

Opinion

Comparison Shopping for Knee Surgery

The same procedure might cost \$20,000 or \$120,000. Here's one way to bring down prices.

By James C. Robinson
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Here we go again. The [Affordable Care Act](#) intends to transform the health-care system, extend coverage, reduce costs and increase quality—all without asking anything of the patients. Consumers will pay with higher taxes, of course, but otherwise will face no incentives to make wise choices, compare price with performance or shop for value. Doctors, hospitals, insurers and, most of all, the government will do that for them, which is hardly reassuring. This reflects what I call the "impossibility theorem" in health care.

The impossibility theorem maintains that patients cannot make good choices, but, rather, must be dependent on the well-intentioned decisions of others. Policy makers believe this theorem by definition. But, just to make sure, they have structured the health-insurance system to ensure that patients are never asked or allowed to make price-conscious choices. The arrangement underlies the innumerable rules, subsidies, entitlements, mandates and prohibitions that collectively make health care the least efficient part of the economy. [ObamaCare](#) makes it worse.

Now the impossibility theorem is being tested. A small number of large employers have developed "reference pricing" for at least some of the services covered by their health-insurance programs, a major shift from traditional benefit designs. Some insurers are incorporating it into their product designs. Under reference

pricing, the employer or insurer sets a maximum contribution it will make toward the payment for a test or treatment. The employee or enrollee can select any hospital or clinic but must pay the difference between the contribution limit and the actual price.

Reference pricing serves as a reverse deductible. Rather than the patient paying up to a defined limit and then the insurer covering the remainder, the insurer pays up to a defined limit and the patient pays the remainder. This has the remarkable feature of exposing the patient to the variation in prices for treatments that are above deductible thresholds. And the patient's contribution isn't limited by an annual out-of-pocket maximum.

Apparently, the prospect of paying more sharpens the attention of buyers on the bottom line, which in turn changes the behavior of sellers.

An example of reference pricing is the initiative by the California Public Employees' Retirement System, or Calpers, for orthopedic knee and hip replacement. Calpers covers 1.3 million employees, dependents and retirees, of which approximately 450,000 are enrolled in its self-insured, preferred-provider organization products.

Calpers was upset after noticing it paid between \$20,000 and \$120,000 for the same procedure across the state, without commensurate differences in outcomes. In January 2010, the retirement organization established a \$30,000 reference-price limit on what it would pay, and the administrators identified 41 hospitals that charged less than the limit while scoring well on quality criteria. Calpers launched an outreach program informing employees that they had their usual coverage at these "value-based" facilities but would have to pay the extra money charged elsewhere.

In collaboration with my colleague Tim Brown, I recently completed an evaluation of the Calpers initiative, comparing consumer choices and hospital prices in the two years before and after implementation. We adjusted for the patients' health status and compared Calpers trends with data for Anthem Blue Cross enrollees who underwent similar procedures but didn't have reference pricing.

Apparently patients are willing to look at the price—when they are the ones paying it. The percentage of Calpers patients selecting low-price hospitals increased to 63% in the year after reference pricing was introduced, from 48% in the year before, and the trend continued into the second year after the introduction.

Even more striking was the effect on pricing strategies. Half of the high-price hospitals cut their rates, many by a considerable amount. (Guess which number they were trying to hit.) Across all hospitals, prices charged to Calpers for joint-replacement surgery declined by 26% in the first year and by even more in the second. The combination of changes in market share and cuts in prices reduced Calpers' expenditures over two years by \$6 million, a much-appreciated gift to a state whose budget deficit has been at Greek levels.

Reference pricing won't be the solution to all the ills of the U.S. health-care system. But it can make a contribution. Employers, insurers and patients themselves can save money in the short term. And in the long term, reference pricing helps disprove the "impossibility theorem" and reinvigorate an older and better one: You cannot fool all of the people all of the time, even in health care.

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