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Reverse Reference Pricing: Rewarding Patients For Reducing Medicare Costs

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Prices for health care services vary significantly, not only across markets but also within markets across settings of care. For example, the same services or care received in hospital outpatient departments (HOPDs) can cost several times as much as care received in ambulatory surgery centers (ASCs), with no difference in quality. This significant variation in prices has led private insurance markets to try a number of

innovations to encourage consumers to price shop for health care services, including high-deductible health plans and price transparency programs. However, despite the thousands of dollars that could be saved by going to low-priced providers, most consumers do not price shop.

Private Insurers Have Used Innovative Approaches To Encourage Price Shopping

There is one solution that has shown impressive results in encouraging price shopping and promoting price competition among providers—reference pricing. Under reference pricing, the insurer sets a reference price, and the patient pays standard cost sharing if he or she goes to a provider with a price below the reference price. However, the patient pays the difference between the provider price and the reference price as additional out-of-pocket costs if he or she goes to a provider with a price above the reference price. Reference pricing forces consumers to make a financial tradeoff between going to more expensive providers and saving money.

For three common outpatient surgical services—joint arthroscopy, cataract surgery, and colonoscopy—the reference pricing program implemented by the California Public Employees' System (CalPERS) increased the use of ASCs by approximately 15 percentage points and reduced overall costs for the procedures by approximately 20 percent with no impact on quality. Because consumers switch from high-priced to low-price providers, hospitals now have an incentive to keep their prices competitive.

CMS Can Learn From Private-Sector Approaches

While this program was implemented for the privately insured market, similar price differences exist in Medicare. Across all outpatient surgical services, the 2015 average Medicare reimbursement amount for ASCs was approximately 67 percent of the average reimbursement amount for HOPDs. Exhibit 1 shows the differences in Medicare reimbursement rates for the 10 outpatient services that account for the largest share of Medicare spending. This difference in prices has not been linked to any difference in clinical quality or patient experience. The Medicare Payment Advisory Commission (MedPAC) estimates suggest that the Medicare system could save $1.4 billion if reimbursement rates were equalized between ASCs and HOPDs. The Centers for Medicare and Medicaid Services (CMS) recently proposed adopting many of MedPAC's recommendations by reimbursing ASCs and HOPDs equally. However, this proposal has already faced opposition from hospitals and rural health providers.

Exhibit 1: ASC and HOPD Price Differences for Common Outpatient Services

Outpatient Services					
Procedure	**Number of Procedures**	**Total Medicare Spending**	**ASC**	**HOPD Price**	**Difference**
Cataract surgery with IOL implant	3,307,921	$2,240,805,681	$978	$1,824	$846
Mohs surgery	733,162	$400,867,869	$245	$453	$208
Colonoscopy	2,691,788	$714,268,755	$475	$878	$403
Gastric tissue biopsy	1,989,643	$347,436,745	$378	$700	$321
Joint injection or aspiration	5,847,354	$346,516,081	$29	$231	$202
Eye drug injection	2,970,047	$318,237,606	$48	$279	$231
Biopsy skin lesion	3,461,185	$315,481,470	$72	$293	$220
Cataract laser surgery	945,271	$270,413,727	$254	$470	$216
Transforaminal epidural injection	1,114,229	$242,533,992	$345	$639	$293
Cataract surgery	284,363	$225,237,766	$978	$1,824	$846

Sources: Data on procedures volumes are from the 2017 Part B Physician/Supplier National Data: Top 200 Level II Current Terminology (HCPCS/CPT) Codes. Data on ASC prices are from the October 2017 Ambulatory Surgical Center (ASC) payment related annual and quarterly ASCFS and Drug file Addenda. Data on HOPD prices are from the October 2017 Hospital Outpatient Propspective Payment System Addenda. Notes: ASCs is ambulatory surgery centers. HOPDs is hospital outpatient departments.

In the face of this backlash, CMS can learn from the CalPERS experience with reference pricing. Although, adopting reference pricing will save money, it does not make sense for Medicare. It might not be politically feasible to impose additional cost sharing on Medicare beneficiaries, even if it is limited to circumstances in which they choose higher-price providers, or to equalize reimbursement rates. A better solution is to share savings with beneficiaries if they choose lower-price ASCs. Under this “reverse reference price” approach, beneficiaries will be rewarded for choosing ASCs instead of being penalized for choosing HOPDs. Beneficiaries will receive a reward—a fixed percentage of the difference in price between ASCs and HOPDs—if they go to an ASC. The rewards could be given as contributions to health savings accounts, as reduced cost sharing for the procedure or service, or reductions in the beneficiary’s Medicare premium.

These rewards should be focused on services that meet two criteria: there is a big difference in the ASC versus HOPD reimbursement rate, and the majority of services are

delivered at HOPDs. The level of the optimal reward will need to be determined in pilots that test the responsiveness of beneficiaries to seek care at ASCs to different reward levels. The level of the rewards might also depend on the balance between the two goals of the program—reducing Medicare costs and reducing the burden of out-of-pocket costs for beneficiaries. Protections should also be designed to make sure that the program does not lead to increases in the use of overutilized services, such as diagnostic imaging services. Our recent research on similar programs offered by private employers shows that rewards lead consumers to choose lower-price providers resulting in lower prices paid for health care services. In addition, we find a modest decline in use of care, perhaps due to greater price transparency associated with rewards.

How To Address Opposition By Providers

This policy of giving rewards for using lower-price ASCs will most likely be opposed by HOPDs. One option to allay some of the concerns of HOPDs is to incentivize HOPDs to voluntarily charge a lower price than the current HOPD price. Those HOPDs that lower their price below a certain threshold will be eligible for the same patient rewards as ASCs. This is a win-win policy for both Medicare and beneficiaries as long as the price discount is higher than the patient rewards. For example, if HOPDs voluntarily agree to a $100 price discount and patient rewards are $50, then under the new policy, Medicare costs are reduced by $50 and beneficiaries gain $50. HOPDs that offer price discounts make up some or most of the costs of the discounts via higher volume or market share. In many other industries, firms use this exact same tradeoff to increase profits. For example, grocery store coupons attract price-sensitive consumers who would have otherwise gone to a competing store. Providers that do not want to make this tradeoff are not forced to change anything. However, they may experience a reduction in volume, as patients go to lower-price providers.

To provide a wider variety of choice, Medicare could institute discount tiers with higher patient rewards for facilities willing to offer higher discounts. For example, a “luxury” HOPD provider would not offer any discount, and patients would thus not receive a reward. A “premium” HOPD provider could offer a 25 percent discount between the HOPD price and the ASC price, which would be split between Medicare and the patient. An “ultra-premium” provider could offer a 100 percent discount and simply charge the ASC price and be eligible for higher rewards to patients. HOPD providers can decide which level of discount, if any, to offer based on their market environment.

This proposal makes sense for several reasons. It reduces both Medicare costs and the patient financial burden of care while simultaneously preserving patient choice. It is “market oriented” because it introduces price competition to Medicare. Provider

participation is voluntary, and it rewards more efficient providers by increasing their market share. Private insurance markets have used a similar approach to lower health care costs. It is time for Medicare to apply these lessons to help address a $1.4 billion problem.

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