

ACS Benefit Services, Inc.

It's Time for a Better Health Plan

July 30, 2014

Employee Benefits and Security Administration
U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

Internal Revenue Service
Ben Franklin Station
P.O. Box 7604
Washington, DC 20044

Center for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244

Re: Referenced Based Pricing Arrangements

To whom it may concern:

On May 2, 2014 the United States Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the Departments) issued additional FAQs (Part XIX) regarding Affordable Care Act (the Act) implementation. Q & A #4 dealt with Reference Based Pricing (RBP) and the compliance of such plan designs with the out-of-pocket limitation requirements of the Act and invited comments regarding RBP compliance to the Departments.

BACKGROUND

ACS Benefit Services, Inc. (ACS) is a Third Party Administrator (TPA) headquartered in Winston Salem, NC and serves self-insured single employer clients primarily located in the southeastern United States. We are also Plan Sponsor and Plan Administrator of our own self-insured Health and Welfare Plan with approximately 200 individuals enrolled. We are responding to the Departments request for comment in our role as a Plan Sponsor with this communication.

This response recognizes the diligence with which the Departments have exercised their duty in promulgating a host of regulations, guidance and FAQs regarding this comprehensive legislation and we hope to add to the dialogue and general understanding of the role of RBP within the Act. While we realize, as articulated in the reply to Question #4, that the Departments have a responsibility to ensure that Participants should not be overly burdened or selected against by a particular plan design it is our goal to set forth both our broad and specific rationale as to how RBP, practiced through professional administration, can and does comport with both the spirit and letter of the law, certainly at least as well as the prevailing network based delivery model.

REFERENCE BASED PRICING OVERVIEW

Any comprehensive review and understanding of Reference Based Pricing must begin with the basic question, “Why does RBP exist?” The exponential growth in both interest in and deployment of various RBP strategies begins with the knowledge that historical models for the funding and delivery of medical health benefits are, at best, deeply flawed and can very often be described as broken.

It is well documented that the cost of medical services in The United States is roughly double the cost of such services in other developed nations while our outcomes are no better and in some respects worse than our developed peers. The primary culprit for this disparity in cost is the price being charged by the providers of service (primarily hospitals) inside a fee-for-service network driven benefit model.

As a Plan Sponsor we observe that the networks themselves (whether PPO, HMO, or EPO) have evolved from part of the solution to part of the problem pushed by a constituency of members and employers who assumed (wrongly as it turns out) that bigger/broader networks would satisfy patient needs while controlling costs. The PPO model has become the preferred strategy for benefit delivery nationally. The vast majority of such network contracts operate as a percentage discount off of charges; therefore, the price being charged has become the over-riding factor in determining the ultimate costs to an employer’s plan. Even the network contracts themselves have become part of the problem with a variety of “outlier” “no audit” and “timeliness” provisions that make it impossible for employers and members to know, at any given moment, if their claims will be “In Network” or “Out of Network” when actually paid. As a Plan Sponsor we find the current environment regrettable and unsustainable.

Additional steps implemented by employers over the years, including the adoption of Utilization Review, Case Management, Pharmacy Benefit Management, Consumer Directed Products (FSA, HRA, HSA), Disease Management, and Wellness Initiatives were all embraced through the marketplace (with varying degrees of success) as efforts to curb the escalation of medical costs without ever addressing the basic issue of the price being charged for the services delivered.

As a Plan Sponsor ACS finds that our RBP plan cuts to the chase, as it were, and addresses the issue head on – what price will the Plan pay for the services delivered?

Instead of abdicating the responsibility for plan costs to the contracting capabilities of a network or the largess of the regional healthcare community the Plan will take an active hand in determining a fair and transparent reimbursement the Plan, its Participants, and their providers can all understand. The methodology the Plan will employ to determine that reimbursement and the range of services that will be subject to the RBP approach will vary in the near term as the marketplace evolves but conceptually the Plan must control the price it will pay or it eventually becomes the de facto financing arm of the healthcare institutions without any say in how efficiently such institutions are run.

On a further philosophical note, RBP is *a* strategy for payment reform but is not the *only* strategy for such reform. The marketplace evolves and we hope that the Departments will be slow to unduly restrain any experimentation that can and will take place over the coming years. Payment discussions and implementations revolving around “Value Based” medicine, “Episode of Care” payment strategies, and “Shared Savings” programs, for example, are occurring today in various areas around the country. Some of these strategies will be network based but some will be provider specific and broad regulations could have unintended consequences insofar as discouraging such payment innovation and limiting Plan Sponsor choice.

