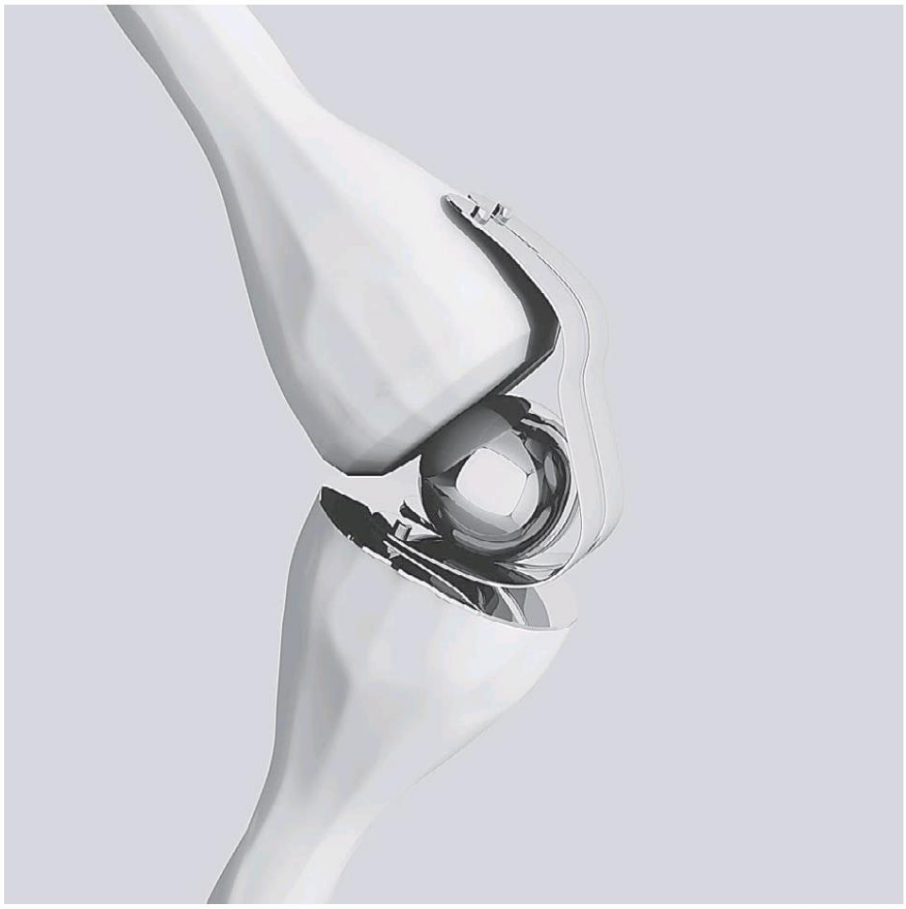
How Surgery Got Cheaper for Many Californians

By AUSTIN FRAKT



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At a time when health care spending seems only to go up, an initiative in California has slashed the prices of many common procedures.

The California Public Employees' Retirement System (Calpers) started paying hospitals differently for 450,000 of its members beginning in 2011. It set a maximum contribution it would make toward what a hospital was paid for knee and hip replacement surgery, colonoscopies, cataract removal surgery and several other elective procedures. Under the new approach, called reference pricing, patients who wished to get a procedure at a higher-priced hospital paid the difference themselves.

For example, in 2011 the Calpers maximum contribution for a knee or hip replacement surgery was set at $30,000. A Calpers patient receiving knee or hip replacement surgery at or below this reference price paid the usual cost-sharing: 20 percent of the cost, up to a maximum of $3,000.

But a patient electing to use a hospital that charged, say, $40,000 paid the usual cost-sharing in addition to the $10,000 above the reference price.

As Calpers initiated the new approach, 41 of the several hundred hospitals in California could provide knee and hip replacement procedures at or below $30,000 and with acceptable quality, as measured by things like low readmission rates and high rates of use of guideline infection controls. Some hospitals charged more than $100,000 for the procedures.

The results of knee and hip replacement surgery reference pricing were striking, as were those for cataract removal, arthroscopy and colonoscopy. In a series of studies, James Robinson and Timothy Brown, University of California, Berkeley health economists, found that under reference pricing, Calpers patients flocked to lower-priced hospitals and outpatient surgical centers. Prices and total spending for the procedures plummeted.

For knee and hip replacements, market share for lower-priced hospitals increased by 28 percent. As higher-priced ones lost market share, many chose to reduce their prices. Prices for the procedures fell by an average of more than 20 percent, saving Calpers and its patients $6 million over two years.

Under reference pricing for cataract removal surgery, the average price paid also dropped by nearly 20 percent, saving $1.3 million over two years. For colonoscopies, $7 million was saved — a 28 percent drop. And for knee or shoulder arthroscopy, prices fell by about 17 percent. For these procedures, Calpers reduced patient cost-sharing if patients chose a free-standing, outpatient surgical center, as opposed to a much more expensive hospital.

The price of reference-priced services for Calpers declined 20 percent during a period of time when health care prices paid by employer-sponsored plans rose by about 5.5 percent.

Despite the success of the effort by Calpers, reference pricing is not a full solution to rampant health care spending growth. Because it relies on encouraging patients to visit lower-priced hospitals and surgical centers, it works only with procedures for which patients can reasonably shop around.

This excludes care over which patients have little control, such as that provided in emergencies or while they are already hospitalized or incapacitated. One study estimated that about 40 percent of health care spending is for services for which patients could shop.

But there is another reason reference pricing is hard to install broadly. It requires patients to have ready access to comprehensible price and quality information. Such transparency is not commonplace. Even when this information is available, consumers with cognitive impairments or who are overwhelmed with illness and other demands would have trouble making the best use of it.

Some consumers might prefer to delegate to insurers the decisions about where to obtain care. In narrow network plans, for instance, insurers select high-quality hospitals and negotiate the best price; patients pay the same amount out of pocket no matter which hospital they visit within the network.

Reference pricing shifts some of the burden of figuring out where to obtain care from insurers to consumers. On the other hand, compared with narrow network models, it preserves broader choice for the consumer.

Reference pricing also requires sufficient competition among hospitals. If the number of hospitals is too low, patients will not have a choice about where to receive care, and hospitals will not have an incentive to reduce prices. Assessing the degree of competition, quality and choice for the purposes of establishing and updating reference prices imposes an administrative cost that should be weighed against any savings.

For this reason, some large employers are contracting with regional "centers of excellence," such as the Cleveland Clinic, to which patients can be referred even if there is limited hospital choice in their hometowns.

Another concern is that reference pricing could encourage lower quality, as health care organizations cut costs to reduce prices. Analysis by Mr. Robinson and colleagues did not find adverse effects of reference pricing, however. "Significant reductions in cost with no change in quality: That's called improved value," he said.

Austin Frakt is a health economist with several governmental and academic affiliations.