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August 1, 2014

Daniel Maguire
Office of Health Plan Standards and Compliance Assistance
Department of Labor
200 Constitution Ave, NW, Ste N-5653
Washington, DC 20210

Dear Mr. Maguire:

The Blue Cross Blue Shield Association (BCBSA) – a national federation of 37 independent, community-based and locally operated Blue Cross and Blue Shield companies (“Plans”) that collectively provide healthcare coverage for more than 103 million members, one-in-three Americans – appreciates the opportunity to respond to the call for comments from the Departments of Labor, Health and Human Services, and the Treasury (“the Departments”) regarding the application of the out-of-pocket limitation to the use of reference based pricing, included in Q. 4, FAQs about Affordable Care Act (ACA) Implementation (Part XIX). As requested, we focus on the standards that Plans use to ensure that individuals have meaningful access to medically appropriate, quality care.

We commend the Departments for supporting an innovative and still evolving advanced benefit design by exempting cost sharing above the reference price from the out-of-pocket maximum requirements of PHS Act section 2707(b). Health services researchers have identified reference based pricing as an attractive instrument because “the continuing escalation in health insurance costs is driving employers to experiment with new benefit designs that increase consumers’ consciousness of cost without shifting excessive financial burdens to patients in need of care”.¹ A recent Employee Benefit Research Institute Issue Brief estimates that potential aggregate savings could reach \$9.4 billion if all employers adopted a

¹ James Robinson and Kimberly MacPherson, “Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers,” *Health Affairs*, September 2012.

reference price for a relatively small set of services that have fairly uniform protocols.² However, we recommend clarifying the FAQ's implied definition of reference based pricing as treating providers who accept the reference amount as the only in-network providers. As explained in our detailed comments, Plans may set a reference price based on the distribution of negotiated prices among in-network providers. A member can go to an in-network provider who accepts the reference amount, or the member can go to an in-network provider who does not accept the reference amount. If the latter, the member pays the difference between the reference amount and the provider's charge; but because the provider is in-network the member is protected against balance billing and also takes advantage of the discounted charge negotiated by the health plan.

Our advice to the Departments is based on our Plans' experience with reference based pricing – or what many of our Plans refer to as reference based benefits (RBB). To date, this experience has been with large employers (self-funded accounts). However, reference based benefits can be an effective benefit design in any line of business, which includes regional accounts or small, fully-insured employers as well. Our Plans' experience corroborates the aforementioned research, a large part of which is based on a program that the California Public Employees Retirement System (CalPERS) developed with Anthem Blue Cross of California.

Regarding our mention in the preceding paragraph of "reference based benefits," the distinction between reference based *pricing* and reference based *benefits* (RBB) is important because these structures are centered around benefit design, not solely pricing. In general, Plans partner with employers to determine the services that would qualify for an RBB structure, to share the cost variation segmented in different percentiles relative to a reference price, and to provide the network of providers. While employers (if self-funded) make or otherwise influence the ultimate decision on the terms of the RBB program, Plans provide input and the expertise on how to structure the main elements of an RBB program: (1) the services included; (2) the reference price; (3) member and provider engagement; and (4) member protections. It stands to reason that any standards that group health plans are required to meet should align with these four areas.

However, before offering detailed comments on setting and applying RBB standards, we would like to highlight four principles of overriding priority that we urge the Departments to follow:

² Paul Fronstin and M. Christopher Roebuck, "Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits," *EBRI Issue Brief*, April 2014.

- **First, as RBB are still early in development, the Departments should abstain from developing rigid standards.** Employers and health plans need the flexibility to design benefit structures that meet the unique needs of the populations being served, and any future standards that diverge from current practices (which we will explain below) will have a chilling effect on innovation and limit the potential of this positive benefit. In the CalPERS example referenced above, an Anthem evaluation of the reference pricing program found that CalPERS paid 30 percent less per surgery on average in 2011 (first year of the program) compared to 2010.³ Flexibility in designing the program to meet the needs of the employer was essential, and no one-size-fits all approach will be able to take into account current and future variations in RBB designs.
- **Second, exempting RBB from the out-of-pocket (OOP) maximum is critical for the success of these structures. Therefore, the burden of proof should lie with regulators, not with plans,** as to whether the reference based program is using reasonable methods to ensure that they provide adequate access to quality providers – the presumption should be that such an advanced, innovative benefit structure is not a “subterfuge.”
- **Third, because RBB are currently “stand-alone” (i.e., generally not integrated into alternative payment models like bundled payments), any standards should be uniform across different design models and product types to avoiding undermining the ability to integrate RBB into new payment models.** RBB appeals to some employers because it allows members to apply their employers’ contributions toward payment for any providers or health care services, which is an alternative, for example, to smaller or preferred networks. However, as EBRI points out, RBB could be coupled with smaller or preferred networks, which might then be used to negotiate lower charges with providers.⁴
- **Fourth, transparency and consumers protections are crucial in the success of RBB programs.** Transparency involves a partnership among employers, health plans, and providers

³ Amanda Lechner, Rebecca Gourevitch and Paul Ginsburg, “The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer,” *HSC Research Brief* No. 30, December 2013.