FAQ (Part XIX) Q&A #4

More specifically we would comment as follows regarding the Departments’ answer to date regarding Question #4:

1. The introductory sentence in the Departments response; “Reference pricing aims to encourage plans to **negotiate** cost effective treatments with high quality providers at reduced costs.” (emphasis added) represents what we fear is perhaps a flawed understanding by the Departments as to what RBP is and how it functions. In a RBP model the Plan Sponsor/Plan Administrator **determines** the price it will pay for the services to be provided. The plan has conducted whatever research and/or analysis it deems appropriate and establishes the reference price it will allow for such services. The plan is entirely agnostic as to what providers its participants will ultimately utilize and typically negotiates with no providers in advance.
2. Since the plan places no limitations on access to providers and there is no network at all, the universe of providers, domestic and foreign, is open to all Participants. The plan design itself is no barrier whatsoever in terms of access to providers (unlike traditional network plan structures) and therefore one component of the Departments concern - access (the “form” if you will) is easily satisfied.
3. The Departments should focus on the “function”, i.e. the concern expressed in the response – will the pricing methodology itself work in a way that is a subterfuge to avoid the requirements of the Act or should RBP otherwise be

prohibited or limited as potentially exceeding the out-of-pocket limitations of the Act.

- a) ACS acknowledges that improperly structured or administered RBP plans that do not contain suitable safeguards for Participants could violate the requirements of the Act and a blanket endorsement of “any” RBP plan by the Departments would not be appropriate.
- b) ACS encourages the Departments to create guidance that specifies components that an acceptable RBP plan must contain in order to be considered compliant with the Act. ACS will suggest examples of such components herein below.
- c) The Departments have previously and specifically provided guidance in FAQ (Part XVIII) Q#4 and in FAQ (Part XIX) Q#2 and Q#3, for example, that amounts charged by providers in excess of a Plan’s specifically expressed allowed amounts (both in and out of network) do not have to be counted toward the out-of-pocket maximums established in the Act. Subject to appropriate guidance that ACS expects as noted above, we believe conceptually that an RBP plan should be treated with exactly the same deference.

The current guidance issued by the Departments anticipates the Participant could be subject to “balance billing” both in and out of network that could amount to tens of thousands of dollars in the aggregate annually. If this scenario is appropriate in a traditional network plan why would it not be so in an RBP format? One could argue that the RBP based plan is more honest with its Participants as they are far more likely to know and understand the potential for such balance billing than enrollees in a traditional PPO.

- d) While the Departments are rightly focused on developments in a new payment strategy, and now seek comment and guidance, the concerns expressed about RBP being utilized as a “subterfuge” to avoid requirements of the Act are misplaced.

RBP strategies in various forms have existed for many years and, in point of fact, predate the Act. It is true that the growing popularity of such plans has been occurring in conjunction with the roll out of the Act but ACS believes this phenomenon to be more a function of employers’ desires to get some control of their costs as opposed to some artful scheme to avoid certain compliance issues.

As currently available networks narrow in focus and restrict provider participation (particularly hospitals), either as a reaction to requirements of public or private Exchanges or in order to serve a

self-insured employer constituency with affordable services, more and more Participants will be faced with serious balance bills in a traditional network plan. Specifically such balance bills are likely to come from out-of-network high cost hospitals such as teaching hospitals. This entirely compliant, highly likely, yet undesirable outcome will not be driven by some ‘subterfuge’ but by marketplace conditions attempting to react to out of control costs. Participants will be subject to balance billing in RBP models but are more likely to have better support tools, better education, and be better positioned to utilize competitive market forces to function on their behalves than their counterparts in a traditional network plan.

COMPONENTS OF AN ACA COMPLIANT RBP PLAN

ACS suggests that the Departments consider some or all of the following components for a RBP plan in order for such plan to be considered compliant with the purposes of the Act. Our suggestions are based on our overall corporate experience in health and welfare plan management and administration over the past thirty-five years and our direct experience and research regarding the administration of our own RBP plan. In the relatively brief time that ACS has been involved with our RBP plan fewer than 2% of the claims paid under the RBP plan (measured both in terms of submitted claims and dollar amounts) have been subject to balance billing initiatives by providers and, to date, no ACS plan member has been turned over to collections or threatened with billing related litigation. We would suggest that statistically these numbers are at least as good as those experienced under a traditional network plan and perhaps better.

These suggestions are in no particular order of importance.

- I. Plan Document/Summary Plan Description (PD/SPD) Language – The Plan must spell out in its most important documents, the PD and the SPD, the appropriate descriptions of how the RBP plan will work. The PD must spell out with appropriate detail the nature of the RBP program, any policies and procedures the Plan will utilize specifically for RBP claims and the basis or specific amounts that the RBP plan will utilize as its Maximum Allowable Charge. The SPD, as the name implies, can contain a summary of the RBP program and will need to specify where communication materials regarding the function of the plan can be found. Subject to applicable Electronic Disclosure requirements of the Departments this material could be available online, in writing, or both.
- II. Plan Support Materials – Plan Support Materials, principally the Member I.D. Card, EOBs, and EPPs must clearly support the RBP methodology being utilized by the plan and provide appropriate information to providers and members about where and how any questions or concerns regarding the RBP plan will be addressed.

