



O'MELVENY & MYERS LLP

BEIJING
BRUSSELS
CENTURY CITY
HONG KONG
JAKARTA†
LONDON
LOS ANGELES
NEWPORT BEACH

1625 Eye Street, NW
Washington, D.C. 20006-4001
TELEPHONE (202) 383-5300
FACSIMILE (202) 383-5414
www.omm.com

NEW YORK
SAN FRANCISCO
SEOUL
SHANGHAI
SILICON VALLEY
SINGAPORE
TOKYO

August 1, 2014

WRITER'S DIRECT DIAL
(202) 383-5110

VIA E-MAIL

WRITER'S E-MAIL ADDRESS
gjacob@omm.com

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

Re: ***Response to Request for Comment on the Application of the Out-of-Pocket Limitation to Reference-Based Pricing Systems***

Dear Sir/Madam:

We are submitting this letter on behalf of Castlight Health, Inc., in response to the Department of Labor's, Department of Health and Human Services', and Department of the Treasury's invitation for comments regarding Question No. 4 of Part XIX of their Frequently Asked Questions about the implementation of various provisions of the Affordable Care Act.¹ The FAQ states:

Reference pricing aims to encourage plans to negotiate cost-effective treatments with high quality providers at reduced costs. At the same time, the Departments are concerned that such a pricing structure may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers. Accordingly, the Departments invite comment on the application of the out-of-pocket limitation to the use of reference based pricing. The Departments are particularly interested in 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.

¹ Department of Labor, Employee Benefits Security Administration, *FAQs About Affordable Care Act Implementation (Part XIX)* (May 2, 2014), <http://www.dol.gov/ebsa/faqs/faq-aca19.html>.

In the words of President Obama: “The cost of our health care is a threat to our economy. It’s an escalating burden on our families and businesses. It’s a ticking time bomb for the federal budget. And it is unsustainable for the United States of America.”² The Affordable Care Act (“ACA”) was enacted in substantial part to stem these spiraling costs, which are distributed among a wide variety of stakeholders, and which themselves represent a substantial threat to access to quality healthcare.

Reference-based pricing, as explained in greater detail below, is a proven and effective means of controlling healthcare costs while maintaining patient choice. By incentivizing individuals to consider affordability among the criteria they evaluate when selecting a healthcare provider, reference-based pricing reduces costs both for individual consumers and the businesses that insure them, while also driving down prices in the healthcare market generally. But the proven cost-cutting impact of reference-based pricing can be realized *only* if health plans are permitted to adopt benefit structures that meaningfully incentivize participants to consider price when consuming healthcare services. The Departments should accordingly adopt standards that will support and enhance the ability of plans to incentivize participants to consider price, while ensuring that bad actors are not able to employ this useful and legitimate tool as an illicit means for denying participants access to quality medical care.

I. About Castlight

Castlight Health is one of the nation’s leading providers of healthcare transparency services. Through its Enterprise Healthcare Cloud, Castlight provides employers applications and services that enable them to deliver cost-effective benefits to their employees, and, in turn, empowers employees to make informed healthcare choices. The Enterprise Health Cloud is powered by the Castlight Data Interchange—which relates medical, pharmacy, and dental claims, provider directories, national and regional quality data, employer and employee information, and other healthcare-related data in a single database. The Interchange, which includes over one billion healthcare claims and is a source for generating actionable analytics, is the industry’s most comprehensive and diverse database of healthcare pricing, quality, and outcome data.

Reference-based pricing is one of the benefit designs that Castlight helps clients implement. Using consumer-friendly tools developed by it and its partners, Castlight enables its clients’ plan participants to easily locate high-quality providers that offer needed medical services for fees at or below the applicable reference price.

² President Barack Obama, Remarks by the President at the Annual Conference of the American Medical Association (June 15, 2009), <http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-american-medical-association>.

