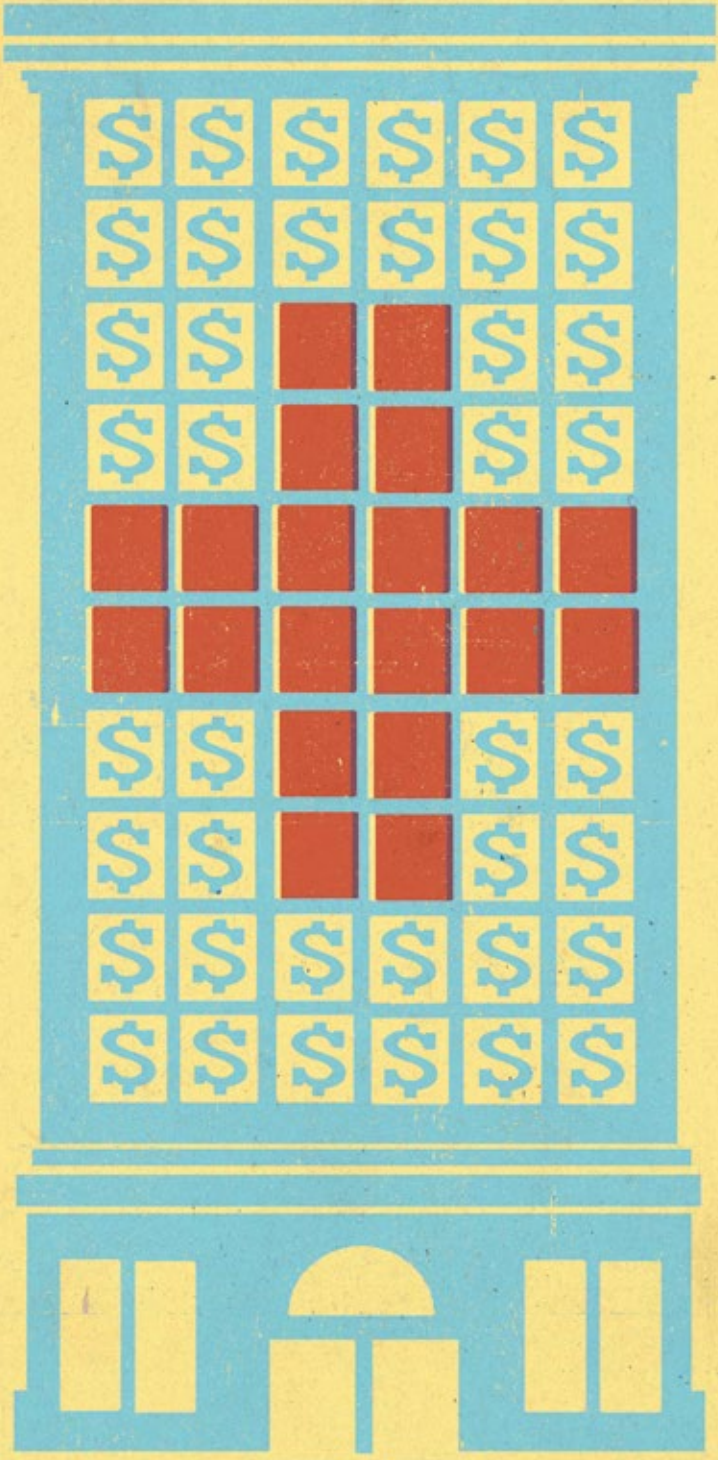


FORCING HOSPITALS TO COMPETE ON PRICE

REFERENCE PRICING COULD CHANGE THE RULES OF THE GAME.

