Reference-Based Pricing: What It Is and Why It Matters

Colorado Culture of Health Conference

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Today’s Goals

1. Explain reference-pricing
2. Describe how it impacts price and outcomes
3. Identify opportunities to use reference-pricing to drive value
Lots of Clouds on the Horizon

- High variability in pricing within a market
- No link between price and outcomes
- Changing role of the consumer
In other industries, experience has shown that consumers can be a powerful force driving market change.

Consumers are paying an enormous share of the cost for their healthcare services.

If we could arm consumers with credible information and a reason to care, could we harness their ability to drive change?
This is Not a New Concept
What is Reference Pricing?

Plan establishes a fixed price for a service

Members can receive the service anywhere

If provider’s price is above the reference price, member pays the difference

If price is below the reference price, member incurs no additional expense
Nuances

• Plans may pay for travel costs if the member has to travel to reach a service provider within the reference price.
• Plans may penalize for use of a more expensive provider by not allowing the extra member cost to accrue to the plan out-of-pocket maximum.
• Plans may incent for use of a service provider within the reference price by waiving copays or other member cost-sharing.
Why Reference Pricing?

• In commercial health care, geographic variations in total expenditures are mostly due to variations in price, not in utilization
• Consumers lack incentive to shop when someone else is paying (insurer, employer)
• For those who do want to shop, limited information on price and quality at the point of decision-making
Primary Goals of Reference Pricing

• Cost Containment
  – Patients choosing providers at the reference price
  – Patients paying the difference between the reference price and the charge through cost-sharing
  – Providers reducing their prices to the reference price

• Predictability

• Cost containment without eliminating choice
Who Has Done It?

- **CalPERS**: Ambulatory procedures.
  - Price for hospital outpatient department was set at average price for an ambulatory surgery center
- **Safeway**: Laboratory tests
  - Price set at 60th of distribution of prices for each lab test in each region
- **Oregon Educators Benefit Board**: Joint replacements
  - Flat rate based on average costs
- **Midsize rural employer in MO**
  - Reprice all billed claims at an average of 25% above Medicare’s allowed price
Outcomes - CalPERS

- CalPERS saved $2.6M in the first year and $5.5M in the first two years without impacting quality of care
- Created a “halo effect”. When CalPERS rates became public during 2012, several other hospitals approached Anthem Blue Cross (administrator) to reduce their contracted rates to $30K (or very close to it).
  - The approved list expanded the following year
CalPERS

Average Price for Colonoscopy Before & After RP

- CalPERS
  - Before RP: $1,800
  - After RP: $1,600
- Anthem
  - Before RP: $1,400
  - After RP: $1,600

Reference Price Implementation
Outcomes – Safeway

Patient and Lab Tests 2010-2013

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number patients</td>
<td>16,445</td>
<td>15,925</td>
<td>14,479</td>
<td>13,744</td>
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<tr>
<td>Total number of lab tests</td>
<td>92,606</td>
<td>89,635</td>
<td>82,638</td>
<td>79,532</td>
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<tr>
<td>Average tests per patient</td>
<td>5.6</td>
<td>5.6</td>
<td>5.7</td>
<td>5.8</td>
</tr>
<tr>
<td>% patients using higher-priced labs</td>
<td>45.6%</td>
<td>17.9%</td>
<td>14%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Average price per test</td>
<td>$27.72</td>
<td>$19.64</td>
<td>$18.43</td>
<td>$18.56</td>
</tr>
<tr>
<td>Anthem Control</td>
<td>$27.72</td>
<td>$29.72</td>
<td>$29.72</td>
<td>$29.72</td>
</tr>
</tbody>
</table>

Outcomes - Safeway

Average Prices Paid for Diagnostic Tests Before & After


$0 | $5 | $10 | $15 | $20 | $25 | $30 | $35

Anthem | Safeway
Outcomes – OEBB

- Utilization remained stable
- Savings of $3M in Year One
- Outlay stabilized after Year One
Outcomes – Rural Employer

- Deductibles stayed the same
- Coinsurance rate stayed the same
- No increase in premiums, which would have increased 23% under status quo

Lockton Companies Case Study, 2016
Outcomes – Member Satisfaction

- Rural outlier providers are challenging
- Cost savings are very visible to the members
  - $1.05M of Safeway savings accrued to patients ($1.7M to Safeway)
- No backlash on quality or outcomes
- More work!
Surgical Complications for Colonoscopy Before & After

- **Anthem**: 5%, 4%, 3%
- **CalPERS**: 1%, 0%

Reference Price Implementation
Price versus Utilization

RP appears to drive price down but not utilization

Limit application to procedures with stable utilization but high price variation
Candidates for RP

• Large variation in price, little variation in quality
  – Elective surgery procedures
  – Lab tests
  – Imaging procedures
  – Drugs
Conditions Not Appropriate for RP

- Emergency services
- Chronic conditions
- Services that are embedded as part of complex procedures
Challenges

• Balance billing patients by OON providers
• High burden on benefits team
• Engagement of members requires ongoing education
• Maintaining accurate and accessible lists of “willing” providers
Challenges

• Provider and insurance company non-disclosure agreements and restrictive gag clauses
• Requires TPA partnership
• Communication with providers regarding basis for RP and lead time for contracting
• Stop-Loss cannot be an auto-adjudication based on prior rates
Federal “Blessing”

- Federal guidance appears to permit employer plans to treat providers that will accept the reference price as the only in-network providers and excluding or limiting cost-sharing for services rendered by other providers as reasonable
  - Must provide sufficient time and ample, easily accessible information for the consumer to make an informed choice of provider
  - Not acceptable for emergency procedures
  - Exceptions process in place
Challenges - Policy

• Potential for cost-shifting to eliminate any real cost savings in the system as a whole
  – While not an issue for employers participating in reference pricing, it does impact those who cannot participate

• Savings don’t permanently change to cost slope unless reference price is adjusted dynamically
Pros

• Colorado’s enormous price variation
• Solid data and analytics – CIVHC and CHI
• Can implement incrementally
Total spending per person is growing at faster rates than prior years:
- 4.6% growth in 2016
- 4.1% growth in 2015
- Sub-3% growth from 2012 to 2014

Spending growth in each year from 2012 to 2016 was almost entirely due to price increases
- Drugs and Hospital - ED and Surgery

Utilization of most health care services remained unchanged or declined, both year-over-year and over the 2012-2016 period
Hospital Costs/Prices in Colorado

Colorado Hip/Knee Replacement Average Total Episode Payments Medicare vs. Commercial

Commercial payments are up to 232% more than Medicare

Analysis based on fiscal year 2013 Fee-For-Service Medicare claims and commercial payer claims in the Colorado All Payer Claims Database (CO APCD, www.comedprice.org). Prices have been rounded to the nearest thousand and reflect average paid “episode” amounts (initial procedure payments AND 90 day post-acute payments), using calculations similar to the Centers for Medicare & Medicaid (CMS) Comprehensive Care for Joint Replacement (CJR) methodology (https://innovation.cms.gov/initiatives/cjr).
Colorado

Pros
• Colorado’s enormous price variation
• Solid data and analytics – CIVHC and CHI
• Can implement incrementally

Cons
• Limited number of major employers
• Only one part of a solution
Discussion

Your thoughts on the feasibility and value of reference pricing
Contact Information

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