TOOLS & SUPPORT
July 2020

Guiding Members to High-Value Choices through Reference Pricing: Self-Insured Schools of California

Common procedures like colonoscopies can be delivered at Ambulatory Surgery Centers (ASCs) instead of pricier hospital-based facilities, without compromising quality of care. Learn how Self-Insured Schools of California's reference-based pricing program generated over three million in cost savings in its first year.

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Case Study

Guiding Members to High-Value Choices through Reference Pricing

Self-Insured Schools of California (SISC) is a public-school Joint Powers Authority (JPA)[1] administered by the office of the Kern County Superintendent of Schools and governed by a Board of Directors composed entirely of school district employees. Based on the philosophy of "schools helping schools," SISC pools resources across school districts to secure affordable and sustainable health benefits coverage for its members. According to SISC, "this keeps millions of dollars in the classroom that would have otherwise been paid out in premiums."

Since its founding in 1979, SISC has seen continuous growth in its membership. To date, SISC offers health care benefits to 330,000 public school employees and their families in over 400 school districts across the state of California. Of these members, approximately 250,000 are enrolled in either a Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plan through either Anthem Blue Cross or through Blue Shield of California; the remainder receive health coverage through Kaiser Permanente.

Core tenets of SISC's mission include a commitment to provide sustainable, long-term health care solutions, and stable, affordable rates. Adhering to these goals in an environment of constant price escalation has impelled SISC to offer new and innovative benefits, such as its waste-free formulary, second opinion services (offered through Advance Medical/Teladoc), no-cost onsite flu shots, and onsite biometric testing.

This case study focuses on the results of a reference-based pricing program SISC launched with their Anthem PPO plan on October 1, 2018 to encourage plan members to seek care from higher-value sites of service. To learn about SISC's initiative, CPR interviewed John Stenerson, SISC's Deputy Executive Officer, in February of 2020 and Sheila Amiri, SISC Account Executive at Anthem Blue Cross, in June 2020.

The Problem & Background

Hospital facilities charge exorbitant prices without any difference in quality

Large anti-trust lawsuits and articles by major news publications have cast an ever brighter spotlight on hospital prices as the top driver of unsustainable health care cost inflation. At the same time, more and more health care has been shifting from inpatient to outpatient settings.

[1] Joint powers are exercised when government agencies formally agree to pool their resources to tackle a common problem or achieve a shared goal. In SISC's case, it works to keep health care coverage affordable for its member school districts.

With this background, SISC staff decided to look at claims data to determine if something could be done through plan design to help keep premiums affordable without moving to higher deductible plans. SISC's claims data analysis revealed that the prices for outpatient procedures performed at hospitals can be significantly more expensive than *the exact same procedures* performed at ambulatory surgery centers (ASCs). What's more, multiple research studies have found *no difference* in clinical outcomes for procedures performed in hospital settings compared to ambulatory surgery centers.[2]

Moreover, ASCs confer the additional benefits of shorter wait times, lower infection rates, and fewer administrative hurdles for patients.

With these data in hand, SISC's leadership approached its Board of Directors with a proposal to implement a new benefit design for PPO plan members.

Designing the Strategy

Engineering incentives for selecting ASCs

SISC's *Value Based Site-of-Care Benefit Change* program focuses on five routine procedures with high volumes and low variation in quality – arthroscopy, cataract surgery, colonoscopy, and upper GI endoscopy with and without biopsy – and sets a maximum allowable benefit (a reference price) **for when these procedures are performed at a hospital facility.** When members select an in-network outpatient hospital facility, they are responsible for their regular deductible and co-insurance *plus* the difference between the reference price and the price of the hospital facility fee.

In an effort to keep the new benefit as simple and easy to understand as possible, the program does not apply the reference prices to ASCs; a member selecting an ASC for any of the five procedures faces no change in benefit. Members are exempted from the program under the following circumstances:

- The member lives more than 30 miles away from an ASC and a nearby hospital offers the procedure for less than the reference price;
- ASC capacity contraints prevent the member from scheduling a procedure in a medically-appropriate timeframe;
- The member's physician provides clinical justification for the member having the procedure performed in a hospital setting.