II. Reference-Based Pricing is a Proven Tool for Reducing Healthcare Costs, and the Departments Should Encourage It

Reference-based pricing is a system used by plan sponsors to encourage participants to shop for healthcare services by price. Medical claims data shows that significant cost variance exists for all common health plan services in all regions across the United States, including for services that evidence little variation in the quality with which the services are delivered.³ The same medical claims data shows that somewhere within the significant cost variance—usually close to the middle of the range—a fair and reasonable price for the service can be identified. This “reference price” represents a price at or below which plan participants can obtain ample access to multiple providers.

In its simplest form, reference-based pricing works by capping the amount a health plan will reimburse a participant for a particular service, based on some measure of the rates charged by providers of that service in the market in which the participant resides. If a participant selects a provider that charges an amount below the “reference price” set by the plan sponsor, s/he will pay nothing (beyond the plan’s standard cost-sharing fees). But if s/he selects a provider that charges an amount above the reference price, s/he will pay the difference between the provider’s price and the reference price (referred to here as an “Excess Payment”). Reference prices are set at a level that ensure participants will have a choice among multiple providers at that price. But the structure of a plan that adopts reference-based pricing provides participants with yet greater choice, as the participant remains free to select a provider that charges more than the reference price, conditioned only on their willingness to bear the excess cost.

Research confirms what logic dictates: quality being equal (a factor discussed below, *infra* Part IV), patients in plans using reference-based pricing will tend to seek out providers who charge amounts below the reference price. One of the most recent and best-documented examples of this comes from the California Public Employees’ Retirement System (“CalPERS”) implementation of reference-based pricing for facility fees for knee and hip replacement surgeries.⁴ In January 2011, CalPERS identified 41 hospitals as so-called value-based purchasing design (“VBPD”) facilities based on whether they charged less than \$30,000 in

³ See Castlight Health, Inc., *New Analysis: Cost of Medical Services Vary Wildly Across the U.S.*, <http://www.castlighthealth.com/price-variation-map/> (last accessed Aug. 1, 2014).

⁴ See, e.g., James C. Robinson & Timothy T. Brown, *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery*, 32 *Health Affairs* 1392 (Aug. 2013); Greg Goth, *CalPERS Reference Pricing Policy Yields Big ROI*, *Health Data Management* (May 23, 2014), <http://www.healthdatamanagement.com/news/CalPERS-Reference-Pricing-Policy-Yields-Big-ROI-48113-1.html>; Press Release, Well Point, Inc., *CalPERS Members Had Similar to Better Outcomes at Facilities Charging Less fo Hip and Knee Replacements* (June 23, 2013), <http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=1832119&highlight=>.

facility fees for a knee and hip replacement, and met specified geographic accessibility and quality standards.⁵ Members selecting a VBPD hospital for their surgery were subject to the plan's standard 20 percent coinsurance, up to an annual maximum of \$3,000. Those selecting a non-VBPD hospital were subject to the same coinsurance, plus the difference between the \$30,000 CalPERS contribution (the reference price) and the hospital's allowed charge. For example, a participant selecting a non-VBPD hospital with an allowed charge of \$40,000 would be required to pay \$13,000: \$3,000 for the annual coinsurance maximum, plus \$10,000 for the difference between \$40,000 and \$30,000.

A study published by James Robinson and Timothy Brown in *Health Affairs* compares changes in joint replacement volumes and prices for CalPERS members at VBPD facilities with those at non-VBPD facilities during the period between 2008 and 2012.⁶ As a control, they compared these changes to changes for non-CalPERS patients (not subject to reference-based pricing), using data from patients enrolled in Anthem Blue Cross, the largest health insurer in California. The results were eye-opening: The number of CalPERS members who selected low-priced VBPD facilities increased by 21.2 percent in the year after the implementation of reference-based pricing, while the number who selected high-priced non-VBPD facilities declined by 34.3 percent. The relative use of VBPD and non-VBPD hospitals by Anthem patients not subject to reference-based pricing, on the other hand, remained almost unchanged between 2008 and 2012. This suggests that reference-based pricing substantially encourages patients to seek lower cost providers while not discouraging them from getting the care they need, since their benefits still cover all necessary services.

