

Appropriate Use Of Reference Pricing Can Increase Value

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July 7, 2015



The California Public Employees Retirement System (CalPERS) purchases coverage for 1.3 million employees (and their families) of the state of California, and of other public entities such as municipalities and transit systems. The organization's purchasing strategy seeks to stimulate providers to compete with each other on price as well as performance, thereby increasing the value offered by the health care system.

CalPERS has long been recognized as a leader in value-based purchasing, including defined contributions towards insurance premiums, quality reporting, and promotion of Accountable Care Organizations. Many of these strategies focus on health insurers and health care providers.

However, CalPERS recognizes that insurer and provider-focused initiatives are hobbled if individual consumers are indifferent to the price of the care they select. More recently, therefore, CalPERS has implemented reference pricing as a consumer-oriented incentive that pursues the same core goals of increasing value in health care through higher quality and lower cost.

CalPERS considers consumer-oriented incentives to be integral to our larger value purchasing strategy. However, we find that [reference pricing](#) has been portrayed in some instances as a substitute for, rather than complement to, insurer- and provider-oriented incentives.

Our critics also argue that we, or someone, should enforce antitrust law to break up hospital systems, mandate bundled pricing, and/or regulate the rates charged by hospitals, in lieu of implementing reference pricing. Whatever the virtues of these policy ideas, and we have mixed feelings about them, they are beyond the means of even the largest purchasers.

What Is Reference Pricing?

With reference pricing, the health care purchaser places a limit on what it will contribute towards payment for a particular procedure, assuring that the selected payment limit allows appropriate access for patients. The payment limit typically is the median or some other mid-point in the distribution of prices in the local market. Consumers who select a provider that charges less than

the purchaser's limit receive standard coverage, with minimal cost sharing. Consumers who select a provider charging above the contribution limit must pay the entire difference.

These excess payments do not count towards the patient's deductible or the annual out-of-pocket maximum. They are conceptualized as a network exclusion, but a milder form of those inherent in narrow-network insurance designs: Reference pricing offers full coverage at cost-effective providers and partial coverage at more expensive providers; narrow-network strategies offer full coverage at some providers and no coverage at others.

Yet, remarkably, choice-sustaining reference pricing has been criticized as unfriendly to consumers, and choice-limiting strategies such as narrow networks have been advocated in its place. It is ironic for critics to accuse reference pricing of creating access barriers (to high-priced providers) and then advocate much more draconian contractual restrictions or punitive regulations for those same providers.

Reference pricing is not for all patients. Appropriately constructed programs permit exceptions based on the clinical needs and geographic location of individual patients. For example, CalPERS provides exceptions from reference pricing when a member lives more than 50 miles from a facility that offers the service below the price limit. It also exempts the patient if the patient's physician gives a clinical justification for using a high-priced facility or hospital setting. Safeway exempts from its reference pricing program laboratory tests for all patients with a diagnosis of cancer.

What Is The Problem, To Which Reference Pricing Is The (Partial) Solution?

Reference pricing addresses the wide variation in the prices charged for similar services across the health care sector. Prior to the implementation of reference pricing, for example, the prices CalPERS faced ranged from \$12,000 to \$75,000 for joint replacement surgery, from \$1,000 to \$6,500 for cataract removal, and from \$1,250 to \$15,500 for arthroscopy of the knee. These are the actual prices negotiated with and paid to the providers, not the (much higher) list prices that providers impose on uninsured consumers who lack bargaining leverage.

This variation is due in part to market consolidation and to regulatory barriers to new provider entry. It is facilitated and enhanced by the consumer's demand for convenient care at any price.

How Does Reference Pricing Affect Consumer And Provider Behavior?

When faced with paying the excessive rates charged by high-priced providers, most consumers shift towards lower-priced providers. For CalPERS, this has occurred for both inpatient and ambulatory surgery. Other employers have obtained analogous changes in consumer choices for laboratory tests, imaging procedures, and drugs.

These changes in consumer choices result in reductions in prices and payments. Some high-priced providers reduce their prices so as to mitigate the threatened loss of volume. Payments by employers and insurers decline as consumers shift to providers that charge lower prices.

The application of reference pricing to inpatient orthopedic surgery led to significant price reductions from some of the hospitals whose initial prices were above the CalPERS payment limit. These price reductions have increased; the number of California hospitals charging prices below the CalPERS reference limit (\$30,000) rose from 46 in 2011 to 72 in 2015.

It should be emphasized that reference pricing has caused actual price reductions, not merely slowdowns in the rate of price growth. This is the way markets are supposed to work.

Reductions in prices contribute to affordability of care. In the first two years after implementation, reference pricing saved CalPERS [\\$2.8 million for joint replacement surgery](#), [\\$1.3 million for cataract surgery](#), \$7.0 million for colonoscopy, and \$2.3 million for arthroscopy.

These savings accrue to the taxpayers of California, a long-suffering population who are being asked to pay for many other worthy projects. Critics of reference pricing need to face the consequences of their criticism, which is that taxes for the public (and payroll deductions for employees) would need to increase to reimburse the high provider charges that a ban on reference pricing would facilitate.

Studies of reference pricing for orthopedic surgery have shown that patient experience, clinical symptoms, functional ability, and quality of life have stayed the same or improved after the implementation of reference pricing. It goes without saying that the quality measures available to reference pricing initiatives are incomplete, but this applies to quality measures available for any public or private strategy to moderate costs.

The CalPERS reference pricing initiative took into consideration all the quality measures that were available to it. None of our critics' preferred cost-reduction strategies, including antitrust enforcement, bundled pricing, and price regulation, have better measures of quality; many of them forgo quality measurement altogether.

