THE Kroger CO.

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VIA E-MAIL: E-OHPSCA-FAQ.ebsa@dol.gov

The Honorable Phyllis C. Borzi
Assistant Secretary of Labor
Employee Benefits Security Administration
200 Constitution Ave, NW
Washington, DC 20210

Dear Assistant Secretary Borzi:

The Kroger Co., one of the world's largest retailers, employs 375,000 associates who serve customers in 2,642 supermarkets and multi-department stores in 34 states under two dozen local banner names including Kroger, City Market, Dillons, Jay C, Food 4 Less, Fred Meyer, Fry's, King Soopers, QFC, Ralphs, Harris Teeter, and Smith's. We also operate 787 convenience stores, 324 fine jewelry stores, 1,261 supermarket fuel centers, and 37 food processing plants in the U.S. Recognized by Forbes as the most generous company in America, Kroger supports hunger relief, breast cancer awareness, the military and their families, and more than 30,000 schools and grassroots organizations.

We are focused on improving the health of our associates and their family members. And, we continue to look for ways to control increasing health care costs for our associates and the company. Over the past several years we have implemented innovative solutions focused on improving health and controlling increasing costs. For example, we offer annual biometric health screenings to our associates and their spouses/domestic partners, provide health coaching for those with a chronic condition or at risk for a chronic condition, and provide Centers of Excellence options focused on high-quality and cost-efficient providers for several conditions. We believe reference-based pricing is another example of an innovative solution we've implemented to support the decisions our associates make when they need health care.

Given our experience and success with reference-based pricing, we appreciate the opportunity to provide comment in response to the May 2, 2014, Frequently Asked Questions (FAQs) prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments)[1]. As health care costs continue to rise, employers and employees alike are seeking ways to become better educated and more efficient consumers of care. A recent study found that 68 percent of employers surveyed plan to adopt reference-based pricing as one of several tools to achieve this end[2]. While we appreciate that the Departments must remain vigilant to ensure that reference-based pricing is not a subterfuge for prohibited limitations on coverage and access, we know that this tool can be powerful in reigning in health care costs, and strongly encourage the Departments to ensure that regulations related to reference-based pricing foster their continued and expanded use.

[1] Frequently Asked Questions, May 2, 2014 (http://www.dol.gov/ebsa/faqs/faq-aca19.html)
[2] http://aon.mediaroom.com/index.php?s=25776&item=136979

For these reasons, we urge the Departments to finalize regulations that prevent costs over and above an appropriately established reference-based price program from being counted towards the out-of-pocket limitation under the Affordable Care Act (ACA).

Background

As the Departments acknowledge, reference-based pricing "aims to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs."[3] This tool also allows consumers to have more information about the services they consume and make better-informed decisions about their health care.

The ACA recognized the value of maintaining reference-based pricing in the individual and group marketplaces. The newly-established Public Health Services (PHS) Act section 2707(b) requires group health plans to ensure that any annual cost-sharing imposed under the plan does not exceed the annual limitation on out-of-pocket maximums described in section 1302(c)(1) of the Affordable Care Act. The Affordable Care Act defines "cost-sharing" to include "(i) deductibles, coinsurance, copayments, or similar charges; and (ii) any other expenditure required of an insured individual which is a qualified medical expense…with respect to essential health benefits covered under the plan."[4] However, under this provision, cost-sharing expressly does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

The Department of Health and Human Services' (HHS) final regulation on standards related to essential health benefits (EHB) explained that "these EHB regulations do not prohibit issuers from applying reasonable medical management techniques."[5] The HHS final regulation therefore refrained from implementing a prohibition on discriminatory cost sharing "in response to comments about the protection of a health plan's ability to control costs through the use of utilization management."[6] To this same end, HHS has only applied cost-sharing limits under PHS Act 2707(b) to in-network visits, in order to "promote health plan affordability."[7]

To ensure that plans can continue to appropriately implement reasonable utilization management measures to control plan costs, as permitted under the final regulations, we urge the Departments to establish that, with respect to benefits obtained by plan participants that exceed the cost of a reference price established by a group health plan, the additional costs of such services incurred by the plan participant – beyond what they would have otherwise paid –will not be included under the cost-sharing limitation for purposes of PHS Act 2707(b).

For these purposes, cost-sharing would include only those deductibles, coinsurance, copayments, similar charges, or qualified medical expenses that a plan participant would incur if he or she elected to receive health care benefits from a provider that charges at or below the plan's reference price. Any additional charges incurred by the plan participant that elects a provider or service for which the costs exceed the plan's reference or target price would not count toward the annual cost-sharing limitation under PHS Act 2707(b).

