July 31, 2014

Department of Labor
Reference-Based Pricing
Via e-mail: E-OHPSCA-FAQ.ebsa@dol.gov

In response to the request for standards that plans using reference-based pricing structures should be required to meet in order to ensure that individuals have meaningful access to medically appropriate care, we believe that first and foremost the consumer/patient must be protected. When insurance plans create a web of networks, it is confusing and burdensome for all involved including the consumer, providers and insurance plans. It has been challenging for both insurance plans and hospitals to identify and pay claims correctly for consumers on the health insurance exchange products. Adding another layer of complexity will only hinder the payment of claims and add additional administrative burdens that will only add costs to healthcare. Challenges with consumers understanding their "networks" have plagued the Affordable Care Act and we believe that if insurers are allowed to supersede their contracted networks with reference pricing networks, the consumer will lose again.

The ACA was supposed to offer protections for the consumer and the law includes specific limitations on out-of-pocket costs for in-network providers. We believe the out-of-pocket maximum requirements of PHS Act section 2707(b) should in fact be considered if a provider is considered in-network, regardless of the reference price. Hospitals negotiate with insurance plans to be included in a specific plan's network. Layering reference-based pricing on top of these already negotiated contracts hurts hospitals that in good faith have signed contracts to be included in a health plan's network. It also harms patients who are left with the bill. Excluding specific services from a network should only be allowed to happen if it was determined at the time of contract negotiation between the insurance plan and the provider. If insurance plans want to implement reference pricing, plans should be required to exclude or carve out services that will be subject to specific reference pricing networks, otherwise the difference between the reference price and the expected payment will be a burden to the patient above and beyond their out-of-pocket limits for in-network providers.

Along with the requirement that insurance plans exclude reference-priced services at the time of contracting, plans should also be required to compute the reference price so that the pricing has some regional basis and the data reflected in the reference pricing is not outdated. Due to multiple factors, healthcare costs are different in every region. Using a national average as a reference price does not take into account regional cost differences and will leave providers that are providing high quality services at a good value out of reference pricing networks simply because they are located in a more expensive place to live. We recommend that if reference priceing is implemented, the plans should be required to take into account regional price variations using the Medicare wage index or some other methodology that can adjust cost based on the region the services are being provided. This will help to ensure that patients will not be

forced to travel to save a little money and will have better access to their local providers of healthcare. When determining the reference-price, the price must be based on data that is not more than one year old and should be adjusted by the Healthcare CPI or the Medicare market basket to ensure that the reference price determined is based on today's cost to deliver care.

Allowing insurance companies to implement reference-based pricing strategies without limitations will open the flood gates of layers upon layers of networks that will only benefit insurance companies. A thoughtful process to determining the reference price and clear determination of "in-network" providers will still leave many confused but is a good start.

Regards,
Tiana Riskowski, Manager Financial Planning
Cottage Health System