "Fee-for-service" encourages health care providers to deliver more care and for that care to be more expensive. Furthermore, there is growing evidence of unwarranted price variation that has no connection to the quality of the care being delivered. Health plans have often been unable to negotiate favorable prices, especially with health care providers bearing strong reputations and considerable market leverage.

Reference pricing aims to offer reasonable alternatives to high-cost providers without compromising quality. Patients have the "carrot" of lower member cost share if they go to providers who charge at or below the reference price. This may make patients more sensitive to the price of services, and more likely to choose cost-effective hospitals or physicians. Reference pricing can thus help exert pressure on high-cost providers to lower their prices.

HOW DOES REFERENCE PRICING WORK?

Reference pricing begins with health plans or employers ascertaining high variability in price for a procedure or service from claims experience, coupled with the fact that the higher prices are not associated with better quality or outcomes. The plan or employer then sets a standard allowable price for that procedure or service that would allow patient members a high-level of coverage at an adequate number of providers. Quality can also be factored into providers' qualification for being paid the reference price. Members choosing providers with higher allowable fees must pay some or all of the difference, encouraging them to seek lower cost options. This standard price might vary with different geographic markets. The responsibility to pay allowable costs in excess of the reference price substantially decreases the "moral hazard" of members, who might otherwise choose high-priced providers knowing that the financial burden of their choice would largely be borne by others.

Reference pricing is effective for services that meet the following criteria:

- Substantial variation in price
- Elective (non-emergency care)
- Well-defined
- Transparent price
- Transparent or indistinguishable quality
- Multiple competing providers in each geography

For instance, if a reference price for the professional fee for a colonoscopy screening is $1,000, and a patient undergoes a colonoscopy at a provider with an allowable fee of $1,000, there is no member cost share, beyond his or her standard co-insurance or co-pay. However, if the patient chooses a provider with an allowable fee of $2,500, the patient will pay the incremental $1,500, or some portion of that difference, in addition to his or her standard co-insurance or co-pay.

Reference pricing is likely to be most effective for procedures that are elective and available from multiple providers in selected geographies. This provides members both the time and information to "shop" for the best value. Prices must be transparent to members to enable them to make informed decisions, thereby driving more effective consumer behavior. Members ideally would also have access to information about provider volume, quality, and outcomes. Providers are more likely to be willing to compete on price for services that have a high-margin, as high fixed costs will make them reluctant to tolerate losses in volume.

For expensive procedures where some members do not live within close proximity to a high-quality, cost-effective provider, a health plan or employer can contract at reference prices with a more limited network and offer affected members travel reimbursement.

Reference pricing can encourage member engagement and help increase member use of high-value (e.g. high-quality, cost-effective) providers. It also sends a powerful signal to providers with high allowed prices that they should reengineer their processes to lower their resource costs so they can compete on price as well as quality and reputation. Experience so far suggests that reference pricing can save substantial costs when it is implemented with adequate communication and thoughtful network development. However, one potential unintended consequence, as expensive providers lower their prices to meet the reference price, is that these providers may increase prices of other services to make up for the revenue loss.

THE RANGE OF APPROACHES TO REFERENCE PRICING

Health plans have deployed a range of approaches to reference pricing, some of which require developing a non-traditional network and some of which incorporate quality measures.

Reference pricing may also vary in how prices are determined, the level of member cost-sharing, and the comprehensiveness of the available network.

The most basic reference pricing is deployed in pharmaceuticals,[2] where a reference price is set for a class of substitutable medications, and members must pay any incremental costs to obtain medications priced higher than the reference price. This is most often applied to classes of medications where there are a number of generic options. In this case, the reference price is usually based on the cost of buying generic medications in the same class. This approach has been put into effect for a number of classes of antihypertensive medications, including beta blockers and angiotensin converting enzyme inhibitors, as well as medicines for ulcers.

However, medical services and procedures are far less standardized than pharmaceutical products, making the reference price process for these more complex. The health plan must determine that the providers willing to accept the reference price can deliver acceptable quality and access. They also must be sure that the cost savings for the procedure subject to reference pricing are not offset by higher volume or the cost of related but not included procedures. Alternatively, a reference pricing strategy could index the price of all services to a published fee schedule, a strategy currently being pursued by the Montana and North Carolina state employee health benefits programs.

The state of Arkansas established a reference price for proton pump inhibitors that was equivalent to the cost of over-the-counter omeprazole and was able to decrease its spending on this class of medications by over 10% without increasing member cost-sharing.[3]

REFERENCE PRICING IN ACTION:

Safeway instituted reference pricing for laboratory tests that were well-established for nonurgent health care needs. The study excluded inpatient hospital tests, emergency department tests, urgent care tests and other care settings where consumers lacked ability to compare laboratory prices.

