HR POLICY ASSOCIATION®
The Association of Chief Human Resource Officers

August 1, 2014

Submitted via email to E-OHPSCA-FAQ.ebsa@dol.gov

Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, D.C. 20210

RE: Request for Public Comment on the Application of the Patient Protection and Affordable Care Act Out-of-Pocket Limitation on the Use of Reference-Based Pricing in Employer Health Care Plans

Dear Sir or Madam:

HR Policy Association ("HR Policy" or the "Association") welcomes the opportunity to comment on the Affordable Care Act Implementation Frequently Asked Questions (FAQ) Part XIX published by the Department of Labor (DOL) on May 2, 2014.[1] The comments below specifically address "Q4: If large group market coverage or self-insured group health plan has a reference-based pricing structure, under which the plan pays a fixed amount for a particular procedure (for example, a knee replacement), which certain providers will accept as payment in full, how does the out-of-pocket limitation apply when an individual uses a provider that does not accept that amount as payment in full?"

HR Policy Association represents the Chief Human Resource Officers of more than 360 of the largest employers in the United States. Collectively, their companies employ more than 10 million employees in the United States, nearly nine percent of the private sector workforce. Together the member companies spend more than $80 billion annually providing health insurance to tens of millions of American employees, their dependents and retirees. As the senior human resource executive for their companies, HR Policy Association members play a lead role in health care strategy, design, and implementation of the health care plans their companies offer to their employees and retirees.

HR Policy appreciates DOL's decision to enable a large group market plan or self-insured group health plan to utilize a reference-based pricing structure until further guidance is provided. The Association strongly believes that reference-based pricing structures used as part of an employer's health care plan design comply with the out-of-pocket maximum requirements of PHS Act section 2707(b) because they effectively treat providers that accept the reference price as in-network providers.[2] Moreover, research shows that reference-based pricing structures have

[1] Employee Benefits Administration, U.S. Department of Labor, "FAQs about Affordable Care Act Implementation (Part XIX)," available at http://www.dol.gov/ebsa/faqs/faq-aca19.html.

[2] It is important to note that there is a variety of reference-based pricing structures. Moreover, employers and insurance carriers can effectively achieve the same result (reducing excessive price variation) by modifying the terms of the contracts for their in-network providers. For example, only those providers in a certain area that accept a certain price for specific services will be considered 'in-network" by the health care plan.

the potential to drive significant health care savings for both employees and employers by creating voluntary incentives to reduce the wide variation in provider prices that currently exists in the United States. DOL should do everything possible to encourage these programs and do nothing to limit or discourage them at this time.

Reference Pricing and the Annual Limitation on Cost-sharing

Section 2707(b) of the Public Health Service (PHS) Act, as added by the Affordable Care Act (ACA), provides that a non-grandfathered group health plan shall ensure that any cost-sharing requirements (excluding premiums and balance billing amounts for non-network providers or spending for non-covered services) under the plan does not exceed the limitations provided for under section 1302(c)(1), annual limitation on cost-sharing.[3] The Department of Health and Human Services has set the 2015 annual limit on the maximum out-of-pocket costs a participant can be required to pay at $6,600 for self-only coverage and $13,200 for coverage other than self-only.[4] The Internal Revenue Service has set the 2015 out-of-pocket annual limit for HSA-compatible high deductible health plans at $6,450 for self only coverage, and $12,900 for coverage other than self-only.[5]

Prior FAQ Part XVIII Q4 clarified that if a plan includes a network of providers, and a participant receives services from an out-of-network provider who charges more than the plan's allowed amount, a practice typically called "balance billing," the plan is not required to count the participant's out-of-pocket costs toward the plan's annual out-of-pocket maximum.[6]

FAQ Part XIX Q4 clarifies that until further guidance is issued, a large group market plan or self-insured group health plan that uses a reference-based pricing program may treat providers that accept the reference amount as the only in-network providers, provided the plan uses a reasonable method to ensure that it provides adequate access to quality providers.

After reviewing FAQ Part XIX Q4 and the ACA, we wish to address two items of concern:

- DOL should not limit the use of reference-based pricing programs because of their ability to drive health care savings; and
- There is no statutory basis for DOL to impose any network adequacy requirements on self-insured employer health care plans.

[3] Public Law 111-148, section 1201 adding Sec. 2707 to the PHA, and Public Law 111-148, sections 1302(c)(1) and 1302(c)(3)(B).

[4] 79 Fed. Reg. 13744 (March 11, 2014).

[5] IRS Rev. Proc. 2014-30, April 23 2014, available at http://www.irs.gov/pub/irs-drop/rp-14-30.pdf. Under the ACA, the generally applicable out-of-pocket (OOP) maximum limits and OOP maximum limits for health savings account-compatible high deductible health plans (HDHPs) were the same in 2014. However, beginning in 2015, there are different amounts for the general OOP maximum and the OOP maximum limits specifically for HSA-compatible HDHPs. This results from the OOP maximum limits for HDHPs being governed by the indexing required in the Internal Revenue Code, while the indexing for general OOP maximum limits is determined by the Department of Health and Human Services.

