

# State Health Reform Assistance Network

## Charting the Road to Coverage

ISSUE BRIEF

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## Reference Pricing: An Overview and Suggested Policy Considerations

Prepared by **Kayla Connor** and **David Cusano**, Center on Health Insurance Reforms, Georgetown Health Policy Institute

This brief provides an overview of reference pricing and an overview of federal guidance to date on the pricing method. Although, as discussed here, a large public plan has met with some success with reference pricing, there are a number of factors that state and federal regulators should consider when reviewing plans that apply the pricing method. Those considerations are discussed here as well.

### I. Reference pricing – an overview

The purpose of reference pricing is to reduce medical costs both for insurers and for purchasers of health care services. It encourages enrollees to obtain services from lower-cost providers and motivates higher-cost providers to lower their reimbursement rates for those same services.<sup>1</sup> Under this model, a health plan generally maintains a broad network of providers but sets a maximum amount—the reference price—that it will reimburse a provider for a specific service.<sup>2</sup> The reference price may be lower than the actual contracted rate between the insurer and provider for that service.<sup>3</sup> If the enrollee chooses to receive the service from an in-network provider whose contracted rate is in excess of the reference price, the enrollee is liable not only for the standard cost-sharing under the policy for amounts up to the reference price, but also for the entire difference between the reference price and the provider's contracted rate.<sup>4</sup> Network providers with a negotiated rate in excess of the reference price may ultimately agree to accept the reference price as full reimbursement in order to avoid a loss in patient volume due to patients accessing services from lower-cost providers. Additionally, referencing pricing is generally used for in-network providers and insurers do not typically reimburse the reference price amount for a service provided by an out-of-network provider.<sup>5</sup>

One study suggests that health plan savings from reference pricing occurs through a combination of: (i) patients choosing providers at the reference price; (ii) patients paying the difference between the reference price and the allowed charge through

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<sup>1</sup> Amanda E. Lechner, Rebecca Gourevitch, & Paul B. Ginsburg, *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer*, Health System Change Research Brief No. 30, December 2013.

<sup>2</sup> Paul Fronstin & M. Christopher Roebuck, Employee Benefit Research Institute, *Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits*, Issue Brief No. 398, April 2014.

<sup>3</sup> *Id.*; Lechner, Gourevitch & Ginsburg, *supra*.

<sup>4</sup> *Id.*

<sup>5</sup> Chapin White & Megan Eguchi, *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*, National Institute for Health Care Reform Research Brief No. 18, October 2014.

cost-sharing; and (iii) providers reducing their prices to the reference price.<sup>6</sup> That same study also suggests that the services best suited for reference pricing are those with fairly uniform protocols and less quality variation among the health care professionals administering them. These types of services include: hip and knee replacement, colonoscopy, magnetic resonance imaging of the spine, computerized tomography scan of the head or brain, nuclear stress test of the heart, and echocardiogram.<sup>7</sup>

One key ingredient to successful reference pricing is setting the reference price itself. For example, in 2011, the California Public Employees' Retirement System (CalPERS) began using reference prices for elective hip and knee replacements.<sup>8</sup> Anthem is the CalPERS administrator and provides the network for CalPERS' self-funded preferred provider organization (PPO) plans.<sup>9</sup> CalPERS partnered with Anthem to incorporate reference pricing for routine hip and knee replacements into these PPO plans. Upon examination of claims data, CalPERS and Anthem found that joint and muscle conditions comprised approximately 7.5 percent of total health care spending, with 10 percent of that 7.5 percent specifically for routine hip and knee replacements.<sup>10</sup> Additionally, Anthem's negotiated rates for the devices and hospital stays for these two services ranged from \$15,000 to \$110,000, and the company determined that \$30,000 would be an appropriate maximum reimbursement amount.<sup>11</sup> Under the CalPERS reference pricing model, CalPERS members using a facility with negotiated rates at or below \$30,000 for hip or knee surgery pay a coinsurance for the cost of the procedure, up to an out-of-pocket maximum of \$3,000. Members using a facility with negotiated rates above \$30,000 pay a coinsurance plus the full amount above \$30,000. For example, if a member is covered under a policy with a 10 percent coinsurance and undergoes knee surgery at a facility that charges \$30,000 for the procedure, the member would pay \$3,000 out of pocket (10 percent coinsurance on \$30,000). However, a member who has that same procedure at a facility charging \$50,000 would pay \$3,000 (10 percent coinsurance on \$30,000) plus an additional \$20,000 for the cost above the \$30,000 reference price.<sup>12</sup>

According to one study, CalPERS saved almost \$6 million in medical costs for knee and hip replacement hospital stays and devices in two years, and its members saved another \$600,000 in lower cost-sharing.<sup>13</sup> The study indicates that approximately 15 percent of these aggregate savings were due to changes in market share favoring facilities with contracted rates at or below the reference price, and 85 percent were due to price reductions at the more expensive hospitals. In fact, the negotiated rates across all hospitals charging in excess of the reference price fell by 34 percent in the first year.<sup>14</sup>

In 2012, CalPERS expanded reference pricing to facility payments for outpatient colonoscopies, cataract surgeries, and arthroscopy, and is still evaluating the impact of this initiative.<sup>15</sup>

## II. Federal guidance

The Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") have issued guidance with respect to reference pricing, but only with respect to the interplay between reference pricing and out-of-pocket maximums.

