In response to rising healthcare costs, some private payers and large self-funded employers are experimenting with benefit designs, including “reference pricing” and “centers of excellence” programs to incentivize patients to choose low-cost, high-quality settings for care. Under many existing benefit designs, once a patient’s deductible and out-of-pocket maximum have been reached for a given benefit period, patients are relatively indifferent to price. This can be problematic given the wide variation in price and quality among providers for certain complex diagnostics and interventions. Under the current paradigm, a patient may pay identical out-of-pocket rates for the same procedure at different settings which have similar quality but enormous variations in total price.

The California Public Employees’ Retirement System (CalPERS), Safeway supermarkets, and Lowe’s Home Improvement are among those working with their payer partners to experiment with these benefit designs to engage their employees in making value based choices. From this they hope to more effectively manage cost while preserving quality for their members.
Reference Pricing

Reference pricing benefit designs expose the patient to the full price charged by high-cost providers. Under reference price arrangements, an insurer will allow a maximum, or reference, price for a procedure. Any price in excess of the reference price is the responsibility of the patient. This benefit design is similar to that of indemnity insurance, which will pay a maximum allowable for an adverse event, such as damages resulting from a car accident. However, contemporary reference pricing ensures that the price is set high enough for patients to receive care with reasonable out-of-pocket costs. This benefit design is best employed for services that vary widely in cost but not in quality, and have wide networks of covered providers. Services that are done in emergency setting should be excluded from reference pricing. Both Safeway and CalPERS have begun to experiment with reference pricing in designing member benefits.

Safeway is a national chain of grocery stores that provides health insurance to over 180,000 employees and dependents through self-insured preferred provider plans and a number of union sponsored health insurance plans. Safeway found ten-fold variations in the price of colonoscopies within a regional market without variations in quality, prompting them to pilot a reference price program for colonoscopies. After providing employees with a list of all facilities that charged less than $1,500, Safeway launched a program in 2009 which set a reference price of $1,500 for colonoscopies. In 2010 this program was expanded nationwide and the reference price was lowered to $1,250. Under this system, as Figure 1 indicates, patients who choose the lowest cost provider in San Francisco, $848, would pay nothing out-of-pocket, those choosing a provider that charges $1,500 would experience a $250 copayment, and those patients visiting the highest cost provider, $5,948, would experience an out-of-pocket payment of $4,734. Safeway has since expanded its reference pricing program to cover routine laboratory tests, and over half of the Current Procedural Terminology codes covered under Safeway’s benefit plan.

CalPERS, who provides coverage for over 1.3 million employees, dependents, and retirees in the State of California, has also experimented with reference pricing benefit designs for orthopedic surgery. In 2009, the facility price charged to CalPERS by providers of hip and knee replacement surgery in California hospitals ranged from less than $10,000 to over $120,000. Given this variation in price among relatively standardized procedures, CalPERS decided to start a reference price program for preferred provider organization members whereby CalPERS would impose a reference price limit of $30,000 for the facility component of the procedure. Over two-thirds of California hospitals
charged less than this amount, and after assessing quality and patient satisfaction, Anthem, the CalPERs plan administrator, initially designated forty-seven hospitals as “value-based purchasing centers.” At these centers, patients would be responsible for 10% of the hospital charge up to $30,000. If the patient elected to visit a provider who charged more than $30,000, the patient would be responsible for their 10% co-insurance on the fee under $30,000 plus the entire fee in excess of $30,000.

**Centers of Excellence**

Center of excellence contracting uses elements of a managed care limited network in which providers offer a price discount for a high volume of patients and apply them to specific procedures. Insurers have long contracted with providers of specialized procedures, such as organ transplantation, and created limited networks of these facilities based on quality. Recent years have also seen an increase in the popularity of international medical tourism where patients travel to low-cost countries of care (Mexico, Singapore, for example) to receive treatment. By combining limited networks for specific procedures with patient travel, insurers are able to expand the geographic scope of specific provider markets and increase competition. Depending on the plan design, patients can be channeled to centers of excellence through either inducements or penalties. CalPERs and Lowe’s have experimented with centers of excellence contracting for their beneficiaries.

CalPERs decided to use centers of excellence contracting with one of its health maintenance organization plans to confront the wide variation in orthopedic surgery cost. Working with Blue Shield of CA, CalPERs divided the state into nine regions and designated one center of excellence for each region. Eventually the program settled on sixteen providers and the plan reimburses travel costs for patients who live more than 50 miles from the center.

Lowe’s Home Improvement covers over 200,000 beneficiaries, 17,000 of whom are enrolled in a health maintenance plan. Lowe’s contracted with the Cleveland Clinic to become its sole center of excellence for cardiac procedures. Lowe’s encourages patients to choose the Cleveland Clinic by waiving all out-of-pocket fees for cardiac procedures at the facility and reimburses travel costs for the patient and those of a companion. Lowe’s plans to create a spine and back center of excellence program with the Cleveland Clinic.

**Conclusion**

Both reference pricing and centers of excellence contracting are targeting unnecessary price variation and rising healthcare costs by attempting to influence where care is provided. The primary mechanism is control of provider site through limiting patient choice but insurers must balance this restriction with resistance from patients and excluded providers. Health systems may be able to
Reference Pricing and Centers of Excellence Contracting: Experimenting with Traditional Cost-Sharing Benefit Design

prevent center of excellence designations by invoking “all or none” clauses whereby an insurer must network with all facilities owned by the health system. In both benefit designs, it is essential that insurers communicate with their members as patients could be subject to prohibitive costs should they venture out-of-network or to a high-priced provider, and exceptions should be made in the case of an emergency. Reference pricing may be more forgiving than centers of excellence for patients who go out-of-network as at least some of their medical expenses will be covered up to the reference price.

Neither benefit design attempts to address the more challenging problem of appropriateness of care and utilization. Reference pricing incentivizes patients to choose quality providers among an array of lower cost providers, while with centers of excellence contracting it is the insurer or plan sponsor who determines which providers offer value as defined by both quality and lower cost. Both methods attempt to mitigate a current problem presented by cost-sharing plans: patients are encouraged to choose low-cost providers up until their deductible and out-of-pocket maximums are met and then they subsequently can disregard price for high cost procedures.

We at BCHT hope to see more such experimentation by a wider range of employers and support efforts by private payers who are exploring options to commercialize versions of these benefit designs for their fully insured clients.

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