Current Perspective

Reference-Based Pricing

Have you seen the headlines? "Aetna Can't Escape Fee-For-Service Medicine 'Fast' Enough." "Anthem Blue Cross' $38 Billion Move From Fee-For-Service Medicine." "U.S. Government Unveils Goal to Move Medicare Away From Fee-For-Service." These are just three of the many recent front-page articles about moving from the fee-for-service model.

Moving where?

Moving to an "alternative payment model" (APM), of which there are many types, including shared savings, bundled payments, accountable care organizations, payment per episode of care, and more. The policy goal is to provide equivalent or better care at a lower cost. Many of these APMs are complex, and some appear to be having minimal cost or quality impact.

One conceptually simple APM is already having a business impact in a number of markets, and it will no doubt soon be a factor in ophthalmology. This is "reference-based pricing" (RBP). RBP makes sense when there is a wide variance in total cost for a definable episode of care—for example, cataract surgery or retinal detachment repair. (Because ophthalmologist payments per procedure are fixed, other factors define the variances.) RBP does not work well for chronic disease management. It has its greatest impact when the price variance is large, and there are judged to be many providers of equivalent high quality.

Here is one real-world example: In a large metropolitan area, a major employer coalition experienced a wide variance in the cost of colonoscopy—from about $900 to nearly $9,000. Studies determined that about 70 facilities (hospitals, ambulatory surgery centers, and endoscopy centers) all had equivalent quality. Despite what you might imagine, the hospitals and independent outpatient centers were nearly equally distributed across the cost spectrum. The employer coalition, working with its health plans, decided to offer first-dollar complete coverage to anyone choosing one of the centers priced below $3,000. Any employee choosing a higher-cost center paid the difference.

In another example, a large commercial PPO plan examined the cost of total hip and knee replacements in California. The range was about $15,000 to $110,000. The plan set a reference price of $30,000 for a standard joint replacement, with patients responsible for costs above $30,000. Initially, 46 hospitals in the network qualified, and more than 50 did not. In these types of surgery, much of the cost is driven by the cost of the joint implant. After the joint manufacturers lowered their prices, most of the hospitals subsequently qualified by price.

Reference-based pricing is attractive to employers and payers because it is simple in concept and effective, given the right set of circumstances. Could this work in ophthalmology? Certainly. It is already working in certain markets where cost variance is high.

It's important to bear in mind that price is only the second cut for inclusion. The first is *quality*, which must be measurable and clinically relevant. In RBP, as in nearly every APM, one key to success is knowing, and being able to demonstrate, that you provide high-quality care. This is where clinical data registries—like the Academy's IRIS Registry—are immensely valuable. The payers know your total costs. Knowing your own clinical data will help keep quality and risk-adjusted outcomes central to the discussion.

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