BERKELEY CENTER
FOR HEALTH TECHNOLOGY

Value In HealthCare: Employer Strategies to Engage Employees

James C. Robinson
Leonard D. Schaeffer Professor of Health Economics
Director, Berkeley Center for Health Technology
University of California

Overview

- Consumerism by Design and by Default
- High Deductibles & Reference Pricing
- Consolidation as challenge and opportunity
- Having our cake and eating it too

"Geez Louise—I left the price tag on."

Consumerism by Design

- Consumerism is rising for some right reasons
- A strong and long term cultural trend towards greater patient engagement and authority
  - From informed consent to shared decision-making
  - Self-monitoring and self-care
- Revolution in data and data systems
  - Internet search for information on disease & treatment reduces the historical asymmetry of information between patients and physicians
  - From information access to digital decision support

Consumerism by Default

- Consumerism is rising for some wrong reasons
  - Purchasers are looking for short-term relief from premium increases, even if it means shifting costs to employees who use the most care
  - The US has an eroding social solidarity, with a growing belief that health and health care are an individual, not collective, responsibility
  - From health care citizenship to consumerism
- Of course, consumer-oriented strategies suffer from their own limitations and failures.
- But, in my opinion, the trajectory towards greater consumer rights, responsibilities, and risks is strong and will continue
- Let's make it work for a better health care system

Consumerism & Organizational Integration

- Consumerism is supported AND challenged by consolidation of physician and hospital systems
- Supported: Consumers need to be able to choose among clinically meaningful care systems, which can be measured in terms of quality and cost. The fragmented cottage industry cannot offer this
- Challenged: Reduced numbers of provider organizations in each local market reduces the potential for competition and permits health systems to raise prices
- Can we have our cake and eat it too? Can we structure consumer choice among cost-effective integrated clinical organizations?

