

Reference Pricing: When Transparency Is Not Enough

In most markets, consumers can compare prices and shop for the items they want. For example, to buy a new pair of shoes, a consumer can typically drive to a shopping mall and choose from a number of stores. Each store typically carries a number of different styles and brands. The consumer might choose to pay \$500 for a designer pair of heels or \$25 for an inexpensive pair of tennis shoes. The consumer can also shop online and have the shoes shipped to his or her home. Regardless of the choice the consumer makes, he or she knows the price and the different options available for the item, allowing the consumer to comparison shop and make choices based on the shoes that best fit his or her needs and budget.

Healthcare Markets Lack Transparency

Unfortunately, almost nothing in the healthcare market matches this model. Patients typically don't know the prices of healthcare services before they are provided, and prices can vary greatly for common procedures like mammograms and colonoscopies, even though there's no evidence that higher prices mean higher quality.[\[1\]](#) A doctor may charge different payers (e.g., private insurers, government programs like Medicaid and Medicare, and self-pay patients) different amounts for the same services, and hospitals typically rely on insured patients to subsidize the cost of care for the uninsured. Patients also do not typically shop for services independently. Rather, they rely on their health insurance carrier to negotiate prices on their behalf and assemble a network of providers that best fit their needs. In addition, the growing trend of provider

consolidation limits an insurer's ability to negotiate contracts in creating provider networks for an insurance plan, and the higher prices that result are passed on to the consumer or employer as higher premiums.

The lack of information accessible to patients is one of the reasons health care costs are going up.[\[2\]](#) In March 2018, a group of bipartisan Senators asked for recommendations about legislation to address price transparency in healthcare. In the request, they note “[i]n virtually every other industry, consumers are able to price shop, compare quality, and then decide what product best fits their needs. In healthcare, the lack of information and the inability to access it hurts patients and prevents normal market forces from driving competition, lowering prices, and improving quality.”[\[3\]](#) In response to this request, the Source [asserted](#) that All-Payer Claims Databases (APCDs) are a key tool in price transparency. We pointed out that a key impediment to wide-spread implementation of APCDs is the current judicial interpretation of the Employee Retirement Income Security Act (ERISA) and called on the Senators to devise a legislative fix.

Transparency Alone is Not Enough

While price transparency is a necessary first step to promote competition, many scholars have noted that price transparency alone has done little to control prices for health care services.[\[4\]](#) One reason for the lack of price shopping, especially among insured patients, is that insurance coverage insulates them from the full cost of their care. Further, since patients typically lack a way to compare providers, some may even choose a more expensive provider, assuming that the provider can charge higher prices because he or she provides

better care. In healthcare, unlike competitive markets like shoe sales, prices often don't correlate with quality, but instead reflect greater market or bargaining power (e.g., consolidation) of the physician group.

To mitigate this problem, some employers and insurers offer high-deductible health plans (HDHPs) in which beneficiaries are responsible for the full cost of their health care until the cost of the care reaches the deductible. Because these plans force individuals to be responsible for more of the costs for their care, the premiums for these plans are typically lower than traditional insurance plans. As a result of the individual mandate and lower prices for HDHPs, enrollment in high-deductible health plans has increased almost 7-fold in the last ten years, from 3 million enrollees in 2006 to 20 million enrollees in 2016.^[5] The reality, however, is that many individuals with HDHPs do not receive necessary care because they simply cannot afford to go to the doctor.

Reference Pricing: Incentivizing Shopping without Denying Care

An alternative method of addressing the moral hazard that arises when insurance insulates patients from the total cost of their medical care is reference pricing. When using reference pricing, an employer or insurer pays up to an established maximum price, the reference price, for a healthcare service. The reference price is typically set at a level that allows patients to receive a healthcare service from numerous high-quality providers without additional contribution. Insurers also typically offer patients a list of providers willing to offer the healthcare service at or below the reference price. The patient must pay for any costs of the service above that price, so reference pricing encourages patients to be more engaged

consumers. Unlike HDHPs, where patients might be forced to forgo care if they cannot afford the procedure, reference pricing ensures that patients get the care they need from providers covered by their plan. Reference pricing thus provides incentives for patients to choose lower-priced providers, while preserving their ability to choose higher-priced providers.

