

ACS BENEFIT SERVICES, INC.

Third Party Administration

July 29, 2014

Employee Benefits and Security Administration
U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

Internal Revenue Service
Ben Franklin Station
P.O. Box 7604
Washington, DC 20044

Center for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244

Re: Referenced Based Pricing Arrangements

To whom it may concern:

ACS Benefit Services, Inc. (“ACS”) appreciates the opportunity to submit comments regarding reference based pricing arrangements (“RBPs”) and the application of the Affordable Care Act’s (“ACA”) cost sharing limitations to RBPs. ACS is specifically interested in the application of the cost sharing limitations to a certain type of RBP not previously addressed by the agencies. This particular RBP is described in more detail below, and we respectfully request consideration of our comments with respect to this RBP, as set forth herein.

ACS is a third party administrator based in North Carolina that primarily provides administration services to self-insured health plans in the southeast United States. There are approximately 37,000 participants in the health plans that we administer. We are continually monitoring the cost to provide health care so that we are best able to assist the plans we administer with effective and efficient delivery of health plan benefits. The most popular vehicle over the last 20 years for delivering health plan benefits has been a network based arrangement because the perception is that network based arrangements provide consistency with respect to costs for covered services and treatments, which are “discounted” as a result of the negotiated contracts. Unfortunately, it has become clear that perception does not always match reality and that network based arrangements are not necessarily the most efficient and effective vehicle. Alternative delivery vehicles are needed to reduce the continually increasing cost to provide health care—costs that are born both by the plans and the individuals covered under such plans. *Appropriately* designed RBPs will serve as effective and efficient vehicles for delivering health plan benefits provided that certain ACA related requirements, such as the cost sharing limitations in PHSA Section 2707(b), are applied in such a manner to enable them to operate successfully. Needless to say, we were elated to see the agencies’ comments with respect to RBPs in FAQ XIX (“FAQ”).

In the FAQ, the agencies acknowledged the value of RBPs while also expressing their concern that such arrangements could operate as subterfuge for the cost limitations imposed by the ACA. To illustrate the necessary coordination between the goals achieved by the cost sharing limitations and the need for alternative delivery vehicles, the agencies addressed an RBP wherein the plan paid a specific amount for certain services or treatments, which certain providers accept as payment in full. In such an arrangement, the agencies indicated that amounts charged to participants by providers who do *not* accept the plan’s referenced based pricing would not have to be treated as cost sharing subject to the out of pocket limitations in PHSA Section 2707(b) (i.e. providers who do not accept the referenced based price as payment in full would be treated as out of network arrangement) so long as the plan provided reasonable access to quality providers. The agencies further requested comments on standards adopted by plans who utilize an RBP to ensure meaningful access to quality providers.

In response to the agencies request for comments, we describe below another type of RBP that we believe provides meaningful access to quality care—even more than the RBP addressed in the FAQ and more than common current network arrangements, without being a subterfuge for the cost limitations imposed by the ACA. We respectfully request that the agencies consider our comments with respect to this type of RBP and confirm their ongoing role in the future of health care as requested.

A New Type of RBP

Plans that utilize this new type of RBP for which we have a particular interest provide benefits in accordance with the following terms and conditions:

- The plan does not utilize a network of providers. Consequently, covered individuals are able to procure covered services from *any* provider they deem appropriate. Contrast that with a network plan, which may ultimately cover services for non-network providers. The structure of a network plan is such that covered individuals are encouraged to receive care *only through network providers* through the imposition of hefty “penalties” imposed on covered individuals in the form of lower plan benefits.
- The plan’s benefits for covered services and the covered individual’s “cost share” are based on the “allowed amount” defined by the plan. The allowed amount is defined by reference to a reasonable, objective standard determined by the plan, such as a percentage (e.g. 150%) of the amounts paid by Medicare for such services or treatments.¹ This accomplishes two very important goals. First, it allows the plan to determine the amount on which benefits are paid without having to rely on contracts negotiated outside the presence of, and participation of the plan. Network contracts rarely if ever give plan administrators a glimpse into the pricing structure established under the contract and they rarely if ever provide any audit rights that would enable plans to ensure claims are properly paid according to those contracts. Paying all benefits based on an objective standard established by the plan eliminates these issues and gives control over costs back to the plan administrator, who is the only stakeholder that has a fiduciary responsibility to