Reference-based pricing impacts not only patient choices about healthcare providers, however—it also affects provider pricing choices. Prior to the implementation of reference-based pricing, there was an upward trend in prices for CalPERS members, with the average price per case rising from \$28,636 in 2008, to \$34,742 per case in 2010. But in 2011, the average price fell to \$25,611—a decline of over 26 percent. Meanwhile, prices for non-CalPERS Anthem members stayed stable, decreasing by one percent. Controlling for various factors, including demographic differences between CalPERS and non-CalPERS members, the authors concluded that reference-based pricing was responsible for a 20.2 percent decrease (\$7,028 per case) in average hospital prices for CalPERS members in 2011, a change that was sustained in the second year after implementation, in 2012. According to the study, the total savings attributable to reference-based pricing in 2011 were \$3.1 million. Of this amount, \$2.8 million accrued to CalPERS from lower payments to hospitals, and \$300,000 accrued to CalPERS enrollees from lower out-of-pocket cost sharing. As a result of these positive findings, CalPERS

⁵ Robinson & Brown, *supra* note 4, at 1393. Note that this price is limited to the hospitals' charges, not to fees charged by the surgeons, and others involved in the insured's care. *Id.*

⁶ See generally, *id.*

expanded reference-based pricing in 2012 to facility payments for outpatient colonoscopies, cataract surgeries, and arthroscopy.⁷

Robinson and Brown are not alone in their findings on the cost-reducing benefits of reference-based pricing. In a recent Employee Benefit Research Institute (“EBRI”) paper, authors Paul Fronstin and M. Christopher Roebuck estimated that potential aggregate savings from reference-based pricing could reach \$9.4 billion if all employers adopted it for certain specified services: hip and knee replacements, colonoscopies, magnetic resonance imaging (“MRIs”) of the spine, computerized tomography (“CT”) scans of the head or brain, nuclear stress tests of the heart, and echocardiograms.⁸ This sum, calculated from a dataset representing roughly three million patients over a three-year period, constitutes an impressive 1.6 percent of all spending on healthcare services among the 156 million people under age 65 with employment-based benefits in 2010. Reference-based prices were obtained by dividing the dataset into 306 hospital referral regions (representing regional healthcare markets), and calculating the 67th percentile price for each service in each market.

Perhaps the best indicator of the potential cost-savings that can result from reference-based pricing, however, is the market’s increasing acceptance of it. For example, one study found that while in 2013, only five percent of employers implemented reference-based pricing in their health plans, an additional 15 percent of employers planned to adopt the strategy in 2014.⁹ Another study found that eight percent of employers were using reference-based pricing in 2013, but that 62 percent were considering adopting it in the next three to five years.¹⁰ Employers are increasingly turning to reference-based pricing because of its proven ability to reduce healthcare costs, while ensuring meaningful access to quality care for their employees.

⁷ See Department of Health & Human Services, Agency for Healthcare Research and Quality, *Reference-Pricing Policy for Hip/Knee Replacements Generates Significant Savings by Encouraging Enrollees to Choose High-Value Facilities* (May 21, 2014), <http://www.innovations.ahrq.gov/content.aspx?id=4069>.

⁸ Paul Fronstin & M. Christopher Roebuck, *Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits*, EBRI, Issue Brief No. 398 (Apr. 2004).

⁹ See Towers Watson and National Business Group on Health, *Reshaping Health Care: Best Performers Leading the Way* (2013), <http://www.towerswatson.com/DownloadMedia.aspx?media={BAD5FE64-62FD-492A-8F24-A3C6E5B075B8}>.

¹⁰ See Aon Plc, *Aon Hewitt 2013 Health Care Survey* (2013), http://www.aon.com/attachments/human-capital-consulting/2013_Health_Care_Survey.pdf.

III. Uniformly Treating Excess Payments as Out-of-Pocket Payments Would Strip Reference-Based Pricing of its Effectiveness

Reference-based pricing can *only* work if healthcare plans are permitted to adopt benefit structures that incentivize employees to consider price when selecting providers. Out-of-pocket maxima are a key benefit design component that have significant implications for the effectiveness of reference-based pricing. Once the out-of-pocket maximum is met, a participant has little or no incentive to give any further consideration to price, as any additional healthcare costs are typically required to be covered entirely by the plan. Thus, measures that unnecessarily increase the speed at which participants reach their out-of-pocket maximums, or that require full coverage by insurers of unjustifiably expensive costs once the out-of-pocket maximum is met, threaten to substantially undermine the viability of reference-based pricing.