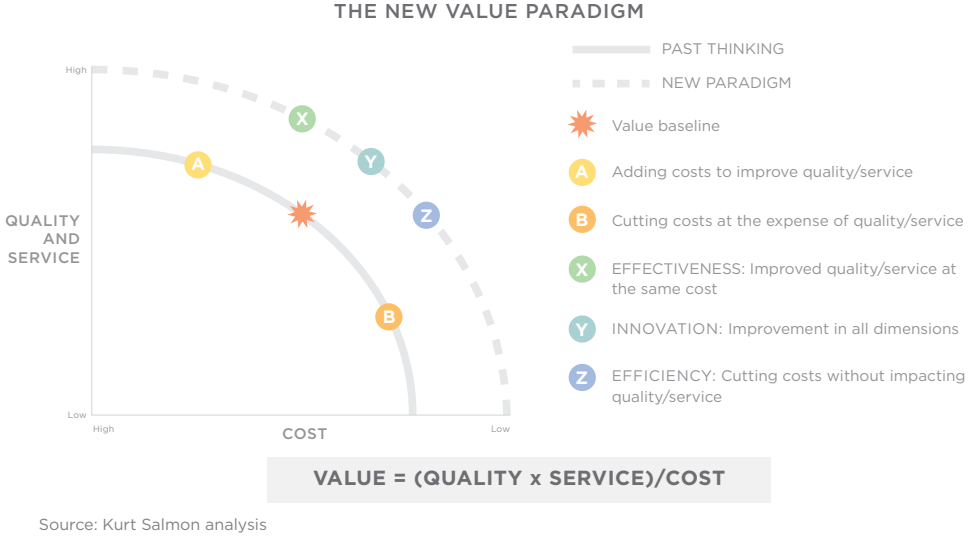
Health care is a major exception to the adage that "you get what you pay for." Prices can vary widely even within a limited geographic area, with no correlation to quality. Colonoscopies in New York City cost anywhere from $740 to $8,500,[i] and in some metropolitan areas, basic laboratory tests done in hospitals cost 8 to 14 times more than those done in physician offices or other community-based settings.[ii]

Such seemingly illogical inconsistencies, together with the opacity of pricing and quality data—where reliable data exist at all—have historically been a barrier to competition in the health care provider sector and have pushed costs to unsustainable levels.

Reference pricing, long used in Europe to manage prescription drug costs, may offer a way to standardize costs and empower consumers to make more-informed health care choices.[iii]

Implemented in the appropriate settings, reference pricing will impose a new operational reality on providers, forcing them to rethink and rebuild their pricing models. As competition intensifies and new state legislation puts teeth into demands for

EXHIBIT 1: In the new value paradigm, care providers cannot trade off between quality and cost to maintain value. Consumers will demand enhanced value at the same or lower cost.



Source: Kurt Salmon analysis

increased transparency, costs will come down and consumers will be empowered in altogether new ways.

Value for the Win

The current interest in reference pricing derives in large measure from the growing availability of reliable, accessible, user-friendly data for measuring value—not as code for "cut-rate" or "cheap," but as a meaningful and quantifiable entity. An increase in the quality of a health care procedure without a concomitant rise in cost would yield higher value; so would a reduction in cost without a decline in quality. Given the variability in pricing for some of the most commoditized procedures, such as colonoscopies and arthroscopic repairs, it is clear that they are vastly overpriced in some markets, thus bringing value down. Reference pricing is designed to bring value back up by facilitating informed decision making and directly rewarding value-based decisions. (See Exhibit 1.)

Indeed, the merits of reference pricing are built into the Affordable Care Act, which requires hospitals to publish a list of standard charges for their services and update it annually. In April 2014, the Obama administration went a step further and approved the

Reference Pricing Defined

The idea is simple: An insurer or self-insured employer caps the amount it will pay for a given procedure. Patients who choose a provider that stays within that cap are responsible only for their customary cost-sharing as set forth in their insurance plan; those who go with a more expensive provider will owe the difference between the reference price as determined by the insurer or employer and the amount charged. That difference is not counted toward their annual out-of-pocket maximums.

Reference pricing lends itself most readily to commodity health care services, which account for one-third of total health care spending.[iv] These are routine, non-urgent procedures where care quality is more likely to be uniform and the risk of complications negligible. They currently include imaging and lab tests, select inpatient procedures such as hip and knee replacements, ambulatory procedures, and physician visits. In time, the mechanism could be extended to health care services with more variability in outcomes, like prenatal care and cancer chemotherapy.[v]

"Shoppable" Services

Commodity, or shoppable, health care services lend themselves better to reference pricing than urgent or high-complexity services.

CRITERIA

- A well-defined service
- Elective, non-emergent
- Scheduled in advance
- Commonly provided by many different providers (hospitals, freestanding outpatient centers, physician offices)
- Significant price variability

use of reference pricing by self-insured employers.[vi]

CalPERS Takes the Field

Reference pricing isn't yet widespread in this country, but it is steadily gaining traction. (See Exhibit 2.) The percentage of employer-sponsored plans incorporating the strategy nearly doubled from 2011 to 2012, and a recent survey by Aon Hewitt found that 68% are expected to adopt it in the near future.[vii]

To date, the most compelling demonstration of reference pricing's potential is a pilot program launched in 2011 by the California Public Employees' Retirement System (CalPERS). Having determined that hospital prices for knee and hip replacement surgery ranged from $15,000 to $100,000 with no difference in quality, CalPERS capped the amount it would pay at $30,000 for the facility charge and compiled a list of 45 hospitals that agreed to meet that reference price. Within two years, CalPERS saved $5.5 million, the cost of joint replacements dropped by 26%[viii] and the most expensive providers had reduced their fees by an average of $42,000 to around $27,000.[ix] CalPERS has since extended the strategy to several more standard procedures, including colonoscopies and arthroscopies.

