

Adopt Advanced Benefit Designs

Cost Driver Targeted: Provider prices

OVERVIEW

Advanced benefit designs employ price transparency and shopping tools that enable enrollees to shop for high-quality, lower-cost providers and services. In return for using lower-cost providers, beneficiaries pay less out of pocket and/or share in the savings with the insurer. Examples of the designs discussed here include reference pricing and enrollee “right-to-shop,” or “smart shopper,” programs.

Reference-Based Benefits

Reference pricing is a payment scheme in which an insurer or employer determines a price that it is willing to pay for certain “shoppable” health care services based on an average or percentile of market-based prices (e.g., 60th percentile). As variations on the approach have evolved, this specific approach is now referred to as “reference-based benefits.”¹ Enrollees who obtain care from a provider with a price at or below the reference price pay only the normally required cost sharing. Enrollees obtaining care from a higher-priced provider pay the normally required cost sharing and the difference between the reference price and the allowed charge.

¹ The term “reference-based benefits” is used to distinguish these benefit design approaches from other forms of reference pricing, such as that used by Montana’s state employee health plan. The approaches are similar in one aspect: a payer sets a price it is willing to pay for a service. However, in the approach employed by Montana, the price is tagged to a normative price (e.g., a multiple of Medicare rates), instead of market-based prices. Moreover, the consumer is not involved in “shopping” for lower cost providers per se, although in some cases they may be subject to balance billing if they use a provider who has not agreed to the reference-based price. Finally, the reference prices typically apply to all services within a category (e.g., all hospital services), rather than specific services.

Smart Shopper

A “right-to-shop,” or “smart shopper,” program is a strategy whereby an enrollee uses an online or mobile platform or a call center to locate lower-cost providers for certain predetermined services. Typically, these include laboratory services; advanced diagnostic imaging; outpatient surgery; and speech, occupational, and physical therapy. These services are considered shoppable because they are offered by multiple providers with comparable quality and have significant price variation in the market. Enrollees that choose a lower-cost provider receive an incentive payment, thus sharing in the savings. These incentives can range anywhere from \$25 to \$500, depending on the service and the provider selected.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Determine level of state involvement. Thus far, states have adopted advanced benefit designs primarily in state employee plans, but they could expand their efforts to other types of plans. For example, states could require one or more of these approaches be offered in state-based marketplace plans. They also could encourage or compel insurers to offer one or more of these products across their fully insured markets. [Virginia, for example](#), requires health insurers in the small-group market to develop a smart shopper program that provides enrollees with direct cash, gift cards, or lower out-of-pocket costs as incentives to seek more affordable care. Florida enacted legislation [authorizing but not requiring](#) insurers participating in the individual and small-group market to develop smart shopper programs for enrollees. Through brokers and employer associations, states also can play an important role in educating employers, including those that are self-insured, about these options.

Oversee contracts between payers and providers to prevent anticompetitive terms. States interested in encouraging the growth of these strategies will likely need to strengthen their oversight of anticompetitive contract terms between payers and providers. Antitiering or antisteering provisions in contracts can limit the ability of purchasers to require higher cost sharing for some higher-cost providers with market power, and states may seek legislative authority to prohibit these terms.

Develop robust price and quality transparency tools and provide consumer education. States may wish to develop their own price and quality tools to help consumers choose high-quality providers. New Hampshire was the first state to develop a [price transparency website](#). States with all-payer claims databases may be in a better position to create such tools. States also can work with vendors to develop transparency tools but will still require pricing data from insurers. States also have an important role to play in educating consumers about the use of these tools, as the evidence suggests that uptake is very limited. In addition, states will likely need to provide significant consumer education around price variability and the fact that they cannot equate higher prices with higher-quality care.

EVIDENCE OF IMPACT

Reference-Based Benefits

Reference-based benefits used in both the California Public Employees' Retirement System (CalPERS) and in the Safeway grocery store chain have been formally evaluated. Both organizations found their strategies resulted in significant savings as enrollees switched to lower-cost providers. In the [Safeway program](#), savings ranged from 10.5 percent (for MRI imaging) to 32 percent (for diagnostic lab testing) while the percentage of enrollees moving to lower-cost providers ranged from 9 percent to 29 percent. Savings in the [CalPERS program](#) ranged from 17 percent (for shoulder arthroscopy) to 21 percent (for colonoscopy). Moreover, with CalPERS, prices charged among higher-priced hip and knee replacement providers dropped by an [average of 34 percent](#).