⁴ Paul Fronstin and M. Christopher Roebuck, “Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits,” *EBRI Issue Brief*, April 2014

to engage members and illuminate disparities in price for “shoppable” procedures. Greater member engagement is starting to have a larger impact beyond simply the RBB savings – as more consumers become engaged in RBB structures, the greater the impact on cost savings we will see throughout our healthcare system. This becomes even more important outside of self-funded employer accounts, since employers may not have the same level of engagement when educating employees on prices of services as they would be when they feel the cost impact directly.

What follows are detailed comments showing how Plans go about structuring reference based benefits: determining the services, establishing reference prices, educating consumers and providers, and protecting consumers. We also draw your attention to a noteworthy analogy with similar IRS guidance for high deductible health plans.

We appreciate your consideration of these comments, and would be happy to provide additional details on any Plan initiatives. If you have questions, please contact Joel Slackman at 202.626.8614 or joel.slackman@bcbsa.com. We look forward to continuing to offer input to help you learn more about this promising benefit design that is proving to lower costs while maintaining quality and promoting consumerism in healthcare.

Sincerely,



Justine Handelman
Vice President, Legislative and Regulatory Policy

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REFERENCE BASED BENEFITS: DETERMINING THE SERVICES INCLUDED

Reference based benefits (RBB) seek to increase consumer transparency, while delivering additional cost savings that Plans' employer partners seek to achieve. Employers are currently partnering with health plans to determine which services are ideal candidates for RBB and to guide their employees to be better

consumers of healthcare by having a greater understanding of how their choices can have a direct impact on healthcare costs.

To determine which services should qualify as candidates for an RBB structure, BCBSA and its Plans have developed the following criteria that are generally used for selecting services for RBB:

- Be common with substantial volume to establish a true market cost.
- Be elective and generally understandable to the member (“a shoppable” service that could be performed at another location).
- Have high price variation between providers/places of service.
- Contain a facility component (e.g., a charge by a hospital or ambulatory surgical center independent of any other professional fees) that can be performed in multiple places of service.
- Represent a comparatively large percentage of a covered population’s total spend (enough volume of services that can drive meaningful savings).
- Have low quality variation between providers or places of service.

In addition to these general criteria, Plans and employers have also structured programs to:

- Select treatment categories that are easily understandable to members, large national employers, and consultants. These treatment categories must be discrete – it should be easy to identify where the episode begins and ends.
- Avoid procedures that are urgent, emergent, or cannot be planned.
- Avoid services associated with conditions that Plans or employers believe have an emotional burden.
- Avoid procedures that have no cost share or restrictions under the ACA (e.g., mandated preventive services).

The Relationship to Quality

Ideally, Plans select services that have uniform protocols and relatively little variation in quality. One challenge is that many procedures and specialties still have limitations in quality metrics. For example, radiology services are ideal candidates for RBB structures – they are shoppable, with wide variations in prices and (logic dictates) have little variation in process or outcomes. However, quality metrics are lacking in this area to quantifiably compare a “high-performing” provider to a “low-performing” provider.

That is one reason the criteria Plans use to select procedures are intended to mitigate risks of limiting members' access to quality care. Moreover, all providers in Plans' networks meet credentialing standards, all providers agree to meet various quality standards to be contracted, fully-insured health plans receive state approval that often includes review of network adequacy, and health plans that are accredited (common among large group market and self-funded employers) follow a variety of standards to ensure access to quality care.

Therefore, we recommend that any standards developed by the Departments reflect health plans' existing approaches to selecting services or procedures as candidates for a reference pricing/benefit structure. These criteria should be flexible and reflect the currently used principles outlined above.