Reference pricing strategies encourage patients to use high-volume hospitals and surgeons who benefit from experience to obtain good outcomes as well as lower costs. Studies for arthroscopy and colonoscopy have found surgical outcomes at low-priced freestanding centers to be equal to those at high-priced hospital-based centers; the implementation of reference pricing reduced costs while not affecting quality for those procedures. (These studies are currently under peer review at medical journals.)

What Are The Limits Of Reference Pricing?

Reference pricing should only be applied to procedures and products that are "shoppable," where consumers have the time to make choices based on both price and performance. There are numerous shoppable services in health care, including scheduled hospital procedures, ambulatory surgical procedures, laboratory tests, imaging procedures, and drugs. Purchasers such as CalPERS work with information technology firms that provide price and quality data to consumers' phones, tablets, and laptops.

Reference pricing should not be applied to emergency procedures or to individual components of care that cannot be selected independently, such as laboratory tests conducted during the course of a physician office visit. It should not be applied to complex conditions that have substantial differences in case mix severity. For example, CalPERS does not include revision surgery after a failed joint replacement, or complex bilateral procedures, in its reference pricing initiative.

Reference Pricing: Not A Panacea, But A Useful And Important Tool

Reference pricing should not be impeded by regulations that would entrench the current health care system. Well-constructed reference pricing offers meaningful choices to consumers and savings to purchasers, with no sacrifice of quality. It helps move health care from a provider-dominated to a consumer-engaged system.

The U.S. Department of Health and Human Services has interpreted reference pricing as consistent with the principles of the Affordable Care Act when implemented by large, self-insured employers, and has adopted a salutary wait-and-see stance. We commend the Department for its cautious support.

Employers need the ability to experiment with new consumer incentives as well as new provider incentives. Consumer choice works well in other sectors of the economy, and it can work well in health care as well, once consumers are given the tools and the incentives.

TAGS: [ACOS](#), [CALPERS](#), [CONSUMERS](#), [HEALTH CARE MARKET](#), [HEALTH CARE PROVIDERS](#), [REFERENCE PRICING](#)

COMMENTS

2 Trackbacks for “Appropriate Use Of Reference Pricing Can Increase Value”

1. [Power To The Patients: How To Increase Consumerism In Healthcare | Corpstrat.com](#)

January 20th, 2016 at 1:02 pm

2. [Reference Pricing and your Medical Bills | FYI Health](#)

October 3rd, 2015 at 4:53 pm

6 Responses to “Appropriate Use Of Reference Pricing Can Increase Value”

1. ***Jon Gludemans, Michael Kolber, and Joel Ario*** says:

While we agree reference pricing could be a helpful tool in controlling healthcare costs, we are concerned that it has the effect of undermining the adequacy of a health plan’s network, as we discussed in a Health Affairs blog post last year (<http://healthaffairs.org/blog/2014/09/18/reference-pricing-and-network-adequacy-standards-conflict-or-concord/>). By indicating that only a subset of “network” providers are willing to accept the amount the plan is willing to pay for a particular procedure, the plan abandons the conventional understanding of a “network.” The Department of Labor, which jointly issued the HHS guidance referenced above, recognized this dynamic and cautioned that reference pricing should only be used by self-insured group health plans if the plans ensure that an “adequate” number of providers accept the reference price. Thus, this guidance might be read not, as the authors do, to take a “wait-and-see” position, but instead to impose the first network adequacy requirement of any kind on self-insured group health plans.

[Read More](#)

July 13th, 2015 at 8:50 am

2. ***Don Levit*** says:

James:

You may be right in those instances, but I have heard at several seminars that reference based pricing is also a certain percentage of Medicare.

Why use an insurer when you have the Medicare “negotiations?”

Don Levit

[Read More](#)

July 11th, 2015 at 4:21 pm

3. ***James Robinson*** says:

There have been various (small) estimates published of the potential impact of reference pricing on total spending, based on a (small) number of identified services that most easily could be subjected to the incentive. Clearly RP is not a panacea, as it is not well designed for complex conditions where the consumer does not have a one-time choice such as where do I go for my elective surgery. But, IMHO, the principle underlying reference pricing is likely to spread widely and have a big impact. That principle is an old one: defined contribution. RP applies it to particular procedures or tests, whereas Alain Enthoven in his famous proposals applied it choice among health insurance plans. Defined contribution is a powerful principle that says society (the employer, insurer, government program) will support and subsidize your health care, but not without limit. You make many of the relevant choices, and you will bear the financial accountability to make those choices wisely, from an economic as well as clinical perspective. Society will pay up to a defined contribution (reference price) limit; you pay the rest.

[Read More](#)

July 11th, 2015 at 1:09 pm

4. **James Robinson** says:

With all due respect, you are incorrect in thinking and hoping that reference pricing substitutes for or does without network contracting. On the contrary, the first step at CalPERS, Safeway and the other firms using reference pricing is to have an insurer negotiate the best prices possible with providers (on behalf of the self insured firms). The employer then establishes its reference price payment limit based on the median or some other midpoint of these prices. This is very different from balance billing under indemnity insurance, where the provider posts any price and the insurer simply passes them to the enrollee after contributing some indemnification payment. Indemnity is not coming back, and should not come back. RIP.

[Read More](#)

July 8th, 2015 at 11:39 pm

5. **Civisisus** says:

Boynton & Robinson might have helped us out by providing their wet-finger guess at the share of health care costs that “referenceable” treatments comprise. How much of a “thing” is this thing, potentially?

July 8th, 2015 at 7:49 am

6. **Don Levit** says:

One big advantage of reference based pricing is it abolishes networks

The key is getting accurate enough data to arrive at a median price

And somehow quality has to be factored in

Does the author or others have any “references” we could contact at National Prosperity Life and Health?

Don Levit

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