Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design?

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ABSTRACT

OBJECTIVES: There is robust evidence that implementation of reference-based pricing (RBP) benefit design decreases spending. This paper investigates employer adoption of RBP as a strategy to improve the value of patients' healthcare choices, as well as facilitators and barriers to the adoption of RBP by employers.

STUDY DESIGN: We conducted a qualitative study using 12 in-depth interviews with human resources executives or their representatives at large- or medium-sized self-insured employers.

METHODS: Interviews were conducted and recorded over the phone between March 2017 and May 2017. Interviewees were asked about their adoption of RBP and facilitators and barriers to adoption. We applied thematic analysis to the transcripts.

RESULTS: Despite broad employer awareness of RBP's potential for cost savings, few employers are including RBP in their benefit design. The major barriers to RBP adoption were the complexity of RBP benefit design, concern that employees could face catastrophic out-of-pocket costs, lack of a business case for implementation, and concern that RBP could hurt the employer's competitiveness in the labor market. The few employers that have adopted RBP have implemented extensive, year-round employee education campaigns and invested in multipronged and proactive decision support to help employees navigate their choices.

CONCLUSIONS: Unless several fundamental barriers are addressed, uptake of RBP will likely continue to be low. Our findings suggest that simplifying benefit design, providing employees protection against very high out-of-pocket costs, understanding which decision-support strategies are most effective, and enhancing the business case could facilitate wider employer adoption of RBP.

Am J Manag Care. 2019;25(2):85-88

US healthcare prices vary widely both across the country and within local markets.[1-3] Reference-based pricing (RBP) benefit design gives patients a financial incentive to switch to lower-priced providers. Under RBP, the health plan determines a "reference price" for a given medical service, and the plan will cover medical expenses for that service up to that price. If a patient receives care from a provider whose negotiated payment is above the reference price, the patient is responsible for paying all medical costs above the reference price (ie, "balance billing"), along with all other cost sharing. RBP is applied only to select medical services, usually those that are nonemergent and for which patients have a choice of providers.

In contrast to deductibles, where the patient pays the "first dollar" of medical expenses, under RBP, the patient is responsible for the "last dollar." The intent is to avoid the observed patient response to high-deductible health plans (HDHPs), for which the evidence suggests almost no effect on price shopping but reductions in needed services,[4-7] and instead to have patients focus on where to receive care. In many cases, a plan's maximum out-of-pocket cost does not apply, so even patients who have reached their maximum in their plan year still have an incentive to select lower-priced providers for RBP services.

Reference pricing has been used for pharmaceuticals in Europe and Canada for more than 2 decades.[8,9] Only recently has RBP been implemented in the United States, with a focus largely on nonpharmaceutical services. Evaluations of US RBP programs have found reduced spending between 13.9% and 31.0% for joint replacement surgery,[10] colonoscopy,[11] laboratory tests,[12] prescription drugs,[13] and ambulatory surgery.[14]

Despite this robust evidence, recent Aon Hewitt surveys report that only 5% to 6% of employers were using RBP in 2015-2016.[15,16] Little is known on why there has been low uptake. To better understand this landscape, we conducted a qualitative study of employers' views of RBP. Specifically, we sought to understand employer perspectives of RBP as a strategy to engage employees in healthcare decision making, their adoption of RBP, and their concerns about RBP.

TABLE 1. Quotations Illustrating Employer Perceptions About RBP Benefit Design and Its Adoption

	Representative Quotations
Perceptions of RBP	•"[RBP is] just another lever to help an employer control cost." •"[RBP can] help steer our [employees] to make better healthcare decisions with the same level of quality." •"RBP would be a more nuanced way to bend the curve."
Employer adoption of RBP	•"I don't think it has seen as much traction as I thought it would." •"All my clients who have looked into it have ultimately decided not to do it."

RBP indicates reference-based pricing.

Source: authors' analysis of qualitative interview data.

DATA AND METHODS

We identified a convenience sample of 13 individuals across 12 organizations, including human resources executives at large self-insured employers (6 interviewees at 6 organizations) and representatives of consulting firms and purchasing coalitions who support employer health benefits decision making (7 interviewees at 6 organizations). Interviewees were selected because they had adopted (n = 4) or closely considered (n = 9) RBP for their organization or on behalf of other purchasers. Neither the proportion of employers who adopted RBP nor these opinions are intended to be representative of all self-insured employers; they are the perspectives of individuals who have considerable experience with employer-sponsored insurance purchasing and who have undertaken serious consideration of issues related to RBP programs.

We developed a semistructured interview guide with open-ended questions focused on 3 domains: (1) efforts to engage employees in their healthcare decision making, (2) perceptions of RBP as a strategy to steer patients to higher value among alternatives (eg, HDHPs, price transparency, narrow provider networks), and (3) facilitators and barriers to implementing RBP. For those who implemented RBP, we asked additional questions about the experience with RBP and lessons learned.

