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## How to Turn Employees Into Value Shoppers for Health Care

by James C. Robinson | 9:30 AM October 21, 2013

Here in the U.S., we fret that our health care system costs too much. We pay too much for diagnostic imaging, drugs, laboratory tests, surgical procedures, and almost everything else. But, given the structure of health insurance, the question should not be “Why are prices so high?” The question realistically should be “Why are prices not even higher?”

Patients are protected by insurance from most of the costs of the care they select and have no reason to shop for the best price. Deductibles and coinsurance expose us to some expenses, but the really expensive tests and treatments appear to many patients to be free. We get past our out-of-pocket cost sharing maximum before we get past the hospital elevator.

The lack of price sensitivity on the demand side of the health care market cannot but influence strategies on the supply side. Why discount prices when you won't get more customers? Why not raise rates and use the revenues to build new facilities, hire new staff, and acquire new clinical technology? Why invest research dollars in developing innovations that are cheaper as well as better? Why not develop new products that offer minor performance improvements in exchange for major price increases? Does this not sound like our health care system?

### Reference Pricing Payoff

One antidote to aggressive pricing by providers is reference pricing by purchasers. Under reference pricing (<http://www.ncbi.nlm.nih.gov/pubmed/22949452>), the employer categorizes drugs by therapeutic class and procedures by geographic market and establishes a limit to what it will pay within each category. The consumer must pay the full difference between the price charged and the limit established by the employer. This contrasts with copayment designs, in which the consumer pays a fixed dollar amount regardless of the price charged, and with coinsurance designs, in which the consumer pays only a percentage (typically 20%) of the price difference. Payments above the employer's reference price are not subject to the consumer's annual out-of-pocket cost sharing maximum.

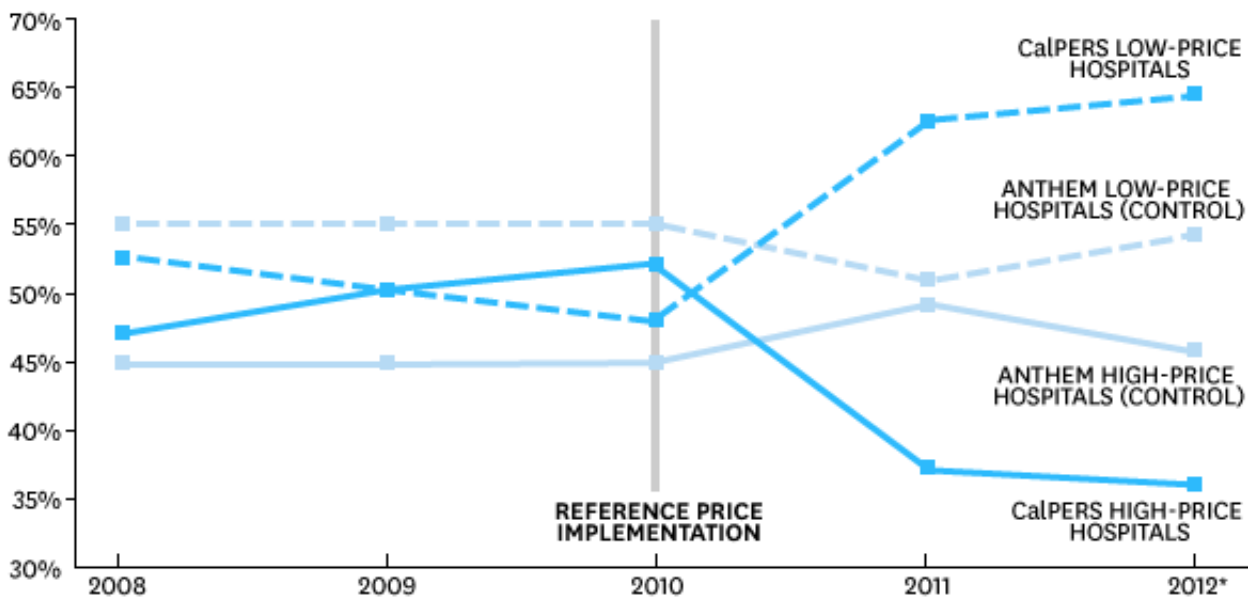
In January 2010 the California Public Employees Retirement System (CalPERS) implemented a reference pricing initiative for patients undergoing total knee and hip replacement surgery. The alliance purchases insurance coverage for 1.3 million public employees, dependents, and retirees in California, of which approximately 450,000 are enrolled in its self-insured PPO product. CalPERS was annoyed with having to pay rates ranging from \$20,000 to \$120,000 for the same procedure at different hospitals, without any indication that higher price was associated with higher quality. It established a reference price limit of \$30,000 and identified 41 “value-based” hospitals that charged less than this limit, performed well on quality metrics,