High-Deductible Health Plans

By Rajender Agarwal, Olena Mazurenko, and Nir Menachemi

High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services

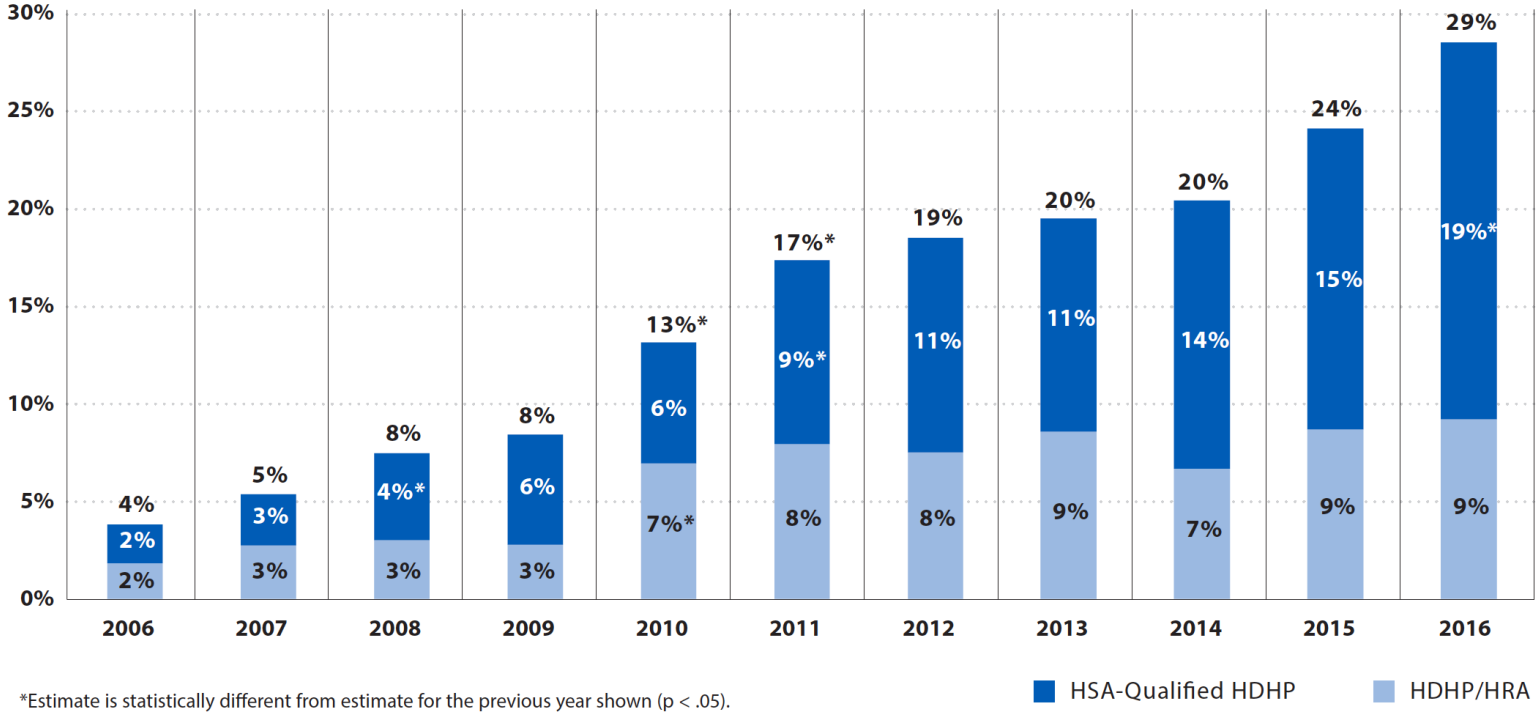
ABSTRACT Enrollment in high-deductible health plans (HDHPs) has greatly increased in recent years. Policy makers and other stakeholders need the best available evidence about how these plans may affect health care cost and utilization, but the literature has not been comprehensively synthesized. We performed a systematic review of methodologically rigorous studies that examined the impact of HDHPs on health care utilization and costs. The plans were associated with a significant reduction in preventive care in seven of twelve studies and a significant reduction in office visits in six of eleven studies—which in turn led to a reduction in both appropriate and inappropriate care. Furthermore, bivariate analyses of data extracted from the included studies suggested that the plans may be associated with a reduction in appropriate preventive care and medication adherence. Current evidence suggests that HDHPs are associated with lower health care costs as a result of a reduction in the use of health services, including appropriate services.

Health Affairs 2017;36(10):1762-68.

HDHP are popular among employers faced with tradeoff of premium versus deductible