- By the third year of the program, there was a 31.9% reduction in average price paid per test associated with the implementation of reference pricing.
- Over three years, total spending on laboratory testing decreased by $2.57 million, with out-of-pocket costs declining by $1.05 million.
- Safeway's total spending declined by $1.70 million at the end of the third year. Taking into account the laboratory tests not included in the pilot, Safeway's estimated savings for reference pricing on all laboratory services is $4.09 million.[4]

CalPERS, which covers more than 1.9 million state and local government employees, retirees and their families in California implemented a reference pricing program in 2011 for employees after finding more than a seven-fold difference in the price for hip and knee replacements.

- CalPERS' reference pricing program was established in collaboration with Anthem Blue

Cross. At that time, Anthem identified 46 hospitals which met volume and quality standards and were willing to perform hip or knee replacement surgery for $30,000 or less for the hospital stay and the prosthetic device.

- Since the launch, fifteen additional hospitals were added to the initiative, meeting quality and volume requirements to be determined high-value facilities, and the program has expanded to include elective cataract surgeries, colonoscopies and arthroscopy procedures.
- After the implementation of reference pricing for CalPERS employees, joint replacement costs at the highest priced California hospitals decreased by one-third. The average cost of a joint replacement at these high-priced hospitals dropped from $43,308 to $28,465 after implementation.
- CalPERS estimates there was a 26% reduction in price paid for a joint replacement in the first two years of the program, generating $5.5 million in aggregate savings.
- The study demonstrated that when consumers are given the financial incentive to compare prices and seek high-quality, low-cost care, hospitals react by dropping their prices. Similarly, the hospitals CalPERS and Anthem jointly designated as "value hospitals" saw increased joint replacement volume compared to hospitals that were not designated "value hospitals."[5]

Reference pricing would optimally include a bundle of all related procedures to avoid cost-shifting and to make it less likely that members would receive unexpected bills. However, many employers are not waiting until bundled payment is more prevalent to institute reference prices for elements of a service (such as the professional or technical fee for a medical procedure such as colonoscopy) or for services delivered on behalf of a large purchaser with strong negotiating leverage within a specified region. The Montana State Health Care and Benefits Division implemented a reference pricing with state hospitals capped at a little more than 200% of Medicare Fee Schedule. The contracts prohibit hospitals from billing patients directly for whatever the health plan refuses to pay.[7] In October of 2018, the North Carolina State Health Plan announced that it would pursue a reference pricing strategy with the expectation of generating $300 million in savings.[8]

The potential cost savings from reference pricing are substantial:

The RAND Corporation estimated in 2009 that if Massachusetts implemented reference pricing to pay for academic medical center care at the rates then paid to community hospitals, private payers in that state could lower their costs by as much as $8.8 billion, and overall costs could decline in the state by up to 1.3%.[6]

IMPLEMENTATION CHALLENGES

Reference pricing requires excellent quality and price transparency tools for members, as well as effective communication about the program at open enrollment and when members seek care throughout the year. Most major health plans are now making prices and information about provider quality transparent to consumers, though some efforts are fledgling and limited in scope. Some employers also make available tools developed by independent vendors so that employees can view price and quality information. Even once pricing information is available, it takes members time and energy to behave as informed consumers.

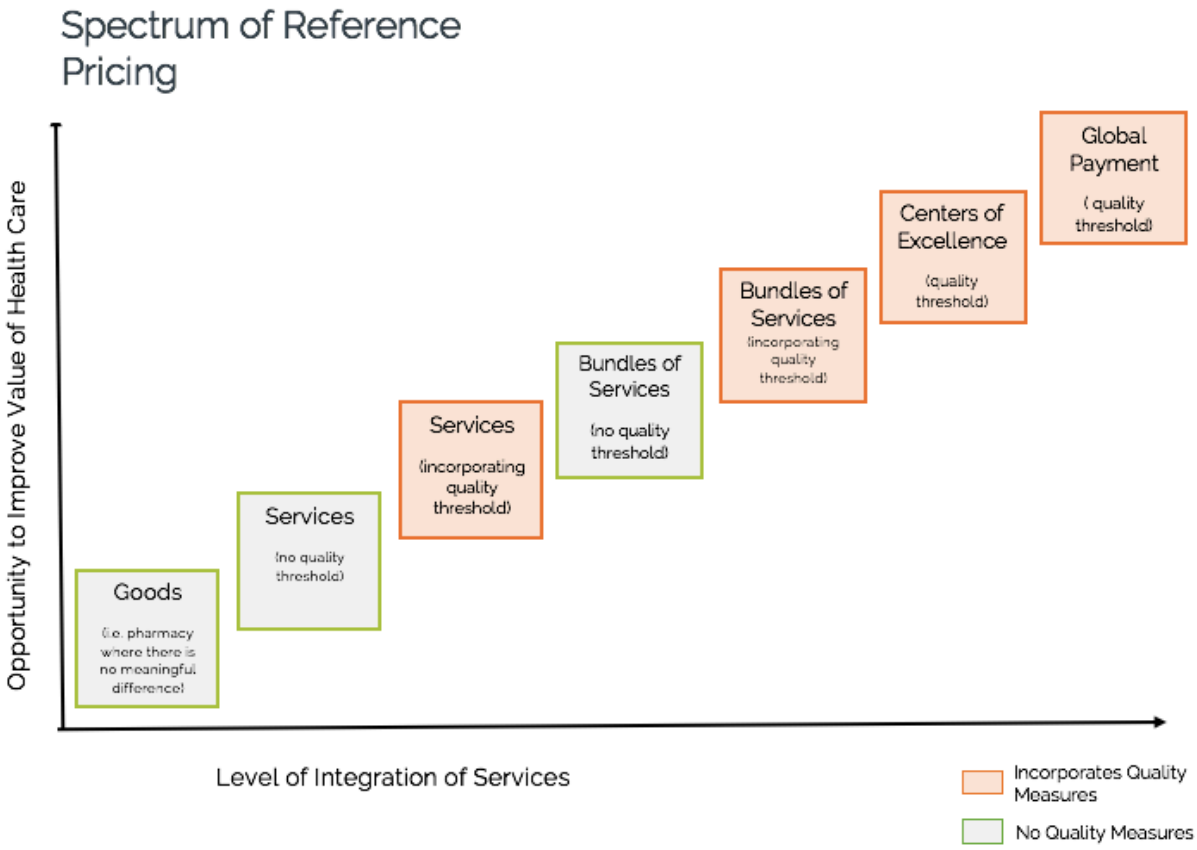
It is likely that there will be many medical services where reference pricing will need to be established on a market-by-market basis. The early adopters of reference pricing for medical services have been regionally based or have focused on a single, pilot market. There will be some markets, especially in rural areas, where lack of competition makes reference pricing feasible only for very high-cost procedures coupled with arrangements to provide care regionally rather than locally.