Reference pricing only works for “shoppable services” – those for which the patient can decide where to obtain care. It should not be used for urgent or emergency services or for portions of care where the patient has little control. For example, reference pricing could be used for the total cost of a non-urgent surgical procedure, but not for the surgeon and the anesthesiologist individually, because the patient has no ability to shop for those providers independently. Nonetheless, reference pricing has been successfully applied to many procedures (e.g., joint replacement, colonoscopies) and components of care (e.g., diagnostic imaging).[\[6\]](#)

Case Study: Reference Pricing for Pharmaceuticals

A study by researchers at the University of California, Berkeley analyzed how reference pricing for prescription drugs affect the choice of drug and cost.[\[7\]](#) Using data from the RETA Trust,[\[8\]](#) an association of 55 Catholic organizations, researchers found that implementation of reference pricing increased the percentage of prescriptions for lower cost drugs in each therapeutic class. To implement the reference-pricing initiative, the RETA trust divided drugs into 78 therapeutic categories using a similar methodology as Medicare and Medicaid. They then set the reference price to the cost of the least-costly drug in each category. The trust also paid for a more expensive drug whenever a physician requested an exemption with

a clinical justification to continue use of the more expensive drug. Without this exemption request from a physician, patients could still choose a more expensive drug, but they were required to pay the price difference. In the first 18 months after implementation, the program reduced the trust's drug spending by \$1.34 million; consumer out-of-pocket costs rose by \$0.12 million from patients who chose not to switch to lower cost prescriptions.

As seen in the above case, reference pricing programs may help promote competition among patented drugs within a therapeutic class – a market which typically [lacks competition](#). If reference pricing becomes widespread, when a drug manufacturer releases a new drug with a price higher than its clinical competitors, the manufacturer would need to justify that higher price with added clinical benefit. This competition would be particularly strong when a generic drug already exists in the class. For example, among statins, a commonly used class of oral drugs to treat high cholesterol, the price for drugs in the class ranges from \$12.30 to \$447.20 for the RETA trust.[\[9\]](#) If a drug proved to have significant clinical benefits, physicians would claim more exemptions, and the insurer could adjust the reference price to the new drug for patients whose conditions were better controlled with the new drug.

Reference pricing for pharmaceuticals in a therapeutic class is similar to the [German policy](#) adopted in 2011 to set the price the government will pay for a new drug. If the newly released drug does not demonstrate improved clinical efficacy relative to other drugs, the price is set at the cheapest comparable treatment. If the newly released drug demonstrates additional efficacy, the government negotiates with the manufacturer to set a new price that reflects its increased effectiveness. In 2015, Germany saved \$1 billion on new drug spending as a result of this policy.[\[10\]](#) As a result, reference pricing has the

potential to increase competition and reduce prices without sacrificing patient access or health.

Realizing the Potential of Reference Pricing

The potential for reference pricing extends far beyond pharmaceuticals. Two of the leaders in adopting reference pricing, the California Public Employees' Retirement System (CalPERS) and the grocery firm Safeway, reduced spending by 20% for joint replacement,[\[11\]](#) 18% for cataract removal,[\[12\]](#) 21% for colonoscopy,[\[13\]](#) 17% for arthroscopy,[\[14\]](#) 12% for computed tomography,[\[15\]](#) and 32% for laboratory assays[\[16\]](#) using reference pricing. A study by researchers at the University of California, Berkeley, estimated that if the insurers Aetna, United Healthcare and Humana all implemented reference pricing for laboratory test for their commercially insured patients, collectively they would save \$7.6 *billion* annually, about 8% of the total spending for this population.[\[17\]](#)

Reference pricing is one way to address many of the limitations of the healthcare market. It promotes competition between providers and drugs by demonstrating their added value to the healthcare system. In addition, reference pricing promotes engagement of patients. In the era of rising healthcare costs, reference pricing, especially when paired with other price and quality transparency tools, stands out as a way to help patients make informed decisions about their providers and the care they receive.