Reference-Based Pricing

Other large health care purchasers, like the California Public Employees' Retirement System (CalPERS) and The Home Depot, Inc., have also implemented benefit design changes using reference-based pricing. SISC drew valuable lessons from these pioneers, such as the importance of clear communications to plan members.

[2] "Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform," *Covered California,* July 2019

Figure 1. SISC Reference Prices Compared to Average Prices Paid in Hospitals and ASCs

Procedure	SISC Maximum Benefit	Average Hospital Paid $[3]	Average ASC Paid $
Arthroscopy	$4,500	$5,241	$2,139
Cataract Surgery	$2,000	$3,182	$1,127
Colonoscopy	$1,500	$2,082	$642
Upper GI Endoscopy w Biopsy	$1,250	$2,146	$541
Upper GI Endoscopy w/o Biopsy	$1,000	$2,376	$372

Figure 2. SISC's Value Based Site-of-Service Benefit Design Change

	Arthroscopy	Cataract Surgery	Colonoscopy	Upper GI Endoscopy with Biopsy	Upper GI Endoscopy without Biopsy
Maximum benefit at an in-network outpatient hospital facility	$4,500	$2,000	$1,500	$1,250	$1,000
There is no limit at an in-network Ambulatory Service Center (ASC)	There is no benefit change at an ASC. The limits at an outpatient hospital facility do not apply at an ASC.				

Note: *The value-based site of care benefit applies to facility fees only. The fees paid to physicians and any other practitioners who assist in the procedure, such as anesthesiologists or radiologists, are not affected by this change.*

Rolling out the Strategy

Creating a compelling story

SISC's Board of Directors approved the new benefit design approach in January 2018, paving the way for program rollout in October of 2018. The challenge ahead lay in communicating the changes in benefit design to SISC's health plan members. SISC aimed to arm its plan members with information they would need to navigate the new benefit design and bring them onboard in support of the new program.

SISC benefits administrators repeatedly remind their members, "We are not an insurance company," but to SISC members, the distinction of roles between SISC who advocates for affordable rates on behalf of its members, and the insurance companies who negotiate with providers and administer claims, is often unclear. Furthermore, the mechanics of communicating with all 330,000 members is complicated by the fact that SISC has limited ways to communicate with members directly – the administrative offices have only about 30% of members' email addresses and very few phone numbers. Consequently, SISC must conduct most communication to its plan members by mail.

[3] Based on SISC's claims data.

As SISC thought about how to communicate the benefit change to members, they started by looking at materials used by other purchasers to inform members of a plan change. They found most of these materials to be somewhat dry and generic. Stenerson and his team wanted to create communications materials that would capture members' attention, provide a persuasive rationale for the benefit change, and convey clear and concise instructions. SISC hired an external consultant to help translate program information into messaging that would resonate with SISC's plan membership, but otherwise used internal resources to launch the communications campaign. They landed on messaging that drew on the common consumer experience of purchasing a car. *"Would you pay three times more for the same car just to cover the dealer's overhead?"* This analogy honed the point that the only difference for certain procedures between hospitals and ASCs was the price of the facility fees.