EXHIBIT E

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2016

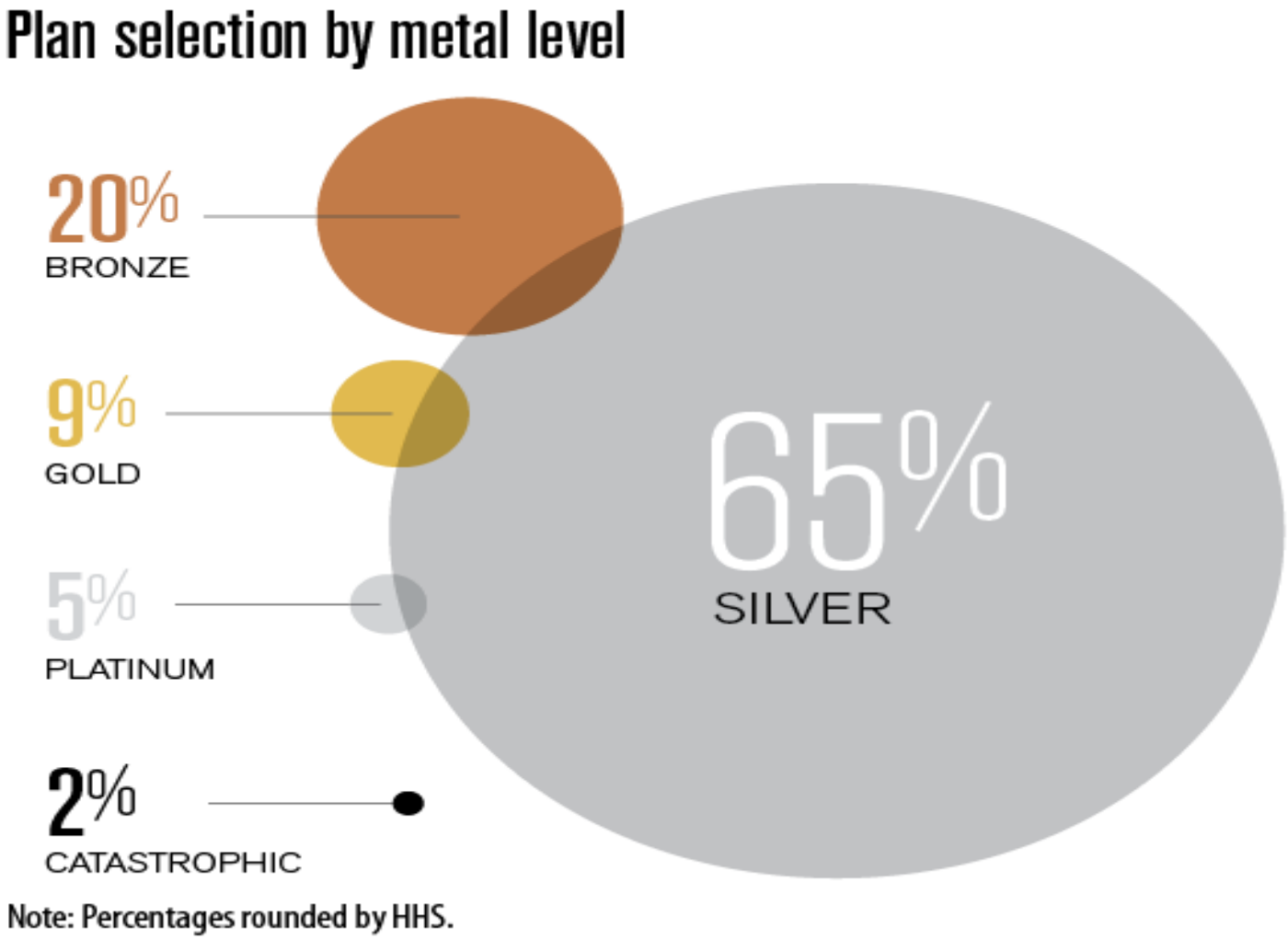


*Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information, see the Survey Methods Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.

HDHP are popular among individuals in ACA Exchanges when faced with same tradeoff



What is a Bronze or Silver Design?

Service	Cost Sharing (Bronze)	Cost Sharing (Silver)
Deductible	$5,000	$2,000
PCP Office Visit	$60 (3 per year)	$45
SCP Office Visit	$70	$65
Urgent Care Visit	$120	$90
ER Visit	$300	$250
Lab Test	30%	$45
X-ray	30%	$65
Generic Drug	$25	$25
Brand Drug	$50	$50
Max OOP: Individual	$6,350	$6,350
Max OOP: Family	$12,700	$12,700

Source: Covered California *Plan Options Participant Guide, 2017*

High Deductibles: Impacts

- Reductions in spending: 10%
  - Savings come from reduction in volume (tests, visits), not from reductions in price (shopping)
  - Reductions in use of both appropriate and inappropriate services
  - No evidence exists on long-term impacts
- Reduction in social pooling of risk and payment
  - Savings accrue largely to healthy enrollees (who pay lower premium and do not incur cost sharing) rather than to sick enrollees (who pay lower premium but then must pay high cost sharing)
  - Insurers encouraging shift to HDHP out of concern for adverse selection (attracting sick enrollees)