REFERENCE BASED BENEFITS: ESTABLISHING THE REFERENCE PRICE

When determining the reference price, or standard allowable price, BCBS Plans leverage a national repository of data from across the Blue system that is updated every six months. The Blue system has developed guidelines around the selection of services and the calculation of Reference Prices for National Delivery (for large employer accounts):

- First, BCBSA calculates new reference costs every six months and may (but does not necessarily) adjust the payment amounts within their historical claims data for any recent changes in negotiated provider arrangements. This coincides with information contained in our National Consumer Cost Transparency (NCCT) data refresh received from Plans. Plans use the NCCT to support web-based tools for members to obtain information on estimated costs for their health care services.
- Second, BCBSA trends the costs calculated using the CPI to ensure the reference prices calculated remain relevant for longer periods and provide the member with a slight cushion for unexpected costs. Cost regions are identified using three-digit zip codes as a baseline (some Plans, however, are using statewide regions) to capture price differences by geography.
- Third, employer partners are asked to select one of five reference price percentiles (50th – the median point – 60th, 70th, 80th, and 90th). In general, Plans and employers are very cognizant of the need to have choice and not to restrict network adequacy – it is for this reason that thresholds are currently set at or above the median (though depending on evolving market conditions, a plan may feel comfortable setting lower reference points in the future). As the impact of percentiles will vary by service (e.g., shoppability of a service, number of providers

offering the service) common practice tends to be to set the reference prices at the 70th or 80th percentiles. From our experience to date, this tends to balance access needs with the opportunity to focus on higher-cost outlier settings or services. Additionally, reference prices tend to include facility and professional fees (including anesthesiology fees, if applicable.)

- Finally, BCBS Plans work with accounts and their members to educate them on the reference price and benefit designs. *BCBS Plans have chosen to set the reference price based on where the member resides, and not the provider's location.* This decision was made because it is easier to communicate RBB to the member in this manner and easier for them to compare services or providers (more on member education below).

Reference prices are not set in any way that undermines network adequacy. Moreover, all fully-insured plans must comply with state law requirements, and as noted above it is common practice for large fully-insured and self-funded plans to be accredited. Accreditors typically require that plans have sufficient numbers and types of providers to permit access without unreasonable delay.

Therefore, we believe the Departments should take a flexible approach in assessing any RBB program, and should not assume that access is insufficient solely on the basis of, say, rigid time and distance criteria; such standards, for example, do not consider other aspects of benefit design such as a travel benefit that may also be available to cover transportation, lodging, and food for the patient and a caregiver at a relatively distant facility.

Moreover, one's definition of "unreasonable delay" is likely to be different for a discretionary procedure (a knee repair to enable an avid runner to race in marathons) than for one that is non-discretionary (a chemotherapy treatment). For that reason, we believe applying one-size-fits all numeric standards for network adequacy would be problematic. Given reasonable criteria for selecting RBB procedures or services, network adequacy is best judged on a case-by-case basis, and deference to any states requirements should apply.

MEMBER AND PROVIDER ENGAGEMENT

Educating members and providers about the new benefit design and cost of healthcare services is essential for RBB to work. BCBS Plans and their employer partners work with both patients and

providers to help them understand the prices of services – for different reasons both parties often are insulated from this information. In a traditional benefit plan that includes a deductible, patients are typically insulated from cost sharing for health care that exceeds the deductible.⁵ Additionally, physicians generally do not have an incentive to learn the prices of the services they recommend to their patients.⁶ With proper engagement of members and providers, RBB fosters competition, exposes providers to the consequences of their pricing, and educates members on high quality alternatives that are available at a much lower price.

Members

The objective of this benefit structure is to encourage the member to consider quality and cost while making their healthcare decisions, which will ultimately translate to lower healthcare costs for employers throughout the country. This has demonstrated, thus far, to be an effective mechanism for lowering costs and increasing member transparency. By giving members an added incentive to shop for high quality/cost-effective providers, coupled with transparency tools, consumers are able to find providers who offer services at or below the designated “reference price”.

BCBS Plans and their employer partners have learned that without extensive communication to members, uptake in RBB or member satisfaction will be low. Examples of member education approaches that BCBS Plans and employer partners are using include:

- Numerous member communications that enhance understanding of coverage available. Examples of these communications include print brochures, emails, and letters to members describing the program and providing information on available providers.
- Benefit summaries and materials for an RBB strategy are in place for certain procedures, directing members to transparency tools on BCBS Plan websites.
- Transparency tools that allow members to easily conduct searches comparing providers/services along with how their selections relate to their benefit plans.
- Highly skilled representatives assist members with navigation of transparency tools or simply provide recommendations of providers under the reference price. Furthermore, for services that require prior

⁵ Fronstin, 2014.

⁶ Fronstin, 2014.

authorization, customer service representatives will also educate the member on RBB should it apply to that service.