Under the Public Health Service Act's out-of-pocket limit provision, the maximum amount a participant can pay in "cost-sharing" for covered services from network providers before his/her health plan is required to reimburse him/her in full is \$ 6,350 under an individual plan, and \$12,700 under a family plan. Significantly, payments that a plan is required by law to treat as falling within the definition of "cost-sharing": (1) must be counted toward reaching the out-of-pocket maximum, and (2) once the out-of-pocket maximum is met, are generally required to be paid in full by the plan. The definition is thus of critical importance to the effectiveness of reference-based pricing; for reference-based pricing to have a meaningful effect in controlling health care costs, Excess Payments must be excluded from the definition.¹¹

The importance of excluding Excess Payments from the Public Health Service Act definition of "cost-sharing" can be illustrated using an example from the CalPERS initiative described above. In 2010, the average CalPERS-member price for knee and hip-replacement surgery across all hospitals was roughly \$35,000, while the average price at non-VBPD facilities was roughly \$43,500. Imagine the reference price was set at \$35,000. If current law was applied, which does not require plans to count Excess Payments as out-of-pocket payments, an individual plan participant would have ample incentive to choose the \$35,000 hospital over the \$43,500 hospital: His/her 20 percent coinsurance payment will cause him/her to reach his/her out-of-pocket limit no matter which hospital s/he chooses, but if s/he elects to go to the more expensive hospital s/he will be responsible for an additional \$8500 Excess Payment above the reference (whereas if s/he elects to go to the hospital that charges fees at or below the reference

¹¹ As the Departments have noted, one way to effectively exclude Excess Payments from falling within the definition of "cost-sharing" is to allow plans to treat providers that charge more than the reference price as out-of-network providers. See Department of Labor, Employee Benefits Security Administration, *FAQs About Affordable Care Act Implementation (Part XVIII)*, FAQ #4 (January 9, 2014), <http://www.dol.gov/ebsa/faqs/faq-aca18.html> ("Under HHS regulations at 45 CFR 156.130(c) implementing Affordable Care Act section 1302(c), cost-sharing requirements for benefits that are EHB from a provider outside a plan's network of providers are not required to be counted toward the annual limitation on out-of-pocket costs.")

price s/he will not pay this Excess Payment amount). If quality at the two hospitals is comparable, this is a result that should be encouraged. But if a rule was adopted that *did* require plans to treat Excess Payments as out-of-pocket payments, the member would have NO incentive to consider price in choosing a provider. Specifically, since the participant would have reached his/her out-of-pocket maximum at either hospital through the coinsurance payment alone, the *plan*, rather than the participant, would have to pay the extra \$8,500 charged by the expensive hospital, leaving the participant with no incentive to pick the more affordable option.

One problem this example helps illustrate is that the services for which reference-based pricing is often most effective from a cost-reduction perspective are those that have the greatest nominal price variations (*e.g.*, greater savings are realized when a consumer chooses a \$20,000 knee replacement over a \$30,000 knee replacement, than when s/he chooses a \$500 X-ray over a \$1,000 X-ray). But the services with the greatest nominal variations in price also tend to be services that are nominally more expensive (*e.g.*, it would be more common for the regional price of a given healthcare service to range from \$80,000 to \$120,000, than to range from \$500 to \$40,500). And by the time the participant has paid cost-sharing on these nominally expensive services, it is very possible that s/he will already be close to or above his/her out-of-pocket maximum, in which case—as illustrated above—his/her incentive to shop for an affordable provider is substantially diminished. The EBRI study described above supports this notion. Of the \$9.4 billion in savings it projected from reference-based pricing, 39 percent would be derived from patients seeking more affordable facilities for hip and knee replacements—the most expensive of the services studied.¹² Notably, this study, like the *Health Affairs* study, assumed that Excess Payments do *not* count as out-of-pocket payments.¹³