Source: Agarwal et al. Health Affairs 2017;36(10):1762-68

High Deductibles: Limitations

- Too much and too little cost sharing
  - Primary & preventive services are under deductible
  - Major procedures are above deductible, giving no incentive for shopping among facilities based on price
- Lack of guidance for consumers and patients
  - Incomplete and sometimes inaccurate information on price, quality, appropriateness across providers
- Annual reset of deductible in January
  - Emergency services are more at risk than are procedures that can be delayed till next plan year
- Financial barrier to access
  - HDHP do not guarantee availability of low-cost service options, and can create major access barriers for consumers with modest means

Reference Pricing

By James C. Robinson, Timothy T. Brown, and Christopher Whaley

ANALYSIS & COMMENTARY

Reference Pricing Changes The 'Choice Architecture' Of Health Care For Consumers

ABSTRACT Reference pricing in health insurance creates incentives for patients to select for nonemergency services providers that charge relatively low prices and still offer high quality of care. It changes the "choice architecture" by offering standard coverage if the patient chooses cost-effective providers but requires considerable consumer cost sharing if more expensive alternatives are selected. The short-term impact of reference pricing has been to shift patient volumes from hospital-based to freestanding surgical, diagnostic, imaging, and laboratory facilities. This article summarizes reference pricing's impacts to date on patient choice, provider prices, surgical complications, and employer spending and estimates its potential impacts if expanded to more services and a broader population. Reference pricing induces consumers to select lower-price alternatives for all of the forms of care studied, leading to significant reductions in prices paid and spending incurred by insurers and employers. The impact on consumer cost sharing is mixed, with some studies finding higher copayments and some lower. We conclude with a discussion of the incentives created for providers to redesign their clinical processes and for efficient providers to expand into price-sensitive markets. Over time, reference pricing may increase pressures for price competition and lead to further cost-reducing innovations in health care products and processes.

Health Affairs 2017;36(3):524-30.

Reference Pricing: Structure

- Focus on tests and treatments where there is wide variation in price without variation in quality
- Payer negotiates its best price (allowed charge)
- It then sets its contribution limit at the minimum, median, or elsewhere on distribution of prices
- Consumer who selects provider charging below this reference price pays nominal cost sharing, but if pick more expensive must pay full difference
- Payer promotes communication to consumers
- Exceptions are made for patients whose physicians submit clinical justification for high priced facility/test

Reference Pricing: Impacts

- Consumers quickly shift to lower-priced options
- This leads to 10-30% decline in prices paid
  - For TJR, evidence of competitive price reductions
- Available metrics (30, 90 day complication rates) show no change in quality
  - No evidence exists on long-term outcomes
- No impact on rate of utilization (because there are always options with low cost sharing)
- Contrast with high deductible health plans
  - Strong impact on price shopping
  - No impact on volume

Source: Robinson et al. Health Affairs 2017;36(3):524-30.

Reference Pricing: Limitations

- Reference pricing targets discrete components of care, rather than more meaningful care episodes
- It targets low hanging fruit: services with major price differences according to site of care
  - ASC versus HOPD: surgery, diagnosis, infusion
  - National versus local clinical laboratory
- Data on price and quality are incomplete and difficult to navigate for consumers. There is no link to appropriateness criteria.
- Some patients should go to HOPD because their case is more severe; reference pricing should be based on clinical criteria (via prior authorization)

Consumer Choice & Provider Integration

- The most intense debate over provider consolidation and consumer choice is in ambulatory (surgical, diagnostic) services
- Most health systems are heavily investing ambulatory services. Some are channeling volume to hospital outpatient departments and/or raising ASC prices above market levels
- MemorialCare has a different strategy

Purchaser Perspectives on Integration

- Policymakers and purchasers recognize the imperative for clinical coordination, and that integrated organizations can do this best
- However, they want the value of these efficiencies to be passed to them, and are displeased to experience price increases (‘monopoly power’)
- When forced to choose, purchasers will channel their members/patients away from integrated systems towards smaller clinical organizations if this is the only way to obtain lower prices
- Higher deductibles, tiered coinsurance, and reference pricing now all target HOPD v ASC

