



From Reference Pricing To Value Pricing

Action Brief

WHAT IS REFERENCE PRICING?

Reference pricing establishes a standard price 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 plans,¹ and is now expanding in the United States to selected medical and surgical services. Many employers already use reference pricing to establish premium contributions for health benefit plans which are more expensive than a “base” plan.

WHAT PROBLEMS DOES REFERENCE PRICING TRY TO SOLVE?

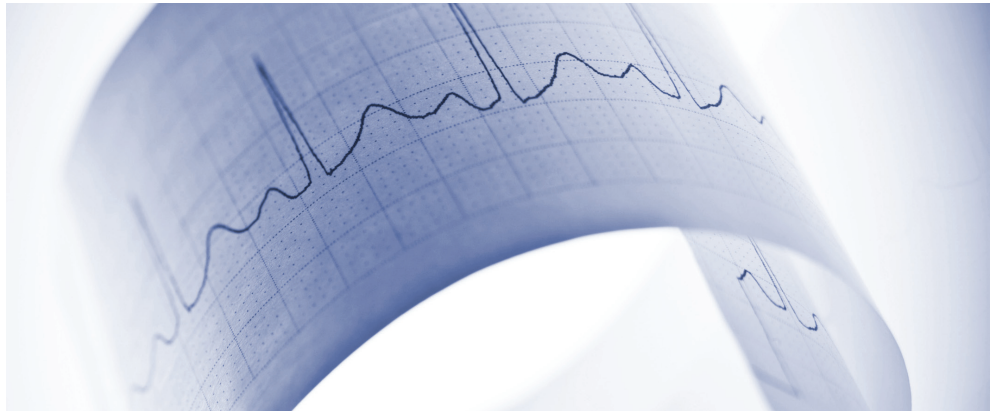
Paying for health care by “unit price” – a fee for each service or treatment delivered – is a major cause of health care inflation in the US. “Fee for service” encourages health care providers to deliver more, and more expensive, care. Furthermore, there is growing evidence of unwarranted price variation that has no connection to the value 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, and in some instances, no 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 service, 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 health plan 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 value. This



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

- Substantial variation in price
- Elective
- Well-defined
- Transparent price
- Transparent or indistinguishable quality
- Multiple competing providers in each geography

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.

For instance, if a reference price for the professional fee for a screening colonoscopy is \$1000, and a patient undergoes a colonoscopy at a provider with an allowable fee of \$1000, there is no member cost share. However, if the patient chooses a provider with an allowable fee of \$2500, the patient will pay the incremental \$1500, or some portion of that difference.

Reference pricing is likely to be most effective for procedures which 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 and to drive 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, where 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 if the selected providers are not close enough to where they live.

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.

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, 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.

For example, 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

However, medical services and procedures are far less standardized than pharmaceutical products, making the reference price process 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.

In another example, Safeway has instituted reference pricing for screening colonoscopy for its employees covered under certain Safeway-sponsored health plans. In the San Francisco Bay area where, for example, screening colonoscopy was costing from \$900 to \$7200, it pegged the facility price for colonoscopies at \$1,250. In the first year of the program, Safeway experienced substantial movement away from the most expensive providers without a decrease in the rate of colonoscopy screenings in the population. To facilitate this shift, Safeway built online information for enrollees that illustrated the out-of-pocket costs at various colonoscopy providers. Safeway has since expanded reference pricing to laboratory and elective high-technology imaging procedures.⁴

In many instances, substantial quality differences among providers makes it valuable to have a quality threshold as well as cost below a price benchmark for a provider to qualify for inclusion in a high-performance network.



CalPERS, which covers 1.3 million state and local government employees, retirees and their families in California, found more than a seven-fold difference in the price for hip and knee replacements, and implemented reference prices for these procedures in collaboration with Anthem Blue Cross. 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. For CalPERS Blue Shield members, sixteen hospitals are designated as ‘centers of expertise’ in nine regions of the state. CalPERS offers modest travel benefits to those who live over 50 miles from one of these providers. A number of providers were willing to renegotiate their contracts and lower their fees to be included in the program. Preliminary analysis by Anthem Blue Cross of partial-year data shows volume at preferred providers increased by almost 7%, and cost per case decreased by almost a quarter.⁵

The potential cost savings from reference pricing are substantial. For example, the RAND Corporation estimated in 2009 that if Massachusetts implemented reference based 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 The state has not yet pursued this approach.