¹ We do not intend to limit the design for which we request approval to one that defines the allowed amount by reference to a percentage of the Medicare cost; we use that merely to illustrate one type of reasonable, objective standard that would be effective. Other definitions of “allowed amount” could also be effective provided that they are objective.

act in the best interests of both the plan and covered individuals. Second, this RBP approach establishes a *uniform* basis for determining benefits that avoid many of the common problems that plague network arrangements, which do anything but establish uniform pricing structures (contrary to popular belief). For example, network arrangements determine prices based on complex and varied contractual provisions to which the plan and the covered individuals are not privy. It is our experience that even providers often do not know the amount that will ultimately be paid for a service or treatment that they will provide due to the complexity of the contracts and the after-the-fact adjustments on services that may depend on any number of variables. Also, it is not uncommon in a network arrangement for a participant to receive services from a non-network provider at a network facility (or vice versa). All of these common problems in network arrangements make it impossible for the plan and/or covered individuals to fully understand the manner in which services or treatments will be paid at any given time. The uniform pricing structure of this RBP ensures consistent results each time services are provided.

- To ensure that all stakeholders—providers and covered individuals-- are aware of the uniform pricing structure, all substantive plan materials (such as enrollment materials, Identification Cards, and Summary Plan Descriptions) clearly identify the allowed amount on which plan benefits and cost share is determined. This ensures that all stakeholders are on equal footing prior to the receipt of services—something that simply doesn't exist in a network arrangement.
- The covered individual's cost share represents the covered individual's coinsurance percentage of the allowed amount not paid by the plan. This cost share is applied towards any deductible and the applicable out of pocket maximums established by the ACA. Amounts charged by a provider *over and above the allowed amount* would NOT be treated by the plan as "cost share" and as such, would not be applied to any deductibles or cost share. This is the only way this type of RBP can be efficient and effective; however, in order to ensure that the RBP does not become a subterfuge for the cost limitations established by the ACA, this RBP includes claims management procedures that call for the plan or third party administrator to contact any provider that indicates that it might not accept the plan's payment as payment in full to explain the RBP and how the plan arrives at the allowed amount so that the covered individual is not balance billed for any additional amounts. We have implemented this procedure with our plans that currently utilize this type of RBP and the data to date indicates that the significant majority of providers agree to reduce the billed charge to the allowed amount. For example, in a 10 month period ending June 30, 2014, a covered individual has actually been charged for amounts over and above the allowed amounts only 211 times out of 9857 claims (2.1% of the claims). To date, none of those providers have followed up with further collection efforts. In our experience, these results are at least as good in managing covered individuals' risk for amounts above allowed plan amounts as common network programs in wider use today.

As indicated above, this RBP provides significant advantages over network arrangements—not only for the plan but also for covered individuals. Greater, more meaningful access to providers is provided in this RBP than what is provided in a network arrangement and all stakeholders have a much better understanding of the benefits that will be provided by the plan before services are ever provided than they do in network arrangements. Perhaps more importantly, the claims management procedures implemented by the plan successfully ensures that the RBP does not

operate as a subterfuge for the cost limitations of the ACA. Consequently we respectfully request that the agencies issue guidance that allows plans that utilize an RBP that is the same or substantially similar to the RBP described above to treat amounts over and above the allowed amount established by the plan as other than cost share. Fundamental elements of the RBP described above include:

- Significant access to providers and facilities without significant restriction or limitation;
- Plan defines allowed amount based on reasonable, objective criteria that is uniformly applied regardless of the circumstances;
- Identification of the allowed amount in all substantive plan materials;
- Claims management procedures designed to negotiate with providers to reduce billed charges to the allowed amount to effectively eliminate balance billing.

Minimum Value Determination

In addition to that which is requested above, we would also request clarifications that any plan that utilizes a permissible RBP be permitted to use the minimum value calculator created by HHS to determine whether the plan has minimum value. Although not clear, one interpretation of the instructions to the minimum value calculator is that it is limited to plans that utilize a network arrangement. As noted above, an RBP that contains the above mentioned elements will provide significant advantages over a network arrangement and as such, should be considered a standard design eligible for the calculator.

We again thank the agencies for the opportunity to submit these comments. If you desire to further discuss our comments, please feel free to contact me at (336) 714-1410.

Sincerely,



R. Douglas Lemmerman
General Counsel