Although the use of reference-based benefits to date has focused on a small number of procedures and services, some researchers have suggested that broader use is possible. [One study](#) proposed 350 shoppable services (about 35% of total health care spending) that would be amenable to price shopping. They estimated that spending for these services could be reduced by 14 percent, potentially curbing total health care spending by about 5 percent.

Smart Shopper

Smart shopper programs have been used in several state employee programs and are becoming more popular in commercial insurance products. [Kentucky's smart shopper program](#) for state employees saved \$13.2 million during its first three years, with employees earning \$1.9 million in shared savings. A [large insurer's "Member Rewards" program](#), which allowed employees from 29 employers to shop for 135 elective services, reduced prices by 2.1 percent for certain services in its first 12 months. Although these savings are small, this evaluation was conducted using the program's first year of data, and most programs have shown larger savings after several years.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

These strategies are best suited for states that have:

- significant price variability of services within a market
- urban markets with adequate numbers of competing lower-cost, high-quality providers
- the data resources to create or assist with the development of a price-comparison tool
- the resources and willingness to support consumer education and engagement around use of price transparency tools
- an interest in market-based approaches.

A right-to-shop or smart shopper strategy is a "carrot" approach that relies on the power of the market to reduce health care prices without penalizing consumers. States may find it more difficult to implement reference-based benefits, as this "stick" approach potentially exposes consumers to significant additional costs. States may also find providers to be less wary of shopping strategies, compared with reference-based benefits.

EQUITY CONSIDERATIONS

These approaches may have a negative impact on health equity if states (or others) do not implement them carefully. With reference-based benefits, individuals may face higher costs if they see certain providers, and it will be important to ensure that lower-income individuals in particular do not forgo needed care because of concerns about costs. It also will be important to limit these strategies to routine health care procedures that can be scheduled well in advance to allow consumers time to conduct the shopping comparisons required.

Having an adequate number of lower-cost providers (including those able to meet the cultural and linguistic needs of diverse enrollees across all geographic regions, especially rural or underserved areas) is also important. States can also be mindful of the impact on individuals with highly complex care needs, who may be less able to shop (because of the complexity of their needs) and are the most impacted by cost sharing. States could consider mitigating this by including an appeals process, allowing for exemptions, or creating a cap on the amount enrollees are required to pay. However, some of these mitigation strategies make program implementation more complex.

Using price-comparison tools also can be challenging for patients with low English proficiency or limited technology access. States can encourage the development of price transparency tools that are as easy to use as possible and available on multiple platforms. They also may require a call-in center to assist patients without access to the internet or who need assistance because of low English-language proficiency, low health literacy, disability, or other reasons.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Advanced benefit designs have several limitations. In general, they create significant administrative burden to implement and require extensive consumer education and engagement.

Another concern is more specific to markets that are already consolidated with a prominent provider system. Hospitals within these systems may include restrictive language in their contracts that limits insurers' ability to steer consumers to lower-priced competitors. When such contractual provisions are in place, states may find it difficult to implement reference pricing or smart shopper strategies.

Another issue is the uncertainty around whether the higher out-of-pocket costs that consumers would face by using a provider above the reference price counts toward their plan's deductible or out-of-pocket limit. Although [joint guidance](#) from the U.S. Departments of Labor, Treasury, and Health and Human Services indicates that these payments can be excluded from out-of-pocket limits, the guidance is somewhat vague, and reporting requirements and oversight may be burdensome.

Additionally, the impact on cost savings is limited by the number of shoppable services. The limited scope raises the concern that providers could simply offset savings on these services by raising prices elsewhere.

Finally, there is nothing that requires employers to choose these programs or for consumers to use them. Without sizeable uptake of these products, they are less likely to influence provider behavior.

RESOURCES

Suzanne F. Delbanco et al., *Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care* (Urban Institute, Apr. 2016).

Brian Blase, *Transparent Prices Will Help Consumers and Employers Reduce Health Spending* (Galen Institute and Texas Public Policy Foundation, Sept. 27, 2019).