



Kaiser Foundation Health Plan
Program Offices

August 1, 2014

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave, NW, St N-5653
Washington, D.C. 20210

Submitted electronically via: E-OHPSCA-AQ.ebsa@dol.gov

Re: *Comments to Reference-Based Pricing FAQ*

Dear Sir or Madam:

Kaiser Permanente appreciates the opportunity to provide comments to the Departments of Health and Human Services, Labor, and Treasury (the “Departments”) in response to the “FAQs About Affordable Care Act Implementation (Part XIX),” published on May 2, 2014 (“FAQ”).¹ Kaiser Permanente is the largest private integrated healthcare delivery system in the United States, delivering health care to more than 9 million members in eight states and the District of Columbia.²

The Affordable Care Act (“ACA”) amends the Public Health Service Act and provides that a non-grandfathered group health plan shall ensure that any annual cost-share imposed under the plan does not exceed the out-of-pocket limits set forth under section 1302 of the ACA. For non-grandfathered individual and group health plans, the 2014 annual limitation on out-of-pocket costs are \$6,350 for self-only coverage and \$12,700 for family coverage. In 2015, this limit increases to \$6,600 for self-only coverage and \$13,200 for family coverage.

The Departments’ FAQ invites comments on the application of the out-of-pocket limitation to the use of reference-based pricing for large group market coverage and self-insured group health plans. The Departments are concerned that reference pricing is a “subterfuge” for the imposition of otherwise prohibited limitations on coverage. In particular, the Departments are interested in 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.

Kaiser Permanente supports innovative pricing models that sustain timely access to high quality care, while providing affordable care to patients. We believe a carefully designed reference-based pricing model could be an important tool for consumers to make health care decisions based on quality and value. However, we share the Departments’ concerns that broad

¹ Accessed: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html

² Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation’s largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 38 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation Health Plan to meet the health needs of Kaiser Permanente’s members.

application of reference-based pricing, *without regard to quality care or reasonable access to providers* would result in increased out-of-pocket costs for members. Generally, this model may be successful if patients are provided with meaningful and transparent information about the provider quality, pricing, and experience of care. Reference-based pricing would expose some patients to greater out-of-pocket costs if they choose to select more expensive providers.

While we are generally supportive of reference-based pricing, we are also concerned that it could be used inappropriately, causing members to have misleading information about coverage levels or the realistic access to quality providers in their networks. Mostly implemented in PPO products, reference-based pricing can serve to effectively create another tier of providers within the in-network provider tier. Given the general market movement toward narrow networks, any “feature” that serves to shrink a network that is already limited must be done with full transparency. Moreover, we believe that reference-based pricing should not be viewed as a substitute for effective provider contracting. Finally, we would urge considerable caution in allowing reference pricing to be applied to non-contracted, out-of-network providers. In a PPO or POS plan, patients believe they will be reasonably reimbursed if they seek services from an out-of-network provider. A patient selecting an out-of-network provider could pay an unreasonably high share of costs if the health insurance plan or self-insured group applied the reference price over the usual and customary rate for payment.

Some large employers have begun to implement reference-based pricing models. The California Public Employees’ Retirement System (“CalPERS”) thoughtfully implemented a reference-based pricing benefit design that accounted for \$3.1 million savings for the plan sponsor and members.³ To implement this pricing model, CalPERS selected elective medical procedures and services with a high variation in price, knee and hip replacement surgery. The plan designated 41 hospitals as “value-based purchasing design” facilities based on the price of the procedure, acceptable quality standards as measured and established by third party reporting entities, and appropriate geographic dispersion. As a result, the pricing design affected consumers’ choices and the market shares of value-based purchasing design hospitals.⁴ We believe the CalPERS approach reflects an appropriate balance of competing concerns in implementing a reference-based model.

Kaiser Permanente believes that any reference-based pricing model should be implemented with standards to ensure consumers are able to access high quality care by providers, without incurring unreasonable costs for medical services. We recommend the following key standards:

- Limit Application of Reference-Based Pricing to Elective and Non-Emergency Services. The use of reference-based pricing should be restricted to services where the covered individual (or financially responsible party) can be reasonably expected to understand the likely cost of the care before it is delivered. Use of reference-based pricing for non-elective services, or those which are largely directed by care providers once a course of treatment has commenced, should be very limited.

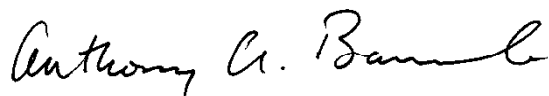
³ James Robinson and Timothy Brown, “Increase in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery,” *Health Affairs*, 32, no. 8 (2013) 1392-1397.

⁴ *Id.* at 1397.

- Access to Quality Providers. In areas with a limited number of hospitals and providers, health insurance issuers and self-insured plans are not able to offer meaningful access to quality providers under a reference-based pricing model. Many states have implemented provider network adequacy standards to provide access based on geographic location or ratio requirements of providers to enrollees. Plans that implement reference-based pricing should adhere to existing state network adequacy requirements.
- High Clinical Quality Standards. Health care providers should meet measurable, evidence-based, definitive quality standards. Health insurance issuers and self-insured plans must demonstrate that providers satisfying these quality standards are available in their networks.
- Establishing Reasonable Reimbursements for Medical Procedures. We are concerned that unreasonably low reimbursements driven by unsustainably low provider pricing would not cover the cost of a medical procedures for most providers, causing unreasonable cost-shifting to consumers. The reimbursement levels set by the health insurer and self-funded plan utilizing a reference-based model should ensure that a member has reasonable and adequate coverage for such medical procedures.

We appreciate the opportunity to comment on this FAQ. If you have questions or would like to discuss our comments further, please contact Erica Pham at 510.271.6616 (email: erica.d.pham@kp.org) or me by phone or email at 510.271.6835 (email: anthony.barrueta@kp.org).

Sincerely,



Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente