



August 1, 2014

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

U.S. Department of Labor
Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance
200 Constitution Avenue, NW, Suite N-5653
Washington, DC 20210

Re: Reference-Based Pricing

Dear Sir or Madam:

The National Business Group on Health is pleased to respond to the Department of Labor, Department of Health and Human Services, and Department of the Treasury's (collectively, the Departments') invitation to comment on the application of the Affordable Care Act's (ACA's) out-of-pocket limitation to group health plan designs that include reference-based pricing.

The National Business Group on Health represents 395 primarily large employers, including 66 of the Fortune 100, who voluntarily provide group health plan coverage and other health programs to over 55 million American employees, retirees, and their families. Our members employ and provide health benefits for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. In addition, our members often operate multiple lines of business and tailor employee work and benefit arrangements to the specific needs of each line of business. Our members' employer-sponsored plans have been a driving force for innovative plan designs that improve the payment and delivery of health care.

As our members continue to implement the ACA's cost-sharing limitations and other group health plan requirements, primary goals will be (1) minimizing administrative and cost burdens associated with these requirements and (2) maximizing use of plan design and network participation rules to improve quality and lower costs of health care. To further these goals, it is critical that employer-sponsored plans, insurers, and governmental programs continue to be able to use price and quality information to identify effective, efficient providers and discourage the use of less effective, less efficient providers. Reference-based pricing is one of the many effective tools that plans have to accomplish these goals.

Supporting plan sponsors' flexibility to adapt their ACA compliance procedures to new, innovative plan designs will help to minimize plan costs, improve health care quality, and allow plan sponsors to devote more resources toward maintaining and improving health benefits for their employees. Therefore, the National Business Group on Health supports the Departments' current interpretation of the ACA's cost-sharing limit provision, as set forth in the Departments' May 2, 2014 Frequently Asked Questions, and we recommend that this interpretation be incorporated into any future guidance. Specifically, we support:

- Acknowledgment that the purpose of reference-based pricing is to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs;
- Acknowledgment that compliance with the ACA's cost-sharing limits does not preclude reference-based pricing structures; and
- Treating group health plans that use reference-based pricing plan designs as in compliance with the ACA's cost-sharing limits, provided plans use reasonable methods to ensure that they provide adequate access to quality providers.

We believe that this interpretation reduces administrative and cost burdens, facilitates value-based purchasing, and allows plan sponsors much-needed flexibility in complying with the ACA's cost-sharing limits.

We also recommend that the Departments, in any future guidance, take into account (1) the current and developing variety of reference-based pricing plan designs and (2) large, self-insured group health plans' continuing efforts to maintain cost-effective, high-quality group health coverage for employees and their dependents. Specifically, we encourage the Departments to consider the following recommendations.

(1) Benefit Design Flexibility

National Business Group on Health members support plan design features that promote demonstrated evidence of clinical effectiveness, efficiency, and value-based benefit design. By prioritizing clinical effectiveness and value-based benefit designs, plans assure that patients receive the highest-value, safest, and most medically appropriate health care services to meet their individual needs. Such a focus also helps group health plans maintain the balance between comprehensiveness and affordability of coverage while improving participants' health and access to health benefits. Plan sponsors' efforts to implement plan designs based on clinical effectiveness also are consistent with HHS's efforts to promote evidence-based and value-based benefit designs and with the ACA's—and our members'—goal of controlling the overall costs of health care.

Our members are at the forefront in adopting cost-effective, value-based plan designs such as reference-based pricing. To continue innovating in this area, however, group health plans need flexibility to set provider participation rules and reimbursement rates that take into consideration a wide variety of factors, including: covered populations and

their geographic locations; regional variations in cost and availability of covered items and services; new evidence of clinical effectiveness for covered items and services; and new evidence related to the optimal frequency, method, treatment, or setting for covered items and services.