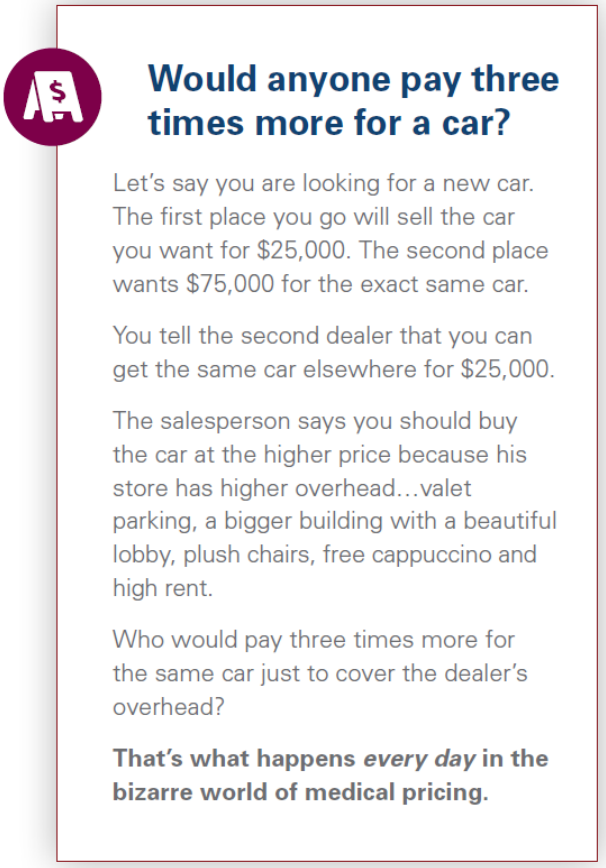


Figure 3. A snippet of SISC's mail campaign

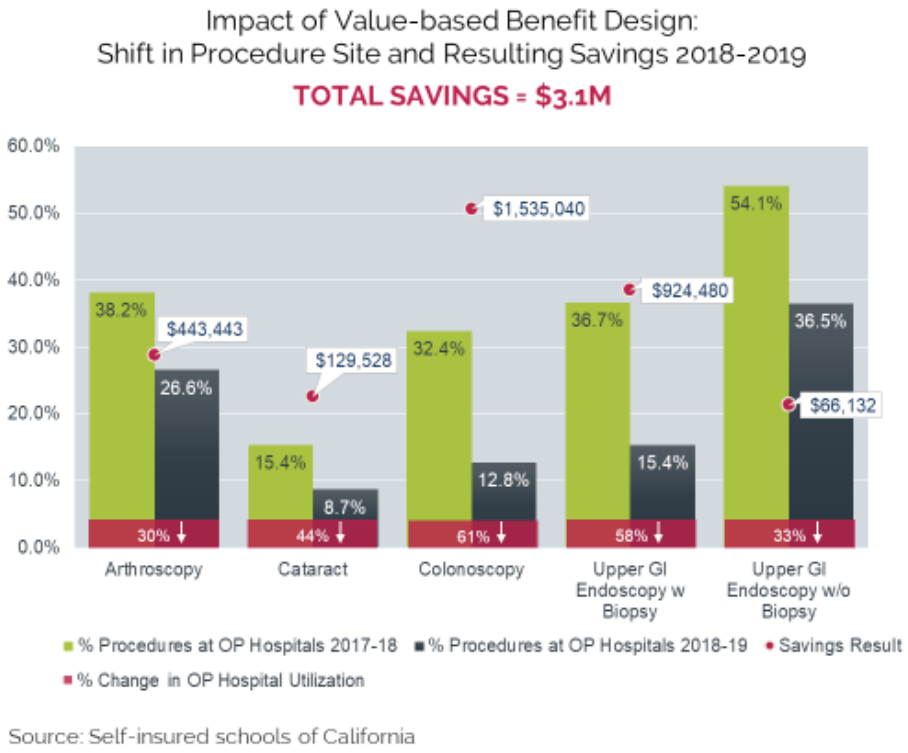
Results

Exceeding expectations

Stenerson and his team projected an annual savings from the *Value Based Site-of-Service Benefit* of between $1.6 - $2.7 million, assuming a 30-50 percent shift from hospital-based facilities to ASCs. In fact, in the year following the program's launch, the program generated **$3.1M in savings**, based entirely on changes in site-of-service. Utilization of hospital-based sites-of-service declined 30 – 61 percent depending on the procedure, and aggregate savings by procedure ranged from just under $67,000 to $1.5 million.