Example of Purchaser Strategy: Arthroscopy of the Knee and Shoulder

Consumer Choice Between Hospital-Based and Freestanding Facilities for Arthroscopy

Impact on Prices, Spending, and Surgical Complications

James C. Robinson, PhD, Timothy T. Brown, PhD, Christopher Whaley, PhD, and Kevin J. Bozic, MD, MBA

Investigation performed at the University of California, Berkeley, California

Background: Hospital-based outpatient departments traditionally charge higher prices for ambulatory procedures, compared with freestanding surgery centers. Under emerging reference-based benefit designs, insurers establish a contribution limit that they will pay, requiring the patient to pay the difference between that contribution limit and the actual price charged by the facility. The purpose of this study was to evaluate the impact of reference-based benefits on consumer choices, facility prices, employer spending, and surgical outcomes for orthopaedic procedures performed at ambulatory surgery centers.

Methods: We obtained data on 3962 patients covered by the California Public Employees' Retirement System (CalPERS) who underwent arthroscopy of the knee or shoulder in the three years prior to the implementation of reference-based benefits in January 2012 and on 2505 patients covered by CalPERS who underwent arthroscopy in the two years after implementation. Control group data were obtained on 57,791 patients who underwent arthroscopy and were not subject to reference-based benefits. The impact of reference-based benefits on consumer choices between hospital-based and freestanding facilities, facility prices, employer spending, and surgical complications was assessed with use of difference-in-differences multivariable regressions to adjust for patient demographic characteristics, comorbidities, and geographic location.

Results: By the second year of the program, the shift to reference-based benefits was associated with an increase in the utilization of freestanding ambulatory surgery centers by 14.3 percentage points (95% confidence interval, 8.1 to 20.5 percentage points) for knee arthroscopy and by 9.9 percentage points (95% confidence interval, 3.2 to 16.7 percentage points) for shoulder arthroscopy and a corresponding decrease in the use of hospital-based facilities. The mean price paid by CalPERS fell by 17.6% (95% confidence interval, −24.9% to −9.6%) for knee procedures and by 17.0% (95% confidence interval, −29.3% to −2.5%) for shoulder procedures. The shift to reference-based benefits was not associated with a change in the rate of surgical complications. In the first two years after the implementation of reference-based benefits, CalPERS saved $2.3 million (13%) on these two orthopaedic procedures.

