

Invited Commentary

Consumer-Oriented Approaches to Cost Containment

Paul B. Ginsburg, PhD

The study by Robinson and colleagues¹ of Safeway's experience with reference pricing for laboratory services adds to a valuable, and promising, body of work examining ap-



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proaches to contain health care costs. By the third year of the program, they found that the average amount spent per laboratory test by Safeway and its employees was 31.9% less than the amount spent by controls, such that the 3-year initiative was associated with \$2.57 million less spent on laboratory testing, including \$1.05 million less in patient out-of-pocket spending.¹

The opportunity for such a large cost reduction derives from the striking variation in negotiated prices for laboratory services. The price for the most commonly prescribed laboratory test, the basic metabolic panel, ranges from \$6.15 at the 25th percentile to \$44.00 at the 75th percentile.

But for reference pricing programs to succeed, some work is required on the part of patients, who may have little awareness of price differences across laboratories, especially differences between those in some physicians' offices and in large commercial laboratories. To take advantage of the savings, patients will have to choose the lower-priced laboratories, often instead of the laboratory at the physician practice. Safeway addressed this through announcement of the initiative and by providing employees a smartphone app to compare the price of a test at each laboratory in the network with the reference price.

Where does reference pricing fit in the context of consumer-focused approaches that private insurers or large employers can use to achieve lower spending not only for laboratory services, but also for the larger market of covered medical services? Broadly, there are 3 such approaches being pursued in the United States today—high-deductible benefit designs, narrow networks, and tiered networks. Reference pricing is a relatively aggressive version of the third. The approaches differ on dimensions such as the information challenges for consumers and the degree to which they support integration of delivery as opposed to fragmentation.

The most common efforts focused on lowering health care spending are combinations of high deductibles and tools for patients that provide information on prices for different providers. Deductibles have been increasing over time, as reflected in growing popularity of plans eligible for Health Savings Accounts (HSA), as well as increases in plans with deductibles below the threshold for HSAs.² The availability of tools for enrollees that show prices by provider specific to their plan has also grown a great deal. A 2013 survey conducted for Catalyst for Payment Reform showed that 98% of responding health plans offer such tools for their enrollees, but only 2% of enrollees use them.³

The problem with this approach to cost containment is the complexity for consumers. Finding out the exact services needed and comparing prices among unfamiliar providers may

be a challenge for many consumers. Another issue is that the approach does not work well for services that cannot be scheduled in advance and for most inpatient services, where even high deductibles are exceeded for almost all hospitalizations. Indeed, since Safeway's health plan already had a high deductible, the savings shown in this study are in addition to what was achieved by the high-deductible approach. This approach also encourages patients to search broadly across the health care system for services "a la carte" rather than commit to an integrated system to take responsibility for their care—also an issue with reference pricing.

Network strategies have the potential to contain costs with less information burden on consumers than high deductibles and with less loss of financial protection. With a narrow network plan, the insurer can negotiate for lower rates and exclude providers with the highest prices, enabling them to offer a lower premium. The consumer needs to factor the breadth of the network and whether specific providers are included in their annual choice of plan. The consumer, in effect, is using the plan as purchasing agent rather than doing their own price shopping. The rapid growth of narrow network products in the Marketplace Exchanges has not been without problems in the area of network transparency and adequacy, but the premium savings have been substantial.⁴ This approach is more supportive of integration, especially for those large systems that can offer an insurance product based on their providers.

Many find narrow networks' required commitment to less provider choice for a year as unduly restrictive and would prefer a tiered network plan, a third commonly used strategy to lower health care spending. These tiered plans are designed for those wanting more provider choice flexibility, allowing choices between providers in a preferred tier (which has lower out-of-pocket patient cost) vs those in other tiers on a point-of-service basis. Like the narrow network, savings come from shifting volume to less expensive providers and additional negotiated discounts. The information needs for consumers are still limited—the tier placement of a provider and the difference in cost sharing

In this context of consumer-focused approaches to achieve lower spending, reference pricing is seen as an aggressive form of tiered network for selected services. Provider choices are still made at the point of service, but the incentive to use providers in the preferred tier—those with prices below the reference price—is much larger. Reference pricing has the advantage of being more flexible than other tiered networks in the sense that providers are sorted into tiers for a specific category of service, eg, laboratory tests, rather than for all services. To the degree that providers are more efficient in some areas than in others, reference pricing can be a more targeted differentiator.

But reference pricing cannot be applied to all medical services. It works best for those services that are most standardized and where variation in quality is less of a concern. It can

be applied only to services that are “shoppable,” meaning that they can be scheduled and are offered by more than 1 provider. White and Eguchi,⁵ using the criterion of high volume and scheduled in advance, estimated that about one-third of spending in a privately insured population is shoppable. An

implication of the estimate is that reference pricing can expand a great deal to a number of other medical services, but other cost containment approaches, including other network strategies, are needed to successfully contain health spending and lower costs for nonshoppable medical services.

ARTICLE INFORMATION

Author Affiliations: Leonard D. Schaeffer Center for Health Policy and Economics, University of Southern California, Los Angeles; Center for Health Policy, The Brookings Institution, Washington, DC.

Corresponding Author: Paul B. Ginsburg, PhD, Brookings Institution, 1775 Massachusetts Ave NW, Room 823, Washington, DC 20036 (paul.ginsburg@usc.edu).

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