Specifically, insurers offering individual and group policies and self-funded plans must limit the amount a member must pay out-of-pocket in a year to meet his or her cost-sharing obligations under a plan.<sup>16</sup> For 2015, the out-of-pocket maximum is limited to \$6,600 for self-only coverage and \$13,200 for family coverage.<sup>17</sup> In January of 2014, the Departments clarified that an insurer or plan may, but is not required to, count out-of-pocket expenses for services received out-of-network towards the out-of-pocket maximum.<sup>18</sup>

<sup>6</sup> Fronstin & Roebuck, *supra*.

<sup>7</sup> *Id.*

<sup>8</sup> Lechner, Gourevitch & Ginsburg, *supra*.

<sup>9</sup> CalPERS Letter to the U.S. Dept. of Labor, July 24, 2014.

<sup>10</sup> Lechner, Gourevitch & Ginsburg, *supra*.

<sup>11</sup> CalPERS letter to U.S. Dept. of Labor, *supra*.

<sup>12</sup> Lechner, Gourevitch & Ginsburg, *supra*.

<sup>13</sup> James C. Robinson, Ph.D., *Reference Pricing: Stimulating Cost-Conscious Purchasing and Countering Provider Market Power*, Expert Voices In Health Care Policy, National Institute for Health Care Management Foundation, October 2013.

<sup>14</sup> *Id.*

<sup>15</sup> CalPERS letter to U.S. Dept. of Labor, *supra*.

<sup>16</sup> Public Health Service Act § 2707(b); 45 C.F.R. § 156.130(a)(2).

<sup>17</sup> "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule" 79 Fed. Reg. 47 (11 March 2014) p. 13802.

<sup>18</sup> See CCIIO, *Affordable Care Act Implementation FAQs - Set 18*, January 9, 2014.

In a May 2014 frequently asked questions (FAQs) document, the Departments addressed the accumulation of costs to the out-of-pocket maximum under a reference pricing model. Specifically, they stated:

“Until guidance is issued and effective, with respect to a large group market plan or self-insured group health plan that utilizes a reference-based pricing program, the Departments will not consider a plan or issuer as failing to comply with the out-of-pocket maximum requirements...because it treats providers that accept the reference amount as the only in-network providers, provided the plan uses a reasonable method to ensure that it provides adequate access to quality providers.”<sup>19</sup>

In other words, if a member receives a service, the cost of that service is in excess of the reference price for that service, and the member is required to pay the difference, insurers and plans are not required to apply that additional amount paid by the member to his or her out-of-pocket maximum. However, the guidance appears to only apply in those circumstances where a plan’s in-network providers are limited to those providers that agree to accept the reference price as payment in full.

In an October 2014 FAQ, the Departments further clarified that they will consider “all facts and circumstances” when determining whether a plan or issuer “provides a reasonable method to ensure access to quality providers” under a reference pricing model.<sup>20</sup> These facts and circumstances include:

1. *Type of service*: Plans should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs, and the Departments articulated the following specific guidelines:
  - a. The period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider; and
  - b. Reference pricing should not apply to emergency services.
2. *Reasonable access*: Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries.
3. *Quality standards*: Plans should have procedures to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.
4. *Exception process*: Plans should have an exception process for services rendered to be treated as though they were at the reference price if access to a provider who accepts the reference price is not available within a reasonable time, or if the quality of service for a particular procedure could be compromised with a reference price provider.
5. *Disclosure*: Plans should automatically provide information on the pricing structure, a list of services to which the pricing structure applies, and the exceptions process. Upon request, plans should provide a list of providers who will accept the reference price for a service, a list of providers who will accept a negotiated rate above the reference price, and information on the process and data used to ensure that an adequate number of reference price providers meet quality standards.<sup>21</sup>

The Departments state that the reference pricing safe harbor applies specifically to fully insured large group plans and self-funded small and large group plans. While insurers offering coverage in the individual and small group markets are not prohibited from using reference pricing, the safe harbor set forth in the Departments’ FAQs would not apply.

Additionally, as stated above, the FAQs appear to apply only in those circumstances where the health plan treats providers that accept the reference price as the only in-network providers. A health plan could allow its members to access a broader set of in-network providers and their negotiated rates, but then require the members to pay the policy cost-sharing percentage or co-pay for amounts up to the reference price for the service plus any amount between the reference price and the negotiated rate for that service. Under this scenario, the plan does not limit its network only to providers who accept the reference price, so it is unclear how the FAQs would apply. One possible interpretation is that the Departments would consider the same or similar facts and circumstances when determining whether a plan provides a reasonable method to ensure access to quality providers. However, the additional costs incurred by a member for receiving the service from an in-network provider who charges in excess of the reference price would accumulate to the out-of-pocket maximum because the FAQs state that only out-of-pocket expenses for services received out-of-network can be excluded from the out-of-pocket maximum.