Despite best efforts at communication, changes in benefit designs can often sow confusion, disruption and abrasion among plan members. However, Stenerson reports that SISC has received almost no push back on the program since its inception. Fewer than 20 members (0.2%) approached SISC about being balance billed and in many cases, SISC determined that the circumstances justified paying the balance on behalf of health plan members. Administrators report anecdotally that some providers were willing to write off the the balance and that in some cases, members simply paid the balance themselves. Stenerson partially attributes the ease of implementation to SISC's TPA for its PPO, Anthem Blue Cross, which had experience with

launching and administering a reference-based pricing program on behalf of CalPERS. For its part, Anthem Blue Cross provided communication blasts to area providers, alerting them to the change in SISC's benefit design. For the two quarters prior to the program's effective date, Anthem Blue Cross notified providers in the quarterly provider newsletter; they also sent a separate mailer to all network hospitals and providers with specialties in gastroenterology, general surgery, ophthalmology and orthopedics.



Source: Self-insured schools of California

Figure 4. Year 1 Program Savings

Key Insights and Lessons Learned

The cost curve won't bend itself

The Milliman Medical Index, which measures the cost of health care, found that in 2020 the cost for a family of four in a Preferred Provider Organization (PPO) is currently $28,653, an increase of 235% since Milliman began tracking in 2005. This "news" will come as no surprise to anyone who studies health care – prices tend to rise and quality indicator tend to remain flat. For purchasers seeking better health care value, change won't come without deliberate action. It is for this reason that SISC seized the opportunity to curb waste and unnecessary spending through the Value Based Site-of-Care Benefit program.

Communication is the secret sauce

The Kaiser Family Foundation's 2019 Employer Health Benefits Survey found that employers have been slow to adopt changes to network and benefit design out of "concerns over disruption, employee backlash, access, and convenience." Stenerson believes these fears are overblown – or at least, that the benefit of affordable health care outweighs the risk of constraining choice. His advice: "Don't let preconceived notions about member disruption get in the way of the pursuit of value."

Moreover, in Stenerson's experience "If you provide a persuasive rationale for a benefit change and communicate it clearly, then most members will appreciate your efforts and accept the change." Once members understood that the *only* difference between a hospital-based outpatient facility and an ASC was the price, the value of the benefit design program was obvious.

There is no silver bullet

The $3.1 M that SISC realized in its first program year is certainly nothing to sneeze at, but it represents less than one percent of SISC's total health care spend. Most changes (even successful changes) provide incremental value, not sweepstakes savings. This points to the need for constant innovation. Purchasers should be diligent about pushing for solutions that offer a win/win for health plan members in that they reduce costs without sacrificing quality and are intuitive for health plan members to navigate. The cumulative gains from these synergistic strategies, over time, prevents purchasers from pushing costs onto health care consumers through higher deductibles, co-insurance, and co-pays.

Next Steps

A focus on primary care

On the heels of the success of SISC's Value Based Site-of-Care Benefit Program, Stenerson and his team plan to continue introducing incentives through benefit design changes, this time with a focus on primary care. Effective October 1, 2020, SISC is enhancing the PPO benefits, such that members will have a $0 co-pay for the first three visits they make to their primary care provider (PCP).[4] Unlike the site-of-service program, the primary care enhancement is expected to increase total costs initially by 0.3%.

The rationale for this change relies on research demonstrating that an enduring relationship with a primary care provider improves the quality of care, reduces use of the emergency room, reduces hospital admissions and lowers total cost of care.[5] SISC anticipates that the savings associated with this program will take time to realize and will be challenging to measure. However, the program directly aligns with SISC's core principles to "serve in the best interests of our member[s] …resist easy answers and insist on providing long-term solutions" and maintains SISC's brand of "fairness, caring and integrity."[6]

[4] Expanded benefits will apply to all plans except for high-deductible health savings account (HSA) plans.
[5] DeVoe JE, Saultz JW, Krois L, Tillotson CJ. A medical home versus temporary housing: the importance of a stable usual source of care. Pediatrics. 2009; 124 (5): 1363 – 71; Shi, L. (2012). The Impact of Primary Care: A Focused Review. Scientifica (Cairo); Weiss LJ, Blustein J. Faithful patients: the effect of long-term physician-patient relationships on the costs and use of health care by older Americans. Am J Public Health. 1996; 86 (12): 1742 – 7
[6] https://sisc.kern.org/our-story/