and were well distributed geographically. It then launched a communications initiative to its members emphasizing that if they used these value facilities they would be subject only to traditional cost sharing but if they used the higher-priced facilities outside of this group they would incur significant financial liabilities.

The results (<http://www.ncbi.nlm.nih.gov/pubmed/23918483>) were striking. The number of CalPERS members selecting low-priced hospitals for their orthopedic procedures increased by 21.2% in the year after implementation, while the number selecting high-priced facilities fell by 34.3%. The percentage of CalPERS members using hospitals with prices below the payment limit rose from 48% in year before implementation to 63% in the year after, and the shift to value hospitals was sustained in the second year.

### ENCOURAGING PATIENTS TO CHOOSE LOWER-PRICED HOSPITALS

Percentage of surgery patients choosing low-priced and high-priced hospitals before and after implementation of “reference pricing.” These pricing initiatives cap what self-insured employers reimburse hospitals for certain procedures and holds patients responsible for amounts over this limit. CalPERS implemented reference pricing in 2010; Anthem did not.



**SOURCE** California Public Employees Retirement System [CalPERS] and Anthem Blue Cross.  
\*Through September of 2012

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([http://hbrblogs.files.wordpress.com/2013/10/low\\_priced\\_hospis\\_5802.gif](http://hbrblogs.files.wordpress.com/2013/10/low_priced_hospis_5802.gif))

These changes in patient choices would have surely been even larger if the hospitals whose prices initially exceeded the CalPERS limit had not reduced their rates in response to the new benefit design. Across the high-priced hospitals as a group, prices for knee and hip replacement declined by an average of 34.3%. Across the state as a whole, including initially low-priced facilities, prices for CalPERS fell by 26.3%.

The combination of increased preference for low-priced facilities and price reductions at high-priced facilities saved CalPERS \$3.1 million in the first year after implementation. Savings for the first two years exceeded \$6.0 million. CalPERS is now expanding reference pricing to ambulatory surgery.

### The Long-Term Goal

Reference pricing is no panacea for the inefficiencies of the U.S. health care system. It does not help with the complex decisions about which treatment is appropriate for which patient. Its focus is on price, not quantity. To function well, reference pricing requires valid and publicly available information on price across competing providers. It works best for tests and treatments where there is only limited variation in quality, or where variation in outcomes can be dealt with by directing complex cases to well-established Centers of Excellence.

Reference pricing is being applied by the Safeway grocery chain to laboratory tests and to diagnostic imaging modalities such as MRI and CT. The WellPoint insurance plan has instituted reference pricing for drugs in several markets. Health plans and Internet-based start-ups are aggregating provider price data and combining it with information on the employers' contribution limits to make transparent for each consumer exactly how much he or she will have to pay at each hospital or clinic. Some major employers, such as Lowe's and Boeing, have established benefit designs that channel patients needing cardiac and orthopedic procedures to the Cleveland Clinic, Johns Hopkins, and other major hospitals in exchange for price and quality guarantees.

It is important not to commit the common error of overestimating the short-term implications of a new initiative and underestimating its long-term implications. Other firms implementing reference pricing may not achieve the CalPERS first-year savings. But the long-term goal of reference pricing is not just to reduce costs to employers but to increase consumer awareness of price and quality differences across providers. Reference pricing is part of a larger effort by employers to transform employees from passive insurance beneficiaries to active shoppers for value.

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