[6] Employee Benefits Administration, U.S. Department of Labor, "FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation," available at http://www.dol.gov/ebsa/faqs/faq-aca18.html.

DOL Should Not Limit the Use of Reference-based Pricing Programs Because of their Ability to Drive Health Care Savings

One of the most significant benefits of reference pricing is its potential to drive health care savings by reducing the wide variation in provider prices that currently exists in the U.S. A recent analysis of employer claims data by Castlight Health found significant price variation across the country for different kinds of medical services that reference pricing may be able to address.[7] Moreover, research strongly suggests that reference pricing programs may be an effective cost-control strategy when applied to frequently performed procedures where the prices charged vary widely across providers but the quality of results is relatively the same.

- A 2006 review of ten studies of a reference-based pricing for pharmaceuticals found that, overall, drug expenditures dropped significantly.[8]
- One study found that a reference-based pricing program run by the California Public Employees' Retirement System for knee and hip replacement surgery saved CalPERS $5.5 million over two years, with most of the savings attributed to providers lowering their prices to meet the reference price.[9]
- Another study estimates employers could reduce health care costs by $9.4 billion, or 1.6 percent of all spending on health care services, if they adopted reference pricing for hip and knee replacement, colonoscopy, magnetic resonance imaging of the spine, computerized tomography scan of the head or brain, nuclear stress test of the heart, and echocardiogram.[10]

In a survey published by Mercer last year, 11 percent of large employers said they were already using reference pricing and another 16 percent said they were considering it. It was also identified as one of the top five cost savers for large employers.[11]

At this point, there is no evidence that employers are using reference pricing as a subterfuge for the imposition of otherwise prohibited limitations on coverage. They are simply trying to manage their health care costs by reducing price variation without negatively impacting quality. Limiting employers ability to utilize reference pricing or imposing network adequacy requirements on their plans if they chose to use such programs, could significantly impact the ability for employers to create high-quality clinically integrated networks, and will create yet another incentive for employers to reconsider what their future health care strategy should be. It could also impede the much need standardization of prices across the United States.

---

[7] Castlight Health, Staying 'In-Network' for Common Medical Services Does Not Guarantee 'Low-Cost,' available at http://www.castlighthealth.com/new-analysis-of-common-medical-services-shows-staying-in-network-does-not-guarantee-low-cost/. Also see: Center for Health Innovation and Analysis, Health Care Provider Price Variation in the Massachusetts Commercial Market, Commonwealth of Massachusetts, November 2012; and Elise Viebeck, Wide differences found in what hospitals charge patients for same procedures, The Hill, May 8, 2013.

[8] Hau Liu, Closing the Gap: Reducing Price Variance in Health Care with Reference-Based Pricing, Castlight Health, July 2012.

[9] James C. Robinson and Timothy T. Brown, Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery, *Health Affairs*, 32, no.8 (2013):1392-1397.

[10] 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, Employee Benefits Research Institute, April 2014.

[11] Mercer's national Survey of Employer-Sponsored Health Plans, Mercer, February 2013, available at http://benefitcommunications.com/upload/downloads/Mercer_Survey_2013.pdf.

There is No Statutory Basis for DOL to Impose Any Network Adequacy Requirements on Self-Insured Employer Health Care Plans

Although the ACA requires health care plans sold in the public exchanges (individual and small group markets) to have adequate networks, it does not require self-insured employers to have adequate networks. Further, the Employee Retirement Income Security Act (ERISA) does not speak directly to plan design issues like network adequacy,[12] and the ACA bars the promulgation of regulations that prohibit "a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act."[13] At the very least, DOL needs to clearly identify the legislative authority it believes it has before proceeding with any further guidance or rulemaking that would impose regulatory mandates or restrictions on network adequacy for self-insured employer plans.

Employers recognize and value the importance of creating and maintaining sufficient provider networks for their employees and should DOL decide to issue further guidance or regulations a one-size-fits-all regulatory approach to measuring network adequacy could have serious unintended consequences. For example, a requirement that self-insured plans contract with a specific numbers and/or types of providers could result in a lower quality of care and higher prices for employees. Moreover, what is considered acceptable or adequate will vary by region and state.

* * *

Employers are trying different health care plan design strategies to improve the health care outcomes for their employees and manage their health care costs. Employers must have flexibility to develop innovative network approaches. We appreciate your consideration of the comments set forth above and strongly urge DOL should do everything possible to encourage these programs and do nothing to limit or discourage them at this time. If the Association can be of further assistance, please contact Mark Wilson at 202-315-5575 or mwilson@hrpolicy.org.

Sincerely,

Mark Wilson
Vice President, Health & Employment Policy
Chief Economist
HR Policy Association

[12] For self-insured employers, ERISA preempts state network adequacy laws and does not replace them with a federal equivalent.

[13] Public Law 111-148, section 1562(d).