

**America's Health  
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July 31, 2014

Daniel Maguire  
Director, Office of Health Plan Standards  
and Compliance Assistance  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Ave, NW, Ste N-5653  
Washington, DC 20210

Re: Request for Information on Reference-Based Pricing Strategies

Submitted Electronically: [E-OHPSCA-FAQ.ebsa@dol.gov](mailto:E-OHPSCA-FAQ.ebsa@dol.gov)

Dear Director Maguire:

America's Health Insurance Plans (AHIP) is writing in response to a request for information concerning reference-based pricing strategies set out in the "FAQs About Affordable Care Act Implementation (Part XIX)" released on May 2, 2014 by the Departments of Health and Human Services, Labor, and the Treasury (the "Departments"). The information request asks for comments on "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." (FAQ 4).

As discussed below, AHIP's member health insurance plans are utilizing reference-based pricing strategies on behalf of employer customers today or evaluating their use in the future. Early evidence demonstrates the value of these approaches in providing incentives for patients to choose health care services from providers that deliver quality care at lower costs. We strongly believe the Departments should not restrict the use of reference-based pricing strategies that promote value in our health care system and help keep premiums affordable for all Americans. AHIP recommends the Departments clarify that insurers in the individual and group markets and group health plans should be allowed to treat health care providers that accept a reference price for a service or procedure as the only in-network providers for such health care.

*Background on Reference-Based Pricing*

In general, reference-based pricing is "where a purchaser sets a maximum allowed amount – the reference price – for a specific medical service or procedure in a specific market. If enrollees

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receive care at a facility that has an allowed amount above the reference price, the enrollee must pay the additional amount out of pocket.”<sup>1</sup> Reference pricing was originally used by purchasers in Europe, Canada, and the United States to control prescription drug costs by encouraging patients to change to generic, therapeutically equivalent alternatives. Under this approach, the reference price is set at or marginally above the generic drug cost and patients are responsible for the cost difference above the reference price if a brand-name drug is purchased.<sup>2</sup>

A number of large group purchasers in the United States have begun establishing reference-based pricing strategies for elective medical procedures and services that have uniform health quality outcomes, but high variation in price – notably CalPERS (orthopedic surgery), Safeway (imaging and laboratory tests), and Kroger (MRI and CT scans).<sup>3</sup> AHIP members report that an increasing number of employer customers are requesting information about reference-based pricing or including requirements for such strategies in requests for proposals for group health plan administration. Employers and health insurance plans see reference-based pricing strategies as part of a broad range of approaches for responding to increasing health care costs and engaging consumers in making informed health care decisions.

#### *Common Elements of Reference-Based Pricing*

Although reference-based pricing for health care services and procedures is relatively new, there are a number of factors that are consistent across the programs that have been undertaken to date:

- Uniform quality in health outcomes/high variability in pricing – reference pricing is typically used for procedures and services where there is a uniform level of health care quality coupled with significant variability in prices charged by health care providers across the market. For example, data provided by Anthem (which administers the CalPERS health plan) indicated hospital prices for hip and knee replacements varied from a low of \$15,000 to a high of \$110,000 across the California market.<sup>4</sup> Safeway’s analysis

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<sup>1</sup> Amanda Lechner, Rebecca Gourevitch, and Paul Ginsburg, “The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer,” Center for Studying Health System Change Research Brief, December 2013 accessed at: <http://www.hschange.org/CONTENT/1397/1397.pdf>

<sup>2</sup> See: Hau Liu, “Closing the Gap: Reducing Price Variance in Health Care with Reference-Based Pricing,” Castlight Health White Paper, July 2012 accessed at: [http://content.castlighthealth.com/rs/castlighthealth/images/RBP-White-Paper\\_July-2012\\_draft4.pdf](http://content.castlighthealth.com/rs/castlighthealth/images/RBP-White-Paper_July-2012_draft4.pdf)

<sup>3</sup> See: James Robinson and Kimberly MacPherson, “Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers,” Health Affairs, 31, no. 9 (2012) accessed at: <http://content.healthaffairs.org/content/31/9/2028.full.pdf+html>. See also: “Reference Pricing: Will Price Caps Help Contain Healthcare Costs?,” Alliance for Health Reform, November 18, 2013 accessed at: [http://www.allhealth.org/briefing\\_detail.asp?bi=310](http://www.allhealth.org/briefing_detail.asp?bi=310)

<sup>4</sup> Lechner, *op cit*.

