REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-14

Subject: Reference Pricing
(Resolution 808-I-13)

Presented by: Jack McIntyre, MD, Chair

Referred to: Reference Committee J
(Melissa J. Garretson, MD, Chair)

At the 2013 Interim Meeting, the House of Delegates referred Resolution 808, "Reference Pricing," which was sponsored by the Louisiana Delegation. Resolution 808-I-13 asked that the term "reference pricing" be substituted for the term "benefit payment schedule" in American Medical Association (AMA) policy, and that the AMA advocate for the option of "reference pricing" in a pluralistic approach to health system reform.

Reference committee testimony reflected interest in the concept of reference pricing and the need for additional information about how reference pricing is being used and its possible implications for patients and physicians. In this report the Council explains the concept of reference pricing, describes examples of how this strategy may be used to influence health care costs in an insurance market, and makes recommendations to ensure that reference pricing strategies do not compromise the quality of patient care.

BACKGROUND

Reference pricing is a benefit design approach in which an insurer establishes a maximum amount it will pay on behalf of an enrollee for a specific procedure, service or therapy, regardless of which provider delivers the service. The purpose of reference pricing is to lower the insurer's cost of covering care provided by relatively high cost providers. The insurer does this by creating incentives for patients to see lower-cost providers, while also preserving some level of patient choice. Under a reference pricing system, patients may seek care from any provider, as long as they are willing to pay for any charges above the reference price. Reference pricing may be used in conjunction with other forms of cost-sharing, such as deductibles, co-insurance and co-payments. However, unlike traditional cost-sharing arrangements, there is usually no limit on out-of-pocket costs associated with payment for services that exceed the reference price.[1]

Reference pricing is generally used for select services where there is a wide variation in price that does not clearly correlate with quality of care or patient outcomes. From a health system perspective, there is some evidence that reference pricing can help lower costs by stimulating competition through increased price transparency and patient engagement. Ideally, reference pricing is not a cost-shifting strategy, but a reflection of a fair price for which quality care can be purchased, and an opportunity for health care markets to adjust accordingly. Providers able to offer the service at or below the reference price can be expected to attract a larger share of plan enrollees. Over time, at least some providers who charge more than the reference price are likely to find ways to lower their costs or differentiate themselves by demonstrating higher value in order to attract more patients.

Reference pricing allows insurers greater control over the amount they pay to providers on behalf of patients. However, the process of establishing a reference price is separate from the network contracting process, and the term "reference price" is not synonymous with "allowable charge." Under a reference pricing system, the reference price represents the amount of money an insurer will pay toward an enrollee's medical service, not the provider charge. Although the reference price will likely influence negotiations, insurers and physicians still negotiate individual contracts to determine contract rates even for services subject to reference pricing. If a provider's contracted rate for a procedure exceeds the reference price set by the insurer, the patient is responsible for paying the difference.

EXAMPLES OF REFERENCE PRICING AND EFFECTS ON PRICE AND ACCESS

Reference pricing was first introduced in Germany in the late 1980s, and has since been used in several countries to help control the cost of pharmaceutical spending in particular. Efforts to control rapid growth of prescription drug costs have resulted in many experiments in benefit design, and reference pricing strategies are potentially useful because of the widespread availability of generic and therapeutic alternatives for many products and medical conditions.

Studies of pharmaceutical reference pricing strategies adopted regionally in British Columbia, Canada, nationally in Germany, Norway and Spain, and in employer-sponsored drug plans in Canada and the US, indicate that reference pricing was associated with decreases in drug prices, increases in medication adherence and utilization of targeted medications, and an overall decrease in payer and patient expenditures. Reference pricing did not appear to have a negative effect on patient access to necessary medications or compliance with drug regimens.[2]

Although reference pricing has not been widely used in the US, the grocery store chain Safeway and the California Public Employees' Retirement System (CalPERS) have both used reference pricing in their benefit designs. Safeway, which covers more than 40,000 employees and their dependents in a self-insured preferred provider organization plan, has moved increasingly toward a more consumer-driven health benefit design, which includes reference pricing.[3] Safeway's use of reference pricing started in 2009 with a pilot program that set a reference price for colonoscopies in a specific regional market where there were tenfold variations in unit prices for the procedure. Safeway expanded the initiative to other markets in 2010, and also extended reference pricing to over half of the laboratory services covered by Safeway's benefit plan. Data are not available on the specific impact of Safeway's reference pricing policies on costs or the patient care experience. Reference pricing is one of many strategies Safeway has employed to manage health care costs, which have remained flat in recent years.[4]

CalPERS introduced reference pricing in 2011 for hospital facility fees associated with hip and knee replacements. CalPERS selected these procedures because there is a large variation in cost within its target market, without a corresponding variation in quality; the surgeries are elective; and the volume of surgeries is sufficient to support quality requirements.[5] CalPERS worked with Anthem Blue Cross to set a reference price that was intended to give members sufficient access to a choice of hospitals, and designated over 40 hospitals as preferred facilities based on price (i.e., at or below the reference price), minimum quality requirements and geographic coverage.