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).



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. While some employers, health plans and third parties are working to make prices transparent to consumers, most efforts are fledgling and limited in scope. Even once pricing information is available, it will take 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 when 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. 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.

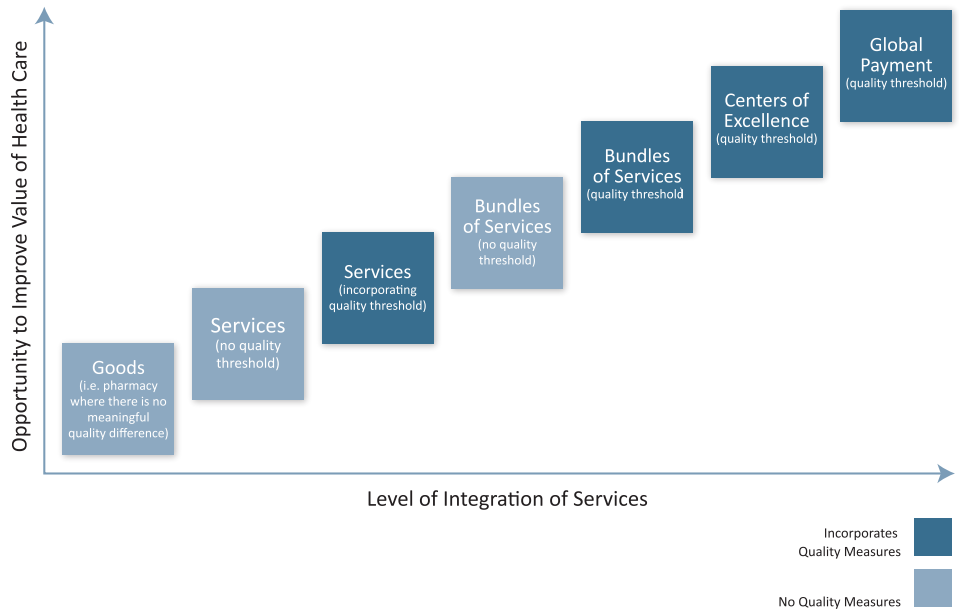
FROM REFERENCE PRICING TO VALUE PRICING

	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 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 rapidly 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 selecting providers based on a minimum quality standard. 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.

Spectrum of Reference Pricing



What steps can a purchaser take?

- **USE** CPR's health plan request for Information (RFI) questions and model contract language available at catalyzepaymentreform.org/RFI.html.
- **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 and other support for informed decision making, including 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.
- **IMPLEMENT** benefit design changes. Employers are also increasingly using health plan designs that have less "first dollar" coverage, with higher deductibles and more member cost sharing features. These plans encourage health plan members to be engaged consumers, who are more likely to review available information and choose the highest value provider to deliver their care.
- **INTRODUCE** legislation to prohibit gag clauses around payment agreements between health plans and providers.
- **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 data sets collected and released in many states, can provide a rich source of data to inform patient and health plan purchasing decisions.

ABOUT US

Catalyst for Payment Reform is an independent, non-profit corporation working on behalf of large employers to catalyze improvements in how we pay for health services and to promote better and higher-value care in the U.S.

ACKNOWLEDGEMENT

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1 Rector TS, Finch MD, Danzon PM, Pauly MV, Manda BS. Effect of tiered prescription copayments on the use of preferred brand medications. *Med Care*. 2003 Mar;41(3):398-406.
2 Kanavos P, Reinhardt U. Pharmaceutical cost containment with reference-based pricing: time for refinements. *Health Aff*. 2003, 22:16-30.
3 Johnson JT, Neill KK, Davis DA. Five-year examination of utilization and drug cost outcomes associated with benefit design changes including reference pricing for proton pump inhibitors in a state employee health plan. *J Manag Care Pharm* 2011 Apr;17(3):200-12.
4 Robinson, JC. Applying value-based insurance design to high-cost health services. *Health Aff* 2010; 29:2009-2016.
5 Anthem Health Services Actuarial. Reference-based pricing – pilot results. presented to CalPERS Health Benefits Committee, 2011 June 15.
6 Eibner, CE, Hussey, PS, Ridgely, MS, McGlynn, EA. Controlling healthcare spending in Massachusetts: an analysis of options. RAND Corporation, 2009.