While the CalPERS experience is the most persuasive to date, it was not the first. In 2008 and 2009, Safeway, the national supermarket chain, instituted reference pricing for drugs, imaging and colonoscopies.[x] More recently, Kroger fixed a reference price of $800 for certain imaging scans in 10 of the 31 states where it does business.[xi]

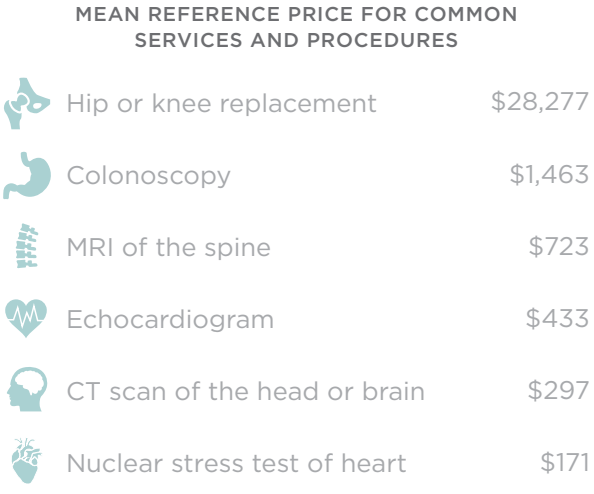
Reference Pricing: The New Playbook?

Over the next few years, we anticipate that reference pricing will increasingly appear in urban and suburban markets where there are both an abundance of large employers

looking to drive down health care costs and competition among health care providers. It bears noting, however, that setting up and administering reference pricing entails a number of costs, from creating appropriate analytics and gathering pricing data to providing the resources employees need to make informed decisions. Thus, acceptable returns will accrue only when there is a critical mass of local employees and an incentive by the employer to incorporate cost parameters into its health plan. By ensuring a sufficient number of claims for a given service or procedure, it will be possible to establish a meaningful reference price and quality metrics.

By the same token, the impact of reference pricing will be greatest in a competitive environment—a defined region with multiple systems, hospitals and freestand-

EXHIBIT 2: Reference pricing for various services, each with fairly uniform care delivery protocols, was analyzed across 230 hospital referral regions.



Source: Paul Fronstin and M. Christopher Roebuck, April 2014

ing facilities—and, importantly, significant price variations across providers with no correlation between cost and quality.

Reference pricing is not without its critics. There are concerns that some low-cost providers will raise their fees to align with reference prices, or that the mechanism will, in some instances, wind up shifting costs to consumers.[xii] Some worry that reference pricing doesn't factor in cost differences associated with each patient's underlying comorbidities and health status, which could lead to more cherry-picking. Some have suggested that the savings benefits are overstated, given its limited applicability to the costliest treatment setting—inpatient care.

And then there is the argument that Medicare has been "reference pricing" at the DRG level for years and yet hasn't meaningfully impacted the way hospitals operate. If the largest single payor in the country can't effect meaningful operational change, why would the adoption of reference pricing by commercial payors matter?

Of course, Medicare doesn't pass along higher costs to the patient; the hospital absorbs any costs over the set price. Medicare patients currently have no incentive to price shop, unlike non-Medicare patients, who would be responsible for paying any costs above a reference price.

What seems certain is that the current system of hospital-set charges, payor-negotiated discounts and patient-sheltered payments cannot last forever. Change is coming—first in the ambulatory space in large urban and suburban markets and eventually to the rest of the country. While still the exception, reference pricing—or a similar price-transparency mechanism—will in time become the norm. ❖

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i *New York Times*
ii NIHCR Research Briefs
iii *GABI Journal*
iv NIHCR Research Briefs
v Ibid.; Health Care Incentives Improvement Group
vi Fierce Health Finance
vii *Modern Healthcare*
viii HSC Research Briefs
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x HSC Research Briefs
xi Ibid.
xii EBRI Issue Briefs