A study published in Health Affairs in August 2013 evaluated the CalPERS program and showed positive results with respect to the goals of a reference pricing strategy.[6] Specifically, CalPERS saved $2.8 million on hip and knee replacement surgeries, reflecting an increase in member use of low-price facilities, a decrease in member use of high-price facilities, and an across-the-board decrease in facility prices ranging from 5.6 percent at low-price facilities to 34.3 percent at high-

price facilities. Similar to the experience with reference pricing for pharmaceuticals, it does not appear that the use of reference pricing for knee and hip surgeries resulted in access problems or a reduction in quality or patient outcomes.

Although preliminary evidence suggests that reference pricing has some potential to reduce prices without compromising patient care, it should be noted that there are several issues that have not been addressed by studies to date. For instance, the analysis of the CalPERS reference pricing program was limited to changes in prices and service use related to joint replacement surgery. The study did not examine whether facilities that lowered their prices for hip and knee replacements implemented corresponding price increases for other services or procedures in the CalPERS system. In addition, the long-range impact of reference pricing on prices has yet to be determined. Although reference pricing appeared to result in short-term adjustments in the market, it is unclear how or if prices will remain lower over time.

A final consideration is whether the results of any particular reference pricing approach are generalizable to other services or health care markets. As noted, reference pricing can be an effective tool for a specific subset of services, but it may be ineffective or even harmful when applied to other services. Although reference pricing may yield cost savings for particular products or procedures, the strategy may have relatively little effect on costs across the health care system.[7]

DISCUSSION

Reference pricing is conceptually consistent with the AMA's broad policy emphasis on patient choice and market-based approaches to enhancing the value of health care. Reference pricing is a defined contribution strategy that creates incentives for patients to be cost-conscious while also allowing them to select care from the provider of their choice. The Council is encouraged by studies that suggest that reference pricing can lead to lower costs without compromising quality. Although there may be limits to the applicability of reference pricing and its potential to substantially reduce health system expenditures, the Council believes that it can be an effective benefit design strategy if implemented appropriately.

Practicing physicians must be actively involved in identifying the services that are appropriate for a reference pricing system to ensure that patient access to high quality care is not jeopardized. As noted, reference pricing is usually applied to a targeted set of services, such as hip and knee replacement surgeries targeted by CalPERS because the procedures are elective surgeries that are relatively common and show a wide variation in cost that cannot be explained by corresponding variations in quality. Reference pricing should be approached cautiously for services that lack defined protocols and where there may be large variations in quality, because the ability to effectively measure, quantify and compare quality continues to be elusive for many services. Additional considerations with respect to what services should be included in a reference pricing strategy include the relative complexity of the service and potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region.

The goals and methodology associated with setting a reference price will have significant implications for how the strategy affects patient access to care, health care markets, and health care costs. Setting a reference price too high could drive providers to cluster prices around the reference price, even if the service could be provided at a lower cost. Setting a price too low could limit affordability for patients, or lead to cost-shifting by providers who need to increase costs of other services in order to lower the cost of services covered under a reference pricing system. Reference

prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers at or below the reference price.

The Council is concerned that reference pricing could, intentionally or unintentionally, create incentives for providers to keep prices low for services subject to reference pricing, while simultaneously increasing prices for other services. As an example, hospitals could decrease their fees for a total hip replacement in order to capture a larger share of the market, but increase their fees for a service that is not included in the reference price, such as post-operative physical therapy. An effectively and fairly designed reference pricing system should not result in cost-shifting to other services in the health care system.

Reference pricing arrangements cannot work effectively without access to reliable, timely, comparable, and understandable information about the price and quality of services subject to reference pricing. Information about the services subject to reference pricing and the potential patient cost-sharing obligations should be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. In addition, systems must be in place to facilitate transparency that allows patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care.

Finally, market conditions and changes in technology or the availability of new data regarding health care delivery will affect the assumptions and expectations that support a particular reference pricing arrangement. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care, and ensure that procedures are in place to make plan modifications as necessary.

The Council is aware that price transparency and the availability of meaningful, appropriate data are critical to efforts to improve the value of health care, including the development and implementation of effective reference pricing systems. The Council on Medical Service is developing a report for the 2015 Annual Meeting that will explore issues associated with facilitating meaningful transparency throughout all parts of the health care system.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 808-I-13, and that the remainder of the report be filed:

That our American Medical Association support the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles:

1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system.

2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region.

3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions.

4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another.

5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement.

6. Insurance companies must notify patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period.

7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care.

8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care, and ensure that procedures are in place to make plan modifications as necessary. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

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