- III. Initial Member Communication and Education – The RBP plan will have many unique attributes that must be clearly outlined to the Participants. The mere distribution of an SPD or even an SBC will not likely be adequate to fully educate members on this new approach. The content, style, language utilized, and resulting questions must be addressed fully. Such information should be distributed and discussed with the Participants at least 30 days prior to the RBP plan going into effect.
- IV. Subsequent Member Communication and Education – After the effective date of the RBP plan as members become exposed to their first direct experience with the program additional communication that reinforces the concepts behind the move to the RBP plan and the procedures to be followed by the Participants should be distributed. This should occur sometime after 90 days from the effective date but before 180 days from the effective date. Additional formal incidents of communication should also take place on a discretionary basis as the Plan Administrator sees fit.
- V. Patient Advocacy Programs – The heart and soul of a well-run and publically accepted RBP program will be its Patient Advocacy Program. Every RBP plan should be required to establish and maintain such a program. Components of such a program should include but perhaps not be limited to:
 - A. Provider Letters (2 to 3) delivered to/from member for appeal levels 1-2
 - B. Provider Letters delivered to provider in response to balance bill (levels 1-2)
 - C. Proactive communication with providers in event of balance bill
 - D. Proactive delivery of Letters to Credit Reporting Agencies
 - E. Interaction with providers for purpose of explaining plan model
 - F. Bi-monthly interaction with Plan Member to update/support where needed
 - G. Coordinated involvement of external professional negotiations service partner in event of collection notice
 - H. Tracking of letters, calls, interaction w/both providers and member
 - I. Tracking of ERISA required provider appeal timeframes and formats
 - J. Coordination of negotiations/settlement (if applicable) with provider
 - K. 800# Patient Advocacy Hotline
- VI. Member Legal Support – Although it is not anticipated that well run RBP plans will eventually have any higher incidents of balance

billing related collection or litigation activities than a network based plan, RBP plans should consider providing legal support for its membership in the formative years of an RBP plan. Participants are ultimately likely to feel more comfortable if they are insulated insofar as possible from aggressive collection tactics by their own counsel.

- VII. The Basis for Determination of the RBP Maximum Allowable Amount – The Plan should be specific about the basis used by the RBP plan as to how the Maximum Allowable Amount for Plan Benefits was derived. ACS believes there are many acceptable methods for arriving at this “reference price” but the Departments should consider creating a standard or base line for such pricing as a means to ensure that the “subterfuge” we are concerned about in this discussion is avoided.

ACS would propose that “140% of Current Year Medicare (DRG or Fee) or equivalent Cost Plus Pricing where a Medicare DRG or Fee does not exist.” be considered as such a base line. In this example Maximum Allowable Charges below this amount would be deemed by the Departments as too low and therefore a “subterfuge” to avoid the purposes of the Act. While Medicare is not necessarily the default basis of all RBP pricing techniques it is publically available data that can easily be utilized by all RBP plans as a litmus test for ensuring compliance. Such data is also readily available to the provider community and can easily be used, where necessary, by such providers to audit the payments received to ensure proper compliance.

- VIII. Guidance for Participants Regarding Providers and RBP – RBP plans should be required to provide information to Participants on a recurring basis of at least every six months as to providers who accept or reject RBP payments.

CONCLUSION

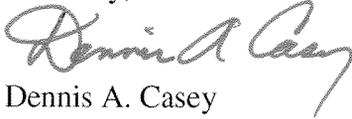
The United States of America, for better or worse, has adopted a health care financing model that is based primarily on the ongoing premise of employer sponsored employee benefits. The entire focus of The Patient Protection and Affordable Care Act was predicated on the assumption of continuing that model. Yet very little progress was made in the Act to make the delivery of such benefits more “affordable” for the employers who are sponsoring such plans and their employees.

RBP strategies are making inroads into accomplishing the goal of making such benefits more affordable and therefore keeping employers and their employees in the system and out of the Exchanges. As a Plan Sponsor ACS believes that the net effect of this will eventually be higher overall payments to providers (versus a future state where employers

will be forced by financial and regulatory circumstances to abandon their plans) and lower overall costs to plans and plan participants.

ACS thanks the Departments for the opportunity to express our views on this subject and would look forward to additional conversation if it is desired.

Sincerely,

A handwritten signature in cursive script that reads "Dennis A. Casey". The signature is written in dark ink and is positioned above the printed name and title.

Dennis A. Casey
Chief Operating Officer