Telephone interviews were conducted from March 2017 to May 2017. They lasted between 30 and 45 minutes and were recorded and transcribed. We analyzed interview data using accepted methods for qualitative analysis.[17] We began with a preliminary set of deductive codes derived from the interview guide, but also allowed for inductive codes to emerge. We identified key themes characterizing employer perceptions of RBP, as well as facilitators and barriers to RBP adoption, and selected quotations to illustrate these themes. The Institutional Review Board at the Harvard T.H. Chan School of Public Health approved this study.

RESULTS

Four key themes characterized employer perspectives on adoption of RBP: (1) Although cognizant of its potential, very few employers have implemented RBP; (2) There are concerns about the complexity of RBP, employee risk of catastrophic out-of-pocket costs, and need for significant communication and decision support; (3) The business case for RBP is not compelling; and (4) Adoption of RBP may hinder retention of and competition for workers. A fuller description of each of these themes follows.

Theme 1: Although Cognizant of Its Potential, Very Few Employers Have Implemented RBP

There was universal agreement with the need to engage employees in their healthcare decision making as a component of a larger strategy to lower healthcare spending. All interviewees believed that RBP could achieve cost savings, and several noted the potential to engage employees as well (see **Table 1** for illustrative quotes). However, adoption of RBP remains low. One representative comment was: "Reference pricing is more on the far end in terms of what employees and employers are actually doing." Key barriers to RBP adoption are captured in the remaining 3 themes.

Theme 2: There Are Concerns About the Complexity of RBP, Employee Risk of Catastrophic Out-of-Pocket Costs, and Need for Significant Communication and Decision Support

RBP is perceived as being a complex benefit design and as complex to implement because employees at a single large employer often work in many different markets in the United States (see **Table 2** for illustrative quotes). There was widespread concern that if all employees face a single, national reference price, employees in some markets would have poor access to providers below the reference price. Adjusting the reference price by market would address this concern but would be more difficult to operationalize and communicate to employees.

The potential for employees to face catastrophic out-of-pocket costs was another concern. Under RBP, employees treated by a high-priced provider are responsible for the entire cost above the reference price. As one interviewee noted, "The company saves money, which is great; however, the employee gets hit with that delta. So it doesn't feel very good." Adverse employee outcomes could also lead to negative publicity, something employers are anxious to avoid.

There was broad awareness of the need for extensive, continuous communication with and education of employees, so they would know about potential cost sharing when seeking care. Interviewees felt that making sophisticated and user-friendly supplemental decision support available through multiple communication channels (eg, telephone and web-based) was critical to help employees choose providers. Dissatisfaction with the currently available tools was one of the factors that drove employers not to offer RBP.

The few employers that offered RBP implemented extensive communication and decision-support strategies. Some conducted targeted outreach (via letters or phone calls) to employees who were scheduled to receive care at a higher-cost provider to inform them about RBP and the out-of-pocket cost consequences of their provider choice. All but 1 employer with RBP offered a "concierge" service

that employees could call for help identifying a low-priced provider. The concierge was also intended to help employees communicate with providers about a high-balance bill if they got one. RBP-focused communication was separated from other benefits communications; one employer developed animated videos to describe RBP, and another printed information about RBP on office supply materials that employees worked with every day. Finally, proactive education about RBP with select referring physicians was also mentioned as a strategy to support employee choices.

TABLE 2. Key Themes Related to Employer Concerns and Associated Challenges With RBP Benefit Design

Employer Concerns With RBP	Representative Quotations
Complexity of RBP	Due to benefit design: • "We are comfortable at the time of enrollment laying out 'here are your choices'...[but once enrolled] we try to make it simple for our people." • "...you have to be a very educated consumer, and that is so hard." Due to geographic variation: • "We have a lot of people in rural areas with limited healthcare competition....We believe that we couldn't do it on a company-wide scale, and that increases the complexity." • "...they have employees that live in [rural areas] and it's much cheaper than [for] those that live in Manhattan, and they are seeing very different providers. Is that fair for the employees?"
Employees' potential to pay catastrophic out-of-pocket costs	• "...concern that employees won't do the extra legwork to figure out that this [provider] is the cheaper one and this is how much it's going to cost me." • "Employer concerns were primarily the disruption to the employees, meaning...the balance billing that could happen as a result of it....A good majority of the employees are lower-paid, under $35,000 a year."
Associated Challenges	**Representative Quotations**
Messaging and communication	• "It's something that we feel would probably be the right thing to do, but the single biggest hurdle is communicating this in a way that captures all those nuances...and to have [employees] say 'You're right!'" • "It's a varied workforce. You have some people in corporate but then some people with a language barrier and they have a hard enough time understanding [an] HDHP without putting any RBP on top of that."
Difficulty reaching employees	• "[We have a] large, lower-wage manufacturing workforce with low access to computers." • "[The majority of] my employees are male....The primary decision maker for most healthcare decisions is not sitting in my office. They're sitting at home, and I have trouble communicating with them." • "There's *so* much communication going out to employees now ... because we're all so, you know, information-heavy...I think employers are worried that employees aren't really reading stuff."
Need for sophisticated decision support	• "We feel it would be an undue burden on our employees to go make them figure this out without better tools and better resources and better transparency." • "We would need a company that offered, by phone, a concierge service as well as online services. For my employee population, I just don't think just online would work."