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[3] Frequently Asked Questions, May 2, 2014, Question 4 (http://www.dol.gov/ebsa/faqs/faq-aca19.html)
[4] PHS Act section 2707(b)
[5] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final* Rule, 78 Fed. Reg. 12834, at 12847 (Feb. 25, 2013).
[6] 78 FR 12848 (Feb. 25, 2013).
[7] *Id.*

Kroger Initiatives

Kroger has been on the forefront of engaging consumers in their own health care by arming them with data about their health and health care choices. We are delivering these innovative services to our employees and customers alike. In 2012, Kroger placed self-use health screening kiosks in all of its pharmacy locations. The Kroger HealthCENTER kiosks provide customers with an easy, free, and secure solution to consistently measure, monitor, and improve body composition and other clinical conditions such as blood pressure, weight, body composition, BMI, color vision and the ability to upload blood glucose numbers and other biometric results.

In 2012, Kroger also implemented a target pricing program for employees. The program focuses on educating employees about the price variation in certain medical services and prescription medications. Through this program, employees are given the tools and information that can help them reduce their health care costs. We believe the Kroger Target Pricing Program can serve as a tested and proven model for other employers seeking to implement reference-based pricing as a tool for employees to understand and impact the cost of their health care choices. We also believe our model demonstrates that when these programs are implemented based on evidence, targeted appropriately, and used by employees, they can help drive down costs without limiting access to quality health care providers and services.

In developing the Kroger target pricing initiatives, we focused on two objectives: to improve health and reduce costs. Our goal has always been to offer high quality health care to our employees and their families, while equipping them with the tools and resources to better understand their treatment options and costs. We have implemented two specific target pricing programs: a radiology program and a prescription medication program. Each program is targeted to specific services within these categories and uses evidence-based design. The development and process underpinning our radiology management program is described further below, to demonstrate that focused, well-designed reference-based pricing programs can drive value-based purchasing by consumers and simultaneously ensure access to a sufficient number of quality providers.

Our radiology management program is limited to outpatient services only; emergent and inpatient services are excluded. The program includes three components: Target Pricing on Select services; use of Anthem's Advanced Imaging Management (AIM) educational Model with Pre-Certification call; and Imaging Cost and Quality Member Outreach. A target price is set for specific services, including abdomen CT, pelvic CT, chest CT, brain CT, and spine MRI. The target price is a "global" price, meaning it is inclusive of both the facility and professional charges. To determine the target price, an opportunity analysis was done by AIM for Kroger in March 2011. Two years of past experience were used. An actuarial analysis of unit cost by grouper code was conducted and an average, median, 25^{th}, and 75^{th} percentile was calculated for each grouper code, inclusive of high and low outliers, and a reference price was selected.

Once the target price was established, we examined additional data to validate the target price and ensure access was maintained. Our team pulled the facility information on global cost ranges from covered facilities in each state, allowing us to illustrate how many facilities would fall at or under the target price in order to validate whether the target prices selected would yield enough access for our membership. Finally, we developed individual state maps showing the location of every Kroger member, overlaid with each imaging facility, and broke out, by procedure category, the proximity of our membership to the target-priced providers. As some members who were located in rural areas had limited access, we have undertaken the consideration of an exceptions process.

Prior to scheduling any high tech imaging procedure, a Kroger employee or their provider must contact AIM by phone or online. AIM then reviews high tech imaging for clinical appropriateness and provides information to providers and employees about safety, quality, and target pricing implications. Pre-certification is done in real-time. For cases that would exceed the target price, an Anthem outreach specialist will contact the affected enrollee to inform them that the selected service exceeds the reference price and offer assistance with alternative site selection, if the patient wishes to switch to an alternative site at or below the target price. This program also allows AIM to track radiation exposure on behalf of our employees and notify providers when a pre-defined limit for exposure has been reached by a patient.

Standards for Ensuring Meaningful Access

The FAQs indicate that the Departments are particularly interested in stakeholder feedback on the standards that plans using reference-based pricing structures should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care. As described above, Kroger took significant steps to ensure that the development of our target pricing structure maintained meaningful access to quality providers of the reference-priced services for all of our employees.

In light of our experience, we respectfully request that the Departments consider the following standard as demonstrating: A group health plan that includes a reference-based pricing structure for certain covered benefits will be considered to provide meaningful access to medically appropriate, quality care, provided that such services:

(1) are readily available to plan enrollees at or below the plan's established target price from more than one provider in the plan's service area; and
(2) where plan participants are made aware, through plan documents, that such services will be subject to a reference price limitation.

We believe these protections will ensure that plan enrollees will continue to have meaningful access to medically appropriate, quality care, while being better engaged in their own health care decision-making.

Conclusion

We sincerely appreciate the opportunity to provide the Departments with our comments and urge you to ensure that regulations governing the interaction between reference-based pricing and out-of-pocket limitations do not impede the expansion of such innovative, consumer-engaging plan designs. Our experience through the Kroger Target Price Initiative demonstrates that evidence-based, appropriately targeted reference-based plan designs can better educate consumers about their health care options and help drive down costs for employees and employers alike. We appreciate your consideration of these recommendations. Please do not hesitate to contact me if we can provide any additional information.

Sincerely,

Theresa Monti

Theresa Monti
Vice President, Corporate Total Rewards