<sup>19</sup> See Dep’t of Labor, *FAQs about Affordable Care Act Implementation (Part XIX)*, May 2, 2014.

<sup>20</sup> See Dep’t of Labor, *FAQs about Affordable Care Act Implementation (Part XXI)*, October 10, 2014.

<sup>21</sup> *Id.*

### III. Suggested policy considerations for state regulators

The Departments have not issued any guidance on reference pricing in the fully insured individual and small group markets, but insurers are not prohibited from implementing such a model in these markets under federal law. Therefore, regulation of reference pricing in the fully insured individual and small group markets falls to the states. Additionally, states have the flexibility to regulate reference pricing in the large group market in a manner that is more protective than the Departments' guidance. This Section III sets forth suggested policy considerations for states when evaluating the use of reference pricing. These considerations fall within the following categories and are in addition to the "facts and circumstances" identified by the Departments (as more fully described in Section II above): (i) transparency; (ii) network adequacy; and (iii) member out-of-pocket expenses.

#### A. TRANSPARENCY

##### a. Transparency in reference pricing methodology

Transparency around the methodology used for establishing reference prices for identified services may be one necessary component for regulators when evaluating an insurer's use of reference pricing. As described above, CalPERS partnered with Anthem to review claims data on two specific services to establish a reference price for those services, and also evaluated the potential cost savings of implementing reference pricing for those services. Regulators may want to consider the type of data and justifications needed to ensure that the reference prices for identified services are fair and reasonable, and that implementation will result in cost savings for enrollees as well as insurers.

##### b. Consumer disclosure

Consumers need clear and understandable disclosure of how reference pricing works. This disclosure should occur prior to a consumer purchasing a product and be set forth in the consumer's policy documents. Regulators should consider disclosure of the following both prior to and following the purchase of a product:

1. How the reference price was established and why it is reasonable
2. Which services are subject to reference pricing
3. Which providers offer these services at the applicable reference price
4. Which providers offer these services above the applicable reference price
5. For these providers, whether they are treated as in-network such that the member pays the difference between the reference price and negotiated rate, or out-of-network such that the member pays the difference between the reference price and the provider's full charges
6. The actual additional cost to the member if he or she accesses these services from a provider that charges above the reference price
7. Whether these additional costs accumulate towards the member's out-of-pocket maximum

Regulators may also want to consider reviewing and approving these disclosures and other reference pricing marketing materials prior to their use.

#### B. NETWORK ADEQUACY

Regulators should consider evaluating network adequacy to ensure that state and federal network adequacy requirements are met with respect to the number of providers that accept the reference price for the identified services. This evaluation may include whether a member has adequate access to all the providers needed to perform a specific service. For example, in the case of a knee surgery, the member would likely need access to a hospital, surgeon, and anesthesiologist, and may also need access to laboratory and radiology services. Therefore, as part of their evaluation, regulators may want to consider a process for determining whether an insurer's members will have access to all necessary providers needed to perform a service at the reference price. For example, in the CalPERS model, only the hospital stay and device for knee and hip surgeries were subject to the reference price. In evaluating a similar model, a regulator may want to consider whether there are a sufficient number of in-network surgeons and other ancillary providers to perform knee or hip surgeries at those hospitals that accept the reference price as full reimbursement for the hospital stay and device.

#### C. MEMBER OUT-OF-POCKET EXPENSES

Under the Departments' FAQs, in those circumstances where an insurer treats providers that accept the reference price as the only

in-network providers, the insurer is not required to apply the cost to the member of paying the difference between the reference price and provider's charge for a service to the member's out-of-pocket maximum. However, a state could take a more protective approach and have these additional costs accumulate to the member's out-of-pocket maximum. This would limit a member's out-of-pocket costs under a product that uses reference pricing to the amounts set forth under federal law (see Section II).

## **IV. Conclusion**

Under reference pricing, a health plan sets the maximum reimbursement amount (the reference price) it will pay to an in-network provider for a specific service. If the member receives that service from an in-network provider who charges in excess of the reference price, he or she is responsible for paying the provider for the total difference between the reference price and contracted rate. Reference pricing provides an incentive for members to seek care from lower-cost providers and for higher-cost providers to align their reimbursement rates with the reference price to avoid losing patient volume. CalPERS provides evidence that reference pricing can, in fact, reduce medical costs by successfully reducing the cost of hospital stays and devices for knee and hip surgeries. However, moving forward, federal and state regulators should consider whether the CalPERS experience translates to the commercial health insurance market in terms of the impact of reference pricing on consumers. The Departments have issued guidance at the federal level, setting forth baseline protections to consumers covered under fully insured large group plans and self-funded small and large group plans. State regulators should consider the necessary protections for consumers in their respective states, with a focus on transparency, network adequacy, and out-of-pocket expenses.