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of claims data showed a variation in colonoscopy pricing in the markets serving their employees, for example a range of \$848 to \$5,984 in San Francisco.<sup>5</sup>

- Elective/Non-Emergency Care – as noted, reference pricing has been used by some employers in connection with imaging, hip and knee replacements, and endoscopy procedures. These are elective services that can be scheduled on a non-emergency basis allowing the enrollee sufficient time to compare provider options and schedule an appointment.
- Emphasis on delivery of quality health care – reference-based pricing is used in connection with medical services and procedures that demonstrate high health care outcomes across all providers. Health care providers participating in the program must meet health care quality standards established by the plan or insurer.
- Robust provider networks – health insurers and group health plans using reference-based pricing provide enrollees with access to a broad range of health care provider options. The plan design ensures that enrollees do not face barriers in obtaining care from a health care provider who agrees to accept the reference price. Patients may also choose other health care providers within the network as long as they agree to pay the difference from the reference price.
- Consumer engagement – one of the stated benefits of reference-based pricing strategies is the ability to give consumers the opportunity to make informed choices among health care services pricing options. As a result, plans and insurers utilizing reference pricing approaches put significant efforts into informing enrollees about the specific services subject to the reference-based pricing, the quality measures and prices charged for the services offered by providers in the market, and what the enrollee is expected to pay if the reference price is exceeded.<sup>6</sup>

### *Consumer Protections*

The request for information from the Departments addresses reference pricing in the context of the Affordable Care Act (ACA) provisions placing annual limits on the amount of out-of-pocket spending by health insurance and group health plan enrollees. The FAQ states that:

Until guidance is issued and effective, with respect to a large group market plan or self-insured group health plan that utilizes a reference-based pricing program, the Departments will not consider a plan or issuer as failing to comply with the

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<sup>5</sup> Robinson, *op. cit.*

<sup>6</sup> Alliance for Health Reform, *op cit.*

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out-of-pocket maximum requirements of PHS Act section 2707(b) because it treats 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.<sup>7</sup>

Presumably the concerns expressed by the Departments are ensuring that enrollees are not challenged in obtaining quality care from health care providers that are willing to accept the reference price for a particular procedure or service.

It should be noted that significant state and federal protections exist today for consumers who have insurance or self-funded group coverage that use reference-based pricing strategies. Twenty-two states and the District of Columbia have implemented provider network adequacy laws including requirements to provide access based on geographic location or establishing a specific ratio of health care providers or specialists to enrollees.<sup>8</sup> On the federal level, Qualified Health Plans offered through an insurance Marketplace must, “maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay . . . .”<sup>9</sup> Most state insurance codes as well as the ACA require insurers and group health plans to provide immediate access to emergency care without prior authorization or cost-sharing.<sup>10</sup>

Enrollees in health insurance and group health plan coverage also have broad rights to challenge decisions limiting benefits, including situations where they would be facing higher cost-sharing. These rights include the opportunity to have a denial reviewed internally by the insurer or plan and for an external, independent review if the denial is based on medical necessity standards.<sup>11</sup>

Finally, it should be noted that reference pricing is used with in-network health care providers assuring that the patient is getting access to procedures and services provided by a medical professional that has met the insurer’s or plan’s health care quality, licensing, and network adequacy standards.

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<sup>7</sup> FAQs About Affordable Care Act Implementation (Part XIX), May 2, 2014, FAQ 4.