[\[1\]](#) Hostetter M and Klein S. **Health Care Price Transparency: Can**

It Promote High-Value Care? The Commonwealth Fund. Quality Matters Archive. April/May 2012. Available from: <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/april-may/in-focus#/#2>.

[2] Rizzolo A. **Lack of Price Transparency in Health Care May Drive Rising Costs.** Public Agenda. 20 October 2016. Available from: <https://www.publicagenda.org/blogs/lack-of-price-transparency-in-health-care-may-drive-rising-costs>

[3] Cassidy B, Grassley C, Young T, Bennet MF, Carper T, McCaskill C. **Letter to Stakeholders.** 28 February 2018. Available from: <https://www.cassidy.senate.gov/imo/media/doc/Cassidy%20Price%20Transparency%20Letter.pdf>.

[4] Mehrotra A, Chernew ME, Sinaiko AD. **Promise and Reality of Price Transparency.** *New Engl. J Med.* 2018; 378:1348-1354. Available from: <https://www-nejm-org.ucsf.idm.oclc.org/doi/full/10.1056/NEJMhpr1715229?query=T0C>.

[5] AHIP. **2016 Survey of Health Savings Account – High Deductible Health Plans.** February 2017. Available from: https://www.ahip.org/wp-content/uploads/2017/02/2016_HSASurvey_Draft_2.14.17.pdf.

[6] Robinson JC, Brown T, Whaley C. **Reference Pricing Changes The ‘Choice Architecture’ Of Health Care For Consumers.** *Health Aff (Millwood)* 2017;3:524-530. Available from: <https://www-healthaffairs-org.ucsf.idm.oclc.org/doi/pdf/10.1377/hlthaff.2016.1256>.

[7] Robinson JC, Brown TT, Whaley C. **Association of Reference Pricing with Drug Selection and Spending.** *N Engl J Med* 2017; 377:658-665. Available from: https://www.nejm.org/doi/10.1056/NEJMsa1700087?url_ver=Z39

[.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dwww.ncbi.nlm.nih.gov.](https://pubmed.ncbi.nlm.nih.gov/24882003/)

[8] <https://www.retatrust.org/c/home>

[9] Mehrotra A, Chernew ME, Sinaiko AD. 2017.

[10] Lauterbach K, McDonough J., and Seeley E. **Germany's Model for Drug Price Regulation Could Work In The US.** *Health Affairs Blog.* December 29, 2016. <http://healthaffairs.org/blog/2016/12/29/germanys-model-for-drug-price-regulation-could-work-in-the-us/>.

[11] Robinson JC, Brown TT. **Increases in consumer cost sharing redirect patient volumes and reduce hospital prices for orthopedic surgery.** *Health Aff (Millwood)* 2013; 32:1392-1397.

[12] Robinson JC, Brown T, Whaley C. **Reference-based benefit design changes consumers' choices and employers' payments for ambulatory surgery.** *Health Aff (Millwood)* 2015; 34:415-422.

[13] Robinson JC, Brown TT, Whaley C, Finlayson E. **Association of reference payment for colonoscopy with consumer choices, insurer spending, and procedural complications.** *JAMA Intern Med* 2015; 175:1783-1789.

[14] Robinson JC, Brown TT, Whaley C, Bozic KJ. **Consumer choice between hospital-based and freestanding facilities for arthroscopy: impact on prices, spending, and surgical complications.** *J Bone Joint Surg Am* 2015; 97:1473-1481.

[15] Robinson JC, Whaley C, Brown TT. **Reference pricing, consumer cost-sharing, and insurer spending for advanced imaging tests.** *Med Care* 2016; 54:1050-1055.

[16] Robinson JC, Whaley C, Brown TT. **Association of reference pricing for diagnostic laboratory testing with changes in**

patient choices, prices, and total spending for diagnostic tests. JAMA Intern Med 2016; 176:1353-1359.

[\[17\]](#) Robinson JC, Brown T, Whaley C. Health Affairs 2017.