There is some danger that reference pricing could encourage providers to seek patients with fewer co-morbidities whose care is likely to require fewer provider resources. Providers might also seek to shift costs to other services and may have the incentive to perform a higher volume of the services subject to the reference price. In addition, some providers have suggested that full price transparency could facilitate collusion and lead to market pressures to increase reimbursement for those providers with current low reimbursement.

POTENTIAL EVOLUTION OF REFERENCE PRICING

	EARLY REFERENCE PRICING	MORE MATURE REFERENCE PRICING
PROCEDURES	Procedures with very small quality variation to allow for a single reference price	Could incorporate quality into pricing – offering patients cost-share that differs based on provider quality ranking
INCLUSIVENESS OF PRICE	Usually either professional or technical, limited to a single CPT code or a small cluster of CPT codes	All-inclusive, potentially including multiple specialties involved in an episode of care
QUALITY TRANSPARENCY	Limited volume and process measures	More extensive outcome measures directly related to each affected procedure
CONSUMER TOOLS	Cost and quality tools integrated with health plan benefits	Bank or financial account (e.g. FSA or HSA) integration

Reference pricing for medical services is likely to evolve as it is deployed in the United States. Reference pricing will likely incorporate quality more fully in the future, whether through lower member cost-sharing at higher quality providers (even if they do not charge the lowest price) or through the establishment of a minimum quality gate when selecting providers. It is likely that the future generation of reference pricing will be more inclusive – incorporating more care before and after a procedure and incorporating both technical and professional fees.



WHAT STEPS CAN A PURCHASER TAKE?

- USE CPR's health plan request for Information (RFI) questions and model contract language available at www.catalyze.org/product/2018-aligned-sourcing-contracting-toolkit/.

- ENCOURAGE your insurer or third-party administrator (TPA) to:
  - Fully disclose the prices they are paying to various providers, either by posting the information themselves or making it available to their employer-purchaser customers or a third-party that can translate it for use by the employer and patient members;
  - Avoid entering into contracts with providers that prohibit the purchaser and the patient from determining and comparing allowable prices;
  - Create easy-to-navigate online tools and other support for informed decision making, including showing member out-of-pocket costs;
  - Conduct analysis of price variation among network providers and share information about areas with widest variation and cost savings opportunities;
  - Develop reference pricing pilots in areas with the greatest potential savings;
  - Introduce new benefit designs that support a sophisticated approach to reference pricing that will engage consumers to be active shoppers while also helping them to identify the highest-value providers and limit out-of-pocket exposure; and,
  - Explore development of centers of excellence paired with reference pricing for episodes of care.

- EDUCATE employees about the potential to save on out-of-pocket costs through selecting high-value providers. CPR's case study on The Home Depot, Inc. illustrates the

need for adequate education and communication. To prepare your employees:
    - Develop a prolonged communication strategy with frequent & repeated communications;
    - Make sure consumers understand how the reference pricing program works and how to ensure they get care at or below the reference price so they don't receive surprise bills; and
    - Get physicians on board! Avoid having physicians refer consumers to providers charging over the reference price.

- SEEK alternate means to create price transparency if health plans will not or cannot meet this need. Many employers have participated in statewide and regional collaboratives that have collected and disseminated quality and cost data. These data, coupled with data from Medicare, other public payer programs, and all-payer claim databases collected and released in many states, can provide a rich source of data to inform patient and health plan purchasing decisions.

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ABOUT US

Catalyst for Payment Reform (CPR) is an employer-led, national nonprofit on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

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