HDHP indicates high-deductible health plan; RBP, reference-based pricing.

Source: authors' analysis of qualitative interview data.

Theme 3: The Business Case for RBP Is Not Compelling

The low potential savings from RBP were also a barrier. Although prior research has shown that RBP adoption may yield substantial savings for a given clinical area, the potential savings were low on net across all services. Therefore, RBP did not justify the necessary investment in communication, marketing, and decision support or the efforts to respond to employee disenchantment from more restricted benefits. One interviewee noted: "The savings were not that substantial, and the main reason is procedures are not...high-dollar procedures. [It] was going to save like $80,000 or something, and it was like, 'OK, for $80,000, this is not worth the hassle.'"

In contrast, employers using RBP emphasized a mission-driven, "do-the-right-thing" motivation, noting that RBP was the beginning of a longer journey toward improving the value of healthcare spending. They said, for example, "There's more to it than just saving money. It's about saving money the right way." These employers also noted that starting with a small RBP program, despite low savings, allowed for the close monitoring of the program (eg, providing support for employee travel when necessary, allowing for exemptions for nonroutine cases) to ensure acceptable levels of quality and access are maintained.

Theme 4: Adoption of RBP May Hinder Retention of and Competition for Workers

The slowdown in the growth in healthcare spending over the past few years in combination with broader economic growth has resulted in private-sector employers facing increased competition for workers. Employers were hesitant to adopt RBP out of concern that it would be viewed negatively by employees. One interviewee noted: "[Many employers] say saving money is not their top priority. [The top priority] is making sure that their employees are happy, making sure they have these nice benefits, making sure the employees are taken care of if they have a problem." Along these lines, firms know "they are competing with...companies who are offering very rich benefits, and they know if they want to get the talent, they also need to do that."

Due to this reluctance to penalize employees for their provider choices (beyond HDHPs, which interviewees noted are pervasive), use of wellness programs, price transparency tools, disease management programs, and access to vendors that provide second opinions are preferred strategies to engage employees in their healthcare choices. These programs, as one interviewee described, rely "less on sticks and more on carrots." Competition for workers through generous benefits was mentioned only among private-sector employers. When interviewees discussed public employers and union funds, they described growing pressure to control healthcare spending and more consideration of adopting RBP.

DISCUSSION

Despite strong evidence that RBP can decrease healthcare spending, our findings suggest that it is unlikely that there will be wide adoption of RBP in its current form in the US commercial health insurance market. Perspectives gleaned from these interviews suggest 3 strategies to facilitate wider adoption of RBP.

First, simplify. Exempting an entire category of low-priced providers from RBP, as CalPERS did for colonoscopies and ambulatory surgery centers (ASCs),[11] gives patients a simple heuristic to guide them (eg, have your colonoscopy at an ASC) versus having to go provider by provider to determine whether they are below the reference price. Improved decision support is also needed. Second, establishing out-of-pocket maximums for RBP so that employees are not at risk of catastrophic costs could alleviate employee disruption and risk. Finally, "turnkey" solutions for employee communication and education, based on best practices that have demonstrated effectiveness, would address concerns about the necessary levels of communication and potential employee backlash.

Employers could also implement alternative forms of benefit design that encourage patients to switch providers but have less of a "stick." Tiered network plans, which sort providers into strata and require patients to pay higher cost sharing if they choose a provider that is in a nonpreferred tier, are similar in conception to RBP but avoid the risk of catastrophic out-of-pocket costs. Several studies have demonstrated that tiered networks lead to savings.[18,19] Another "carrot" option is to implement rewards programs in which patients receive money if they go to a lower-priced provider. Although these are becoming more popular,[20] there have been no rigorous evaluations of their impact.

Limitations

This paper has important limitations. The sample was purposefully selected using a limited number of respondents who had adopted RBP or had seriously considered its adoption, and the findings may differ in other settings. However, participants' responses, viewed collectively, enable us to report on a broad range of opinions held across employer representatives with expertise on this topic.

CONCLUSIONS

In the past year, growth in healthcare spending has begun to increase again, which will likely place increasing pressure on all employers to decrease spending. RBP holds great promise as a strategy to lower spending. Yet without redesign of RBP so as to achieve broader take-up by employers, this promise of RBP appears likely to remain unrealized. ■

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Source of Funding: Funding from the Robert Wood Johnson Foundation (grant #73721) for this research is gratefully acknowledged.

Author Disclosures: Dr Mehrotra reports that, unrelated to him, Harvard has implemented rewards for its employees, a related form of benefit design. The remaining authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (ADS, AM); acquisition of data (ADS, SA); analysis and interpretation of data (ADS, SA); drafting of the manuscript (ADS); critical revision of the manuscript for important intellectual content (SA, AM); provision of patients or study materials (ADS); and obtaining funding (ADS, AM).

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