continued

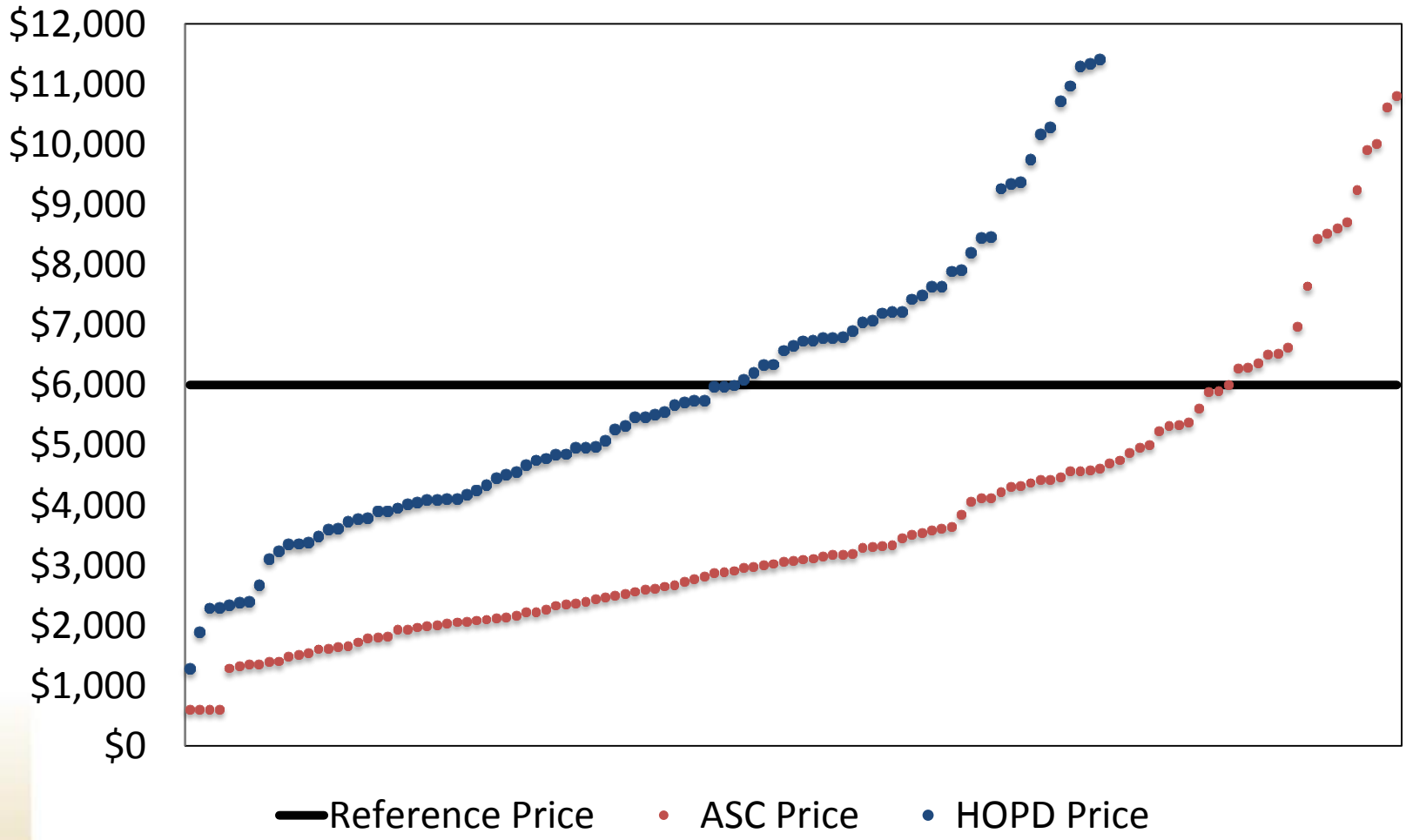
J Bone Joint Surgery Am 2015;97:1473-81

California Public Employees Retirement System

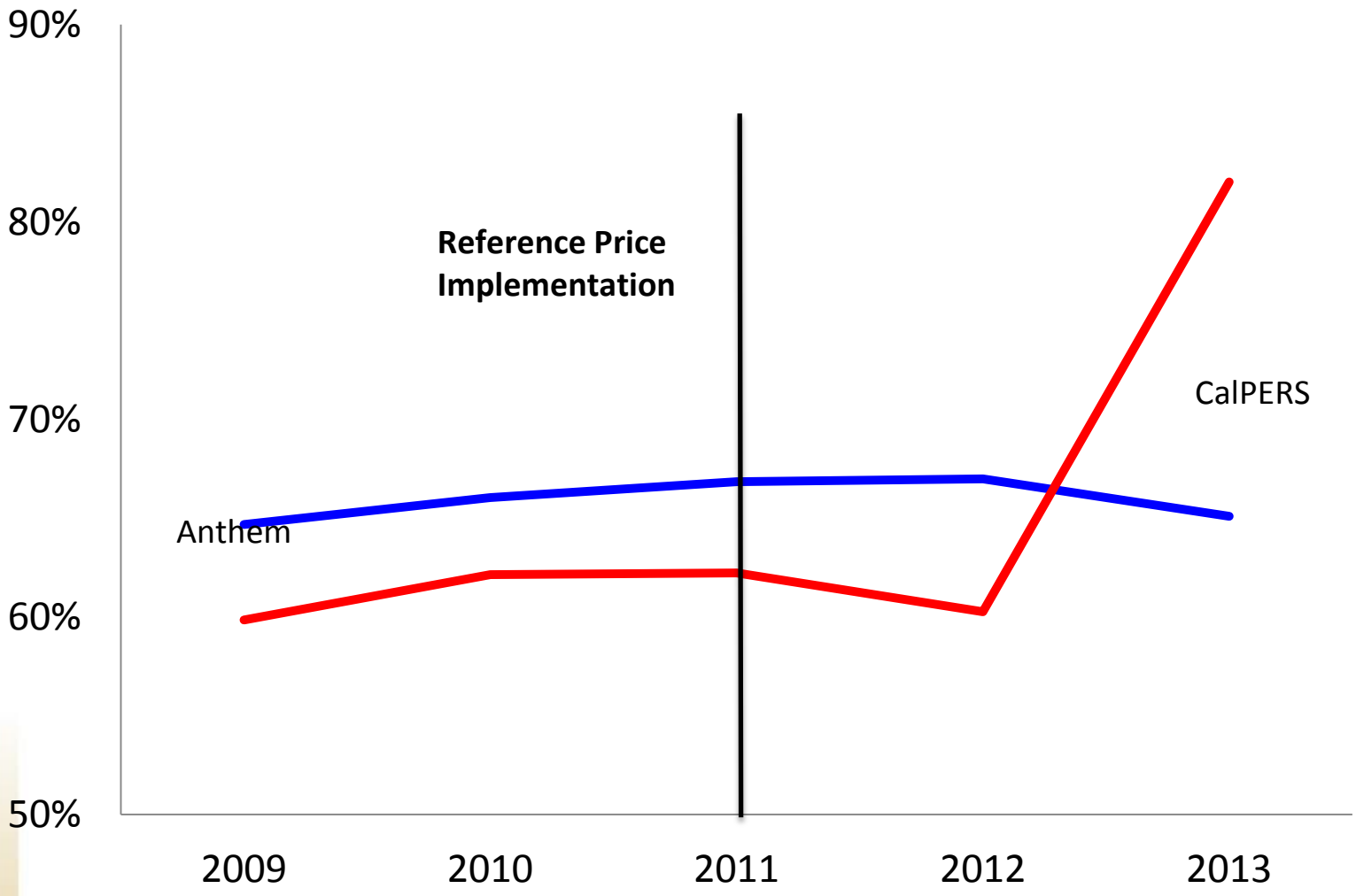
- In 2011 CalPERS pioneered reference pricing for TJR when faced with price variation in CA from $25,000 to $120,000
- It subsequently expanded to ambulatory procedures, including arthroscopy, to favor ambulatory surgery centers (ASC) over hospital outpatient departments (HOPD)

- Reference payment limit was set for HOPDs at the level of the average price charged by ASC