Therefore, we recommend that any future guidance related to reference-based pricing take into account:

- *Variations in reference-based pricing plan designs.* We note that the Departments' May 2, 2014 Frequently Asked Questions specifically address the reference-based pricing structure that treats providers that accept a reference amount as the only in-network providers. However, plan sponsors should have flexibility to adopt other reference-based pricing plan designs that are suitable to their plan populations' needs and geographic locations. For example, some plans pay a fixed amount for certain procedures but do not designate specific providers as the only in-network providers. Our members view this structure as a network design strategy as well but may prefer to provide more in-network options for participants and providers.
- *Future developments in reference-based pricing plan designs.* We also emphasize that reference-based pricing is a new value-based plan design and will likely evolve in the future. Currently, only 6% of our survey respondents have reference-based pricing plan designs.¹ Plan sponsors that have adopted reference-based pricing are still in the early stages of monitoring provider participation, quality of services, participant satisfaction, and plan costs. As new evidence on quality, availability, and price of services develops, and as more transparency data become available, our members will need to be able to modify their plan designs to ensure cost-effective, high-quality care. Therefore, it is important that the Departments' guidance not be overly prescriptive.

We believe that the standard of requiring adequate access to quality providers set forth in the Departments' May 2, 2014 Frequently Asked Questions provides necessary flexibility while ensuring that plan participants have access to high-quality care.

(2) Access to Medically Appropriate, Quality Care

When considering or adopting reference-based pricing plan designs, two of our members' primary concerns are access and quality of care. Reference-based pricing plan designs include extensive protections to ensure access and quality for participants, and we emphasize that our members do not view reference-based pricing as a subterfuge for

¹ Towers Watson & Nat'l. Bus. Grp. on Health, *The New Health Care Imperative: Driving Performance, Connecting to Value*, 19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care (2014), <http://www.towerswatson.com/DownloadMedia.aspx?media={B5CC3143-9B78-4B92-96A4-3F569300406F}>.

imposing limitations on coverage. In addition, plan participants—as health care consumers who are becoming increasingly aware of unexplainable, wide price variations for the same services—value information about appropriate levels of payment for quality health care services.

For plan sponsors, adopting a reference-based pricing plan design does not only involve setting specific payments. Generally, the process also includes, but is not limited to, the following features designed to ensure access to and quality of care:²

- Setting the reference price at a specific percentile of all network providers offering a service in a specific geographic area, which percentile may vary depending on the total number of network providers in the area;
- Limiting reference-based pricing to services and procedures that are widely available, standardized, and have high variations in price, such as diagnostic imaging, musculoskeletal procedures, or laboratory services;
- Limiting reference-based pricing to services and procedures that can be planned in advance by participants;
- Providing tools that participants can use to select providers based on cost and quality through websites, third-party applications, and other communications;
- Excluding emergency and catastrophic services from reference-based pricing plan designs;
- Encouraging or providing incentives for participants to obtain care at Centers of Excellence to ensure high-quality care;
- Establishing an appeals process specifically for reference-based pricing plan designs, which allows exceptions to reference prices when medically appropriate;
- Monitoring the availability of providers by geographic area to ensure adequate access; and
- Monitoring participant satisfaction and access to providers.

We also note that reference-based pricing plan designs serve the goals of (1) encouraging competition and cost containment among all providers and (2) encouraging consumerism and greater engagement in health care decisions among plan participants. We believe that these efforts will help to lower the overall costs of health care for employers and employees.

² Rich, Pamela and Brenna Shebel, *Reference-Based Pricing: Creating Health Care Shoppers*, Benefits Quarterly (March 2014) at 25.

(3) Good Faith Compliance with ACA Cost-Sharing Limits

To date, our members have complied in good faith with the Departments' guidance related to the ACA's cost-sharing limits. In many cases, bringing plans into compliance involved developing new recordkeeping systems to track total cost-sharing amounts and coordinating multiple plan vendors—processes that required substantial resources. While doing so, our members have remained committed to offering a wide range of health benefits that often exceed those available in the small group market. We believe it would be unnecessary and still more costly to require group health plans to comply with additional rules related to reference-based pricing. We also believe that restrictions on reference-based pricing would run counter to the stated goals of the ACA, which include promotion of value-based purchasing and other payment reforms to improve the quality and affordability of care.

Thank you for considering our comments on reference-based pricing. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

A handwritten signature in black ink that reads "Brian Marcotte". The signature is written in a cursive style with a long, sweeping underline.

Brian Marcotte
President