<sup>8</sup> *See*: Ala. Admin. Code §420-5-6-06; Cal. Admin Code tit. 28 §1300.67.2; Col. Stat. §10-16-704; Conn. Stat. Ann. §38a-472f; Del. Admin Code §1403-11.0; D.C. Stat. §31-3171.09; HI Rev. Stat. §432F-2; Code Me R. 02-031 Ch. 850 §1; MD Ins. Code §31-115; Mich. Stat. §§550.1501c, and 550.3428; Minn. Stat. §62K.10; Mo. Stat. 354.603; Mont. Code. Ann. §33-36-201; Neb. Rev. St. §44-7105; N. H. Admin Code Ins. 2701.02 *et seq.*; N.C. Admin Code tit. 11.r.20.0301 and 20.0302; Ore. Rev. Stat. §743.817; 28 Pa. Code §§9.651 and 9.679; R.I. Stat. §23-17.13-3; S.D. Codified Laws §58-17F-5 *et seq.*; Tenn. Code Ann. §56-7-2356; Tex. Admin. Code tit. 28 §3.3704; and Wash. Admin. Code 284-43-200.

<sup>9</sup> 45 CFR §156.23(a)(2).

<sup>10</sup> *See*: 26 CFR §54.9815-2719AT(b); 26 CFR §2590.715-2719A; and 45 CFR §147.138 (b)

<sup>11</sup> *See*: 26 CFR §54.9815-2719T, 29 CFR §2590.719-2719, and 45 CFR §147.136.

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The Departments – along with state insurance regulatory agencies – currently have oversight and enforcement tools that could be brought to bear if an insurer or group health plan is using reference based pricing in a way that denies consumers access to needed and affordable care.

### *Support for Reference-Based Pricing Initiatives*

Reference pricing is one of a variety of approaches that are being considered today to addressing rising health care costs and to encourage consumers to make choices based on value. Early programs have yielded savings – for example, it is estimated that CalPERS saved \$3.1 million in 2011 from reference-pricing applied to knee and hip replacement surgery resulting from enrollees accessing providers that agreed to accept the reference price and other hospitals lowering prices. A portion of these savings accrued to enrollees from lower out-of-pocket spending.<sup>12</sup> Kroger estimated an approximate 30 percent decrease in cost based on the use of reference-based pricing strategies in the first few years of its program. The savings from these programs were achieved without sacrificing quality in health care outcomes.<sup>13</sup>

The Departments have previously recognized that insurers and group health plans may apply differential cost-sharing approaches to give enrollees incentives to utilize certain health care providers without violating ACA limits on out-of-pocket spending. For example, insurers and plans may use value-based insurance designs under which patients may be charged a co-payment for preventive services provided by certain in-network providers (e.g., hospitals) as long the same services are available at no cost-sharing from other in-network providers (e.g., ambulatory surgery centers).<sup>14</sup>

We believe a similar approach should be taken with respect to reference-based pricing strategies. As long as patients receive reasonable access to quality health care providers that follow the reference price, the insurer or group health plan should not be required to accumulate cost-sharing toward the ACA's annual out-of-pocket limitations that is paid by an enrollee who chooses services from a provider that charges above the reference price. In addition, health insurers in the individual and small group markets should be permitted to adopt reference-based pricing strategies as appropriate.

AHIP believes that all stakeholders – consumers, health insurers, health care providers, and the government and private purchasers – have a strong interest in preserving access to health care that is high quality and affordable. Reference-based pricing is an integral part of the strategies that will be used to achieve this goal and the Departments should not discourage the use of reference pricing strategies that enhance value in our health care system.

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<sup>12</sup> Robinson, *op cit*.

<sup>13</sup> Alliance for Health Reform, *op cit*.

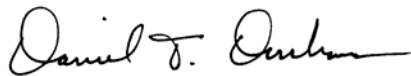
<sup>14</sup> See: "FAQs About Affordable Care Act Implementation Part V," December 27, 2010 (FAQ 1) and "FAQs About Affordable care Act Implementation," Part VI, April 1, 2011 (FAQ 3).

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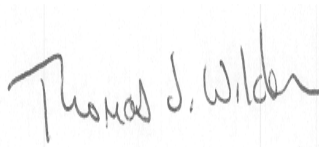
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AHIP appreciates the opportunity to comment on this important issue and looks forward to working with the Departments to address any concerns.

Sincerely,



Daniel T. Durham  
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Thomas J. Wilder  
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