IV. Castlight's Extensive Experience Supporting Reference-Based Pricing for Health Plans Shows That Targeted Means can be Used to Ensure That Reference Prices are not Improperly Used to Deny Access to Quality Healthcare

The Departments' invitation for comments expresses concern that some unscrupulous plan sponsors could use reference-based pricing systems as a subterfuge to improperly impose otherwise prohibited coverage limitations on health plan participants. In essence, plan sponsors could (in theory) set reference prices for some or all services so low that they effectively denied participants meaningful access to quality care. Despite the increasing use of reference-based pricing, Castlight is not aware of any instances in which this kind of improper use of reference prices has been reported to have occurred.

Nevertheless, Castlight views the concerns expressed by the Departments as legitimate, and recommends the adoption of common-sense limitations that Castlight has found to be effective in ensuring that reference prices do not serve as a restriction on its clients' plan participants' access to quality care. Broadly speaking, these solutions fall into five categories,

¹² See Fronstin & M. Christopher Roebuck, *supra* note 8, at 15.

¹³ See *id.* at 5; Robinson & Brown, *supra* note 4, at 1393.

discussed in turn below: (A) ensuring that reference prices are based on actual and up-to-date pricing data; (B) adopting a percentile floor below which reference prices cannot be set; (C) calculating reference prices based on the specific features of the geographic market where the plan participant resides; (D) limiting the services for which reference-based pricing is used; and (E) limiting the situations in which reference prices are applicable.

A. *Ensuring that reference prices are based on actual and up-to-date pricing data*

At the most basic level, to ensure reference prices are not a sham, they must be set *with reference to* actual data concerning prices actually charged by healthcare providers in the market in which a participant consumes healthcare services. Any plan using reference pricing should be required to collect and use (either itself, or through a service provider) up-to-date healthcare service pricing data when setting reference prices. Pricing data, and the reference prices that plans set with reference to that data, should be updated at least annually. The use of out-of-date data to set reference prices would create risk that the price set would not actually afford participants meaningful access to quality care.

B. *Adopting a percentile floor below which reference prices cannot be set*

Castlight believes plan sponsors should be accorded substantial flexibility in determining reference prices. Some plan sponsors are trying to simply direct members away from the very highest cost providers (in which case they may set the reference price at the 80th or 90th percentile) while other plan sponsors are trying to achieve cost savings (in which case they may set the reference price at the 50th percentile or below). To ensure meaningful access to quality care, however, reference prices must be set at a level that is greater than or equal to that charged by at least a minimum number of providers. For this reason, the Department could consider establishing a percentile floor—perhaps the 25th or 30th percentile, to be adjusted as experience with reference-based pricing develops—below which plans cannot go when setting reference prices.

C. *Calculating reference prices based on the specific features of the geographic market where the plan participant resides*

Most consumers of healthcare services—whether by choice or out of necessity—obtain their services in the local geographic area in which they reside. Castlight therefore believes that to ensure participants meaningful access to quality care, reference prices should account for the specific features of the geographic market in which they apply. For instance, calculating the reference price for an inpatient procedure in New York City based on what providers typically charge for the same service in Omaha could easily result in a reference price at which there are insufficient numbers of providers available to plan participants.

Castlight has resolved this problem by examining each of the country's 929 zip code regions (determined by referring to the first three digits of zip codes) to determine local health care pricing and buying patterns. Based on this analysis, Castlight has grouped the 929 regions into 50 categories, each consisting of regions with similar healthcare markets. Reference prices

are then set on a category-by-category and service-by-service basis (*e.g.*, laboratory tests, CT scans, MRIs, knee replacement surgeries) and are made applicable to participants based on where the participants reside, as opposed to where the plan sponsor is headquartered. This is important because sometimes the market where a participant resides can differ dramatically in its healthcare pricing structure from the location at which the plan sponsor resides (*e.g.*, if the participant commutes to work from a rural/suburban area to an urban area). Critically, if Castlight determines that, despite these efforts to take local conditions into account in setting reference prices, there are insufficient providers in a particular zip code market offering a particular service at or below the reference price, the reference price for that service is waived. This feature ensures that reference prices never deny participants meaningful provider choice in the place where they live.