Providers

Plans educate local providers about how RBB work, and how to help direct patients to cost-effective sites of care. BCBS Plans work with providers to instruct them on how to determine whether RBB applies to their patients, specifically by checking eligibility and benefits as they normally would. Additionally, providers are educated on where they stand regarding the reference price point in relation to other providers – this fosters dialogue between the provider and Plan to determine how to partner in an RBB structure, or to provide the opportunity to make the provider more competitive with regard to price.⁷

MEMBER PROTECTIONS

A member can go to an in-network provider who accepts the reference amount, or the member can go to an in-network provider who does not accept the reference amount. If the latter, the member pays a flat fee or the difference between the reference amount and the provider's charge; but because the provider is in-network the member is protected against balance billing and also takes advantage of the discount negotiated by the health plan.

As noted previously, RBB are meant to preserve choice by enabling members to shop for non-urgent services based on a balance of quality and cost thresholds. Thus far, RBB have been implemented in broad network products that seek to maintain wide access but allow for cost controls through changes in the benefit design.

However, as RBB are still relatively new, health plans and employers have worked to ensure that sufficient consumer protections are in place should there be confusion around benefits that lead to selecting a service above the reference price unknowingly, potentially leaving the consumer with a large out-of-pocket bill.

⁷ Increasing price competitiveness was observed in the CalPERS program: soon after CalPERS rolled out the reference pricing program, several non-designated hospitals renegotiated their contracted price with Anthem – for all Anthem-covered patients not just CalPERS members – growing Anthem's list of designated hospitals from 45 to 54 hospitals by September 2012. Lechner and others, 2013.

For example, Anthem Blue Cross of California worked with CalPERS on a reference based benefits strategy that created a special pre-service appeals process (a “leniency” program) that is outside of the standard member appeals/grievance process that allows for members to work with the employer or health plan to reconcile issues related to RBB. Health plans work with employers to determine how they would like similar “leniency” programs applied – and in some cases, depending on the procedure/service, if there was a health plan error (such as inaccuracies in pricing information) then members are held harmless for costs above the reference price.

Another employer working with a BCBS Plan has instituted a RBB structure, that if there are not enough choices below the RBB in a particular area, the member is not required to pay extra for services above the reference price.

The amounts which members end up paying above the reference price will vary by employer – Plans honor their client’s requests for how to (or how not to) apply RBB structures towards the OOP maximum. In some instances, members are liable for the full amount above the reference price; in other examples members pay a fixed amount above the reference price. The latter approach is more conducive to less-costly services, as well as application to the OOP maximum since the most expensive procedures would undermine RBB structures if costs above the reference price could be applied to the OOP maximum.

Another example where members are protected in RBB structures is when they go into the hospital for a service, and if a complication develops or additional services need to be provided that were not part of the original visit, reference pricing gets dropped and members are held harmless for additional costs. Since the member did his or her part to select a provider under the reference price, BCBS Plans have been working to ensure that members are not penalized for unforeseen circumstances that may occur in the clinical setting.

BCBS Plans are in the early stages of tracking the impact of RBB on utilization by site of service, cost and patient satisfaction. As RBB structures continue to evolve, Plans will continue to adapt these benefits to meet the needs of the employers and members they serve.

CONSISTENCY WITH IRS GUIDANCE

Finally, we note that the FAQ’s treatment of amounts above the reference based benefit (RBB) limit is consistent with similar IRS guidance that treats amounts paid by covered individuals in excess of usual, customary and reasonable (UCR) benefit limits for qualified high deductible health plans (HDHP). Q/A 16 of IRS Notice 2004-50 states, in relevant part, that “... amounts paid by covered individuals in excess of

UCR that are not paid by an HDHP are not included in determining maximum out-of-pocket expenses.” IRS considered the restriction of benefits to UCR to be reasonable, and it is consistent to view RBB in the same light as UCR. This is particularly so given that the maximum out-of-pocket limitations established under Section 1302(c) of the Affordable Care Act (ACA) are based on HDHP cost-sharing limitations set forth in Internal Revenue Code (Code) Section 223. Had IRS believed that payment on the basis of UCR would potentially result in inadequate access to providers, then it would have qualified its response to Q/A 16 of Notice 2004-50. Therefore, as long as the relevant RBB is consistent with amounts paid for a medical service in a geographic area based on what network providers are usually paid for the same or similar medical services, excluding amounts in excess of a particular RBB from the maximum out-of-pocket expenses is consistent with IRS guidance. (Modified from the CMS definition of Usual, Customary and Reasonable available at <https://www.healthcare.gov/glossary/UCR-usual-customary-and-reasonable/>.) If this consistency standard is applied – along with reasonable, flexible approaches to structuring RBB programs, as practiced by Blue Plans – members will be assured of adequate coverage within the applicable network.