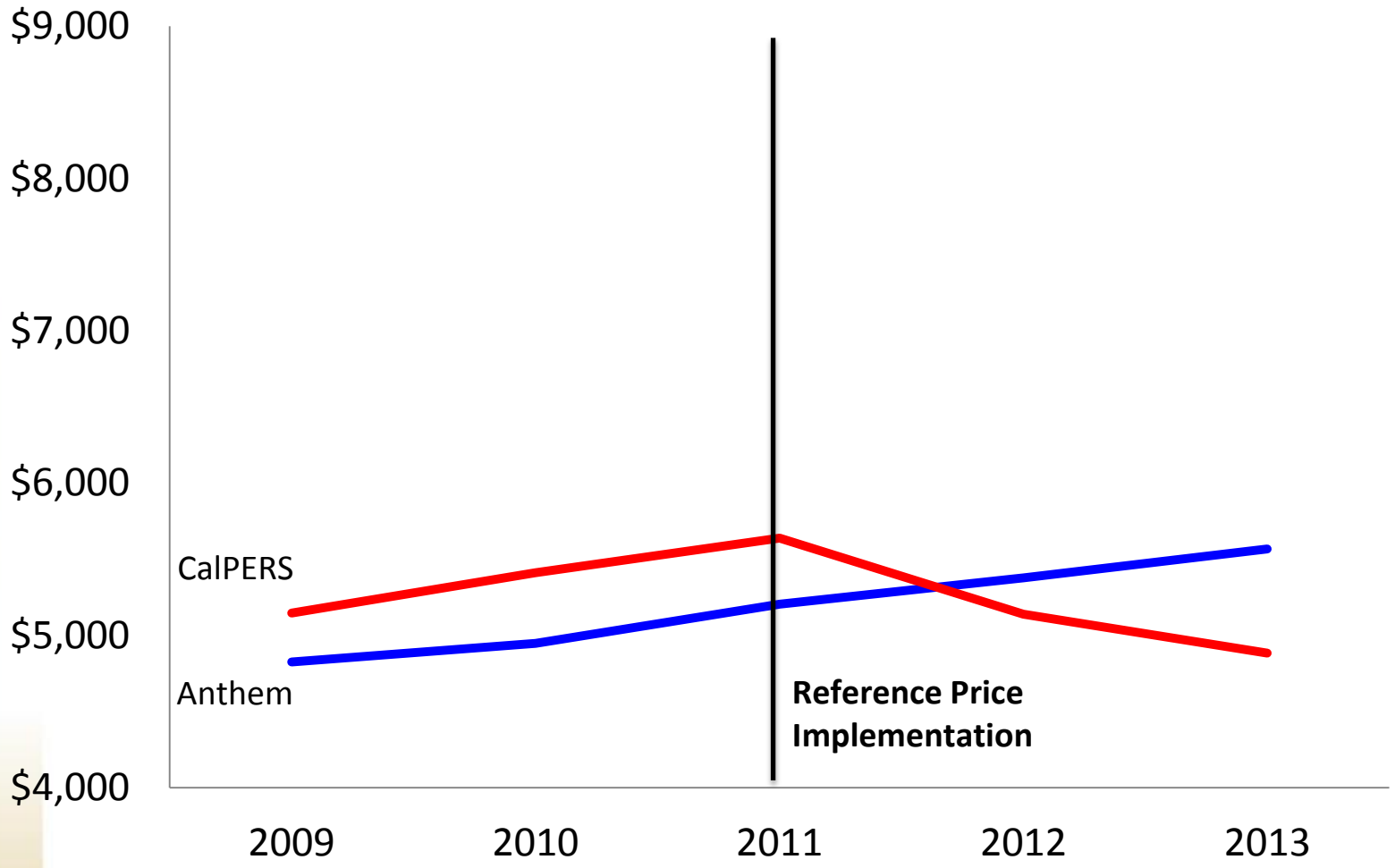
Price Variation Prior to Implementation of Reference-Based Benefits: Knee Arthroscopy



Percentage Selecting ASC over HOPD: Knee Arthroscopy



Change in Average Price Paid: Knee Arthroscopy



An Alternative Strategy? MemorialCare

- MemorialCare is diversifying rapidly into ambulatory services through acquisition, JV, partnerships
- However, its patient and pricing strategy differs from that of many other systems, and is interesting
  - HOPD prices are higher than ASC prices,
  - But only patients with higher severity, who need to backup that a hospital provides, are channeled to HOPD
  - Other patients are channeled to ambulatory settings, in JV with physicians and ambulatory chains
  - ASC prices are set at community levels
- From the purchaser perspective, this could show the path to creating meaningful, price-competitive coordinated care

Conclusion: Managed Coordination

- Consumerism is here to stay; let's make it work
- Providers must develop clinically coordinated and cost-effective choices for consumers
- Today's HDHP and reference pricing are FirstGen
- Today's integrated delivery systems are FirstGen
- This is managed competition 2.0
- Let's call it managed coordination

BERKELEY CENTER
FOR HEALTH TECHNOLOGY

Explore more at our website:

bcht.berkeley.edu

Reference Pricing

What is Reference Pricing? How does it work? Does it generate savings? Explore pilot program results for Diagnostic Tests, Surgery, and Pharmaceuticals.