Castlight encourages the Departments to consider mandating that, as a condition for Excess Payments not to be treated as out-of-pocket payments, a plan must (1) calculate reference prices in a manner that takes into account the specific pricing features of the healthcare markets in the zip codes where the participants reside; (2) determine on a service-by-service basis whether there is a sufficient number of providers within the zip code market that offer the service at or below the reference price, so as to provide participants a degree of choice; and (3) waive reference prices in markets where there is insufficient choice.

D. *Limiting the services for which reference-based pricing is used*

Reference-based pricing is most appropriate for services that can be delivered in a relatively uniform manner and that thus tend to have small variations in quality. Accordingly, of the hundreds of services with respect to which Castlight currently helps plans implement referenced-based pricing, roughly 265 are lab services (such as blood work), and roughly 80 are imaging services (such as MRIs and CT scans), many of which have fairly uniform protocols.¹⁴ Castlight has also found, however, that there are a variety of *procedures* that are typically provided in a uniform manner (at least with respect to the services provided by the facility at which the procedure is conducted). These also often have fairly uniform protocols, and include services ranging from inpatient hip and knee replacements to outpatient screening colonoscopies.¹⁵ In total, Castlight helps facilitate reference-based pricing for roughly 25 different procedures.

¹⁴ See, *e.g.*, Fronstin & Roebuck, *supra* note 8, at 1, 4 & 6 (noting that MRIs and CT scans were included in the study because they have fairly uniform care-delivery protocols).

¹⁵ See, *e.g.*, *id.*; Press Release, Well Point, Inc., CalPERS Members Had Similar to Better Outcomes at Facilities Charging Less for Hip and Knee Replacements (June 23, 2013), <http://ir.wellpoint.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=1832119&highlight=> (noting that the CalPERS pilot program, described above, “lowered the price of members’ hip and knee replacement surgeries . . . while also demonstrating similar to better outcomes at lower-cost hospitals”) (emphasis added).

Determining whether a particular procedure is suitable for reference-based pricing is a complex task that different organizations currently conduct in different ways. Castlight accordingly urges the Departments to allow plans to continue to make their own informed decisions about whether a service is suitable for reference-based pricing based on broad, non-exclusive criteria such as uniformity of delivery. The Departments could consider, however, specifying an exemplary list of services that the Departments have determined are particularly suitable for reference-based pricing.

E. *Limiting the situations in which reference-based pricing is applicable*

Even if a service is suitable for reference-based pricing generally, there may be situations where individuals are not in a position to shop for an affordable provider, and pressuring them to do so could exacerbate their medical condition, or trigger unexpected financial consequences. To accommodate these situations, Castlight has developed a set of exclusion criteria that define when reference prices are inapplicable. For example, in the plans for which Castlight facilitates reference-based pricing, reference prices do not apply in medical emergencies, or for lab and imaging services that are performed for a participant while s/he is hospitalized in an inpatient facility. Similarly, reference prices will be waived if services are performed in an emergency room or ambulance, or in connection with care for a member under age 18. The Departments could thus consider adopting similar reasonable limitations on the medical situations in which reference-based pricing can be applied.

CONCLUSION

Recent studies show that there is substantial reason for optimism about the role reference-based pricing can play in stemming the nation's rising healthcare costs. But for these efforts to succeed, plan sponsors must be accorded flexibility to structure plan benefits in a manner that strongly incentivizes participants to consider affordability when selecting a healthcare provider. As explained above, treating Excess Payments as out-of-pocket payments under the Public Health Service Act would severely and unnecessarily impair the effectiveness of reference-based pricing. Castlight accordingly urges the Departments not to take any action that would require plans using reference-based pricing to treat Excess Payments as out-of-pocket payments. The Department should instead consider adopting targeted limitations on reference-based pricing of the sort described above, which have been demonstrated to be effective at ensuring that participants who are subject to reference prices retain meaningful access to quality healthcare.

Sincerely,



Gregory F. Jacob