Reference pricing has played a key role in health plan benefit design for more than a decade. For example, it is a major reason that many consumers regularly opt for generic drugs over brand names. The price for the generic drug serves as the standard, or reference, price, and if a consumer wants a more expensive brand name, he or she has to pay the difference.

But it is the more recent use of reference pricing for major procedures such as knee and hip replacements that is turning heads. The California Public Employees’ Retirement System (CalPERS), the largest healthcare purchaser in California, in 2011 launched a reference-pricing program for total hip and knee replacements that saved $2.8 million in the first year alone, according to an evaluation published in the journal [Health Affairs](http://content.healthaffairs.org/content/32/8/1392.abstract).

Nevertheless, standalone reference-pricing programs also have drawbacks for consumers. If consumers don’t understand the price of a full episode of care, they can get left on the hook for unforeseen costs. Moreover, if consumers are being encouraged to pick providers willing to meet or beat the reference price, it is important for patients to be able to determine if the providers offer high-quality care. That is why experts from [Catalyst for Payment Reform](http://www.catalyzepaymentreform.org/) (CPR) and the [Health Care Incentives Improvement Institute](http://www.hci3.org/) (HCI3), two organizations that support payment reforms, suggest that employers and other purchasers pair reference-pricing programs with bundled payments.

Using reference pricing in tandem with bundled payments is one example of how payment reform paired with the right benefit and/or network design can help reduce costs and improve care. This article explores three effective pairings for employers that want to guide employees to high-value healthcare choices.

“While consumers are unlikely to know how their providers are paid, if motivated financially and otherwise, they may act on meaningful distinctions in price and quality by choosing higher-value providers, saving money for themselves and whoever else is footing the bill for their care,” says Suzanne Delbanco, executive director of CPR, an independent non-profit pushing for better value in U.S. healthcare.

**Reference Pricing and Bundled Payment**  
When using reference pricing, payers or purchasers establish a maximum amount they will pay to serve as a reference point for consumers. (CalPERS, for example, set a $30,000 cap on the price it would pay for a hospital share of a knee replacement operation.) Typically, plan members are then required to pay any amount above the reference price. The reference price sends a signal to providers about what price purchasers consider reasonable and makes patients sensitive to the price of services, steering them toward more cost-effective providers. It is also imperative that consumers have information about the quality of different providers, particularly for complex procedures where price and quality can vary significantly.

Pairing reference pricing with a bundled payment for an episode of care, like a total joint replacement, is effective for several reasons. First, episode-based prices are like prix fixe dinners — it is easier for the consumer to understand the entire cost of the meal. What consumer knows enough about all the tests, procedures, and services on the menu for an episode of care to predict the total cost? Second, a “package price” limits consumers’ financial liability – the price of the episode covers the costs of all the care associated with a procedure, from preoperative imaging to physical therapy afterward.

For the employer, bundled payment should improve the predictability of the costs because the price does not vary with the specific services rendered to each patient. Under bundled payment, providers also have more accountability for defined outcomes and are financially liable for costs above the defined price, encouraging them to deliver the highest-quality, most efficient care. More details on this approach are available in a [paper](http://www.catalyzepaymentreform.org/images/documents/matchtochangemarkets.pdf" \t "_blank) CPR and HCI3 co-authored in 2013.

**Value-Based Insurance Design and Care-Coordination Fees**A second effective pairing is value-based insurance design (V-BID) and care-coordination fees. V-BID can help consumers to differentiate between high- and low-value providers, and between high- and low-value services, adding in the element of medical necessity. V-BID uses the levers of traditional insurance design, including co-pays, deductibles and co-insurance, to steer consumers toward higher-value care based on their health status and needs. It’s a simple formula: By reducing cost-sharing for certain high-value services and providers and increasing cost-sharing where there is low value, value-based insurance designs encourage consumers to seek high-value. V-BID also discourages them from seeking care not likely to improve their health.

Coupling V-BID with care-management fees, or shared savings or shared risk, is another potent pair. For example, a purchaser could implement a value-based benefit design that encourages chronically ill patients to seek care for their conditions and remain on their medications. The purchaser could then work with payers and providers to implement delivery reforms that may improve care coordination and management, such as an accountable care organization (ACO) or patient-centered medical home. These are supported by payment arrangements with shared savings, shared risk and/or care-coordination fees. When used together, V-BID and the right payment strategies could result in better care management for the chronically ill and better utilization of appropriate care and services, ultimately saving money.

**Tiered and Narrow Networks and Pay for Performance**A third effective pairing is tiered and narrow networks and pay for performance. In tiered networks, members pay different levels of co-payments, co-insurance and/or deductibles depending on their plan design and the “tier” of the provider delivering a covered service. Typically, tiered networks mean significantly higher cost sharing for services received from providers not in the most preferred network. The tiering of providers is ideally based on both comprehensive cost and quality information. High-cost providers, regardless of their quality, or providers that use resources less efficiently do not make it into the preferred tiers. With narrow networks,health plans only cover services from providers considered in-network. Consumers that seek care out of network must pay significantly higher fees, if not foot the entire bill.

To help ensure employees get high-quality, more affordable care, employers and other purchasers can combine tiered and narrow networks with an effective pay-for-performance program. Much like V-BID, a network strategy gives consumers financial carrots and sticks to seek care from specific providers, without restricting their access to others. The network strategy encourages consumers to get their care from “top tier” providers thought to deliver better, more efficient care. Paying those providers rewards for superior performance may give ongoing incentives to raise quality further.

http://content.healthaffairs.org/content/32/8/1392.abstract

# **Benefit Design and**

# **Payment Reform:**

# **A Powerful Pair for Change**

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Source: National Association of Health Underwriters Education Foundation