Comments to the Departments of Labor, Health and Human Services, and the Treasury

RE: FAQs about Affordable Care Act Implementation (Part XIX), Limitations on Cost-Sharing under the Affordable Care Act: Standards for Reference-Based Pricing Structures

Submitted by Community Catalyst

August 1, 2014

Community Catalyst respectfully submits the following comments to the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) in response to the Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act (ACA). In particular, the Departments seek comments on standards for reference-based pricing structures to ensure that individuals have meaningful access to medically appropriate, quality care.

Community Catalyst is a national non-profit advocacy organization dedicated to securing access to quality, affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state, and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We greatly appreciate the opportunity to provide comments on standards for reference-based pricing structures. We recognize that reference pricing is a strategy that has the potential to reduce excessive prices and generate cost savings for our health care system. At the same time it has the potential to create barriers to access and confusion for consumers. Our current health care system lacks the cost transparency, reliable quality measures, and consumer education necessary to effectively implement reference pricing on a broad scale. Therefore, we strongly recommend the Departments establish criteria to limit reference pricing to programs that can demonstrate adequate resources to establish a program that meets the standards we propose below.

Additionally, we are concerned that health plans could circumvent the out-of-pocket maximum in the ACA while still giving the appearance of maintaining a broad provider network. Therefore we recommend that until reference pricing guidance is issued and effective, out-of-pocket costs incurred

due to an enrollee seeking treatment outside of a plan's reference-pricing program should count toward an enrollee's out-of-pocket limits.

We have focused our comments on a few areas where we believe federal standards are necessary to ensure consumer protection. Below are comments on choice of services for reference-pricing programs, network adequacy, consumer education and support, appeals, and evaluations.

We recommend that the Departments limit reference pricing to standard, non-emergency services with sufficient claims data that demonstrate a wide variation in price for the service, but not quality, within the plan's providers. Reference prices should be set only for services for which consumers have time to compare the plan's providers based on cost and quality, and come to an informed decision on which provider to choose. Examples of appropriate services include hip and knee replacement, screening colonoscopies, and routine imaging procedures. With these procedures, consumers have time to consider alternatives and make informed decisions. For example, when the California Public Employees' Retirement System (CalPERS) implemented reference pricing for knee and hip replacement surgery in 2011, it excluded any emergency knee or hip replacement, which would otherwise be included if it wasn't an emergency procedure. They did this to protect patients from a situation where they don't have time to choose a provider. Also, we believe that a service subject to a reference price must be simple and common enough to create a robust data set for quality comparison demonstrating variation in price, but not quality. CalPERS, for example, found that the negotiated hospital price for hip or knee replacement spanned from $150,000 to $110,000 with no related difference in hospitals' quality scores, which were based on readmission rates, infection rates and the rate of revision of the original surgery.

We recommend that the Departments set standards for determining a reference price to ensure that consumers have adequate access to care by quality providers. Payment limits, or the reference price, must be set high enough so that the price reflects what the majority of high-quality providers within that region charge for care. Programs must be able to demonstrate that there will be an adequate network of providers charging the reference price or less across all of the geographic regions that the program serves, including rural and underserved regions. For example, when CalPERS implemented its reference pricing for knee and hip replacement, its data analysis showed close to two-thirds of hospitals in California that performed hip and knee replacement surgeries on its members charged less than the reference price of $30,000. We believe standards around network adequacy are necessary to ensure that plans do not implement a reference-pricing program that would create unduly limited provider networks for the selected service.

The Departments should also require plans to collect data that demonstrates quality among the providers available within the set reference price. CalPERS, for example, measured hospital's quality based on accreditation by recognized quality accrediting entities, whether the hospital performed a sufficient number of joint replacement surgeries annually, and the hospital's scores on surgical prevention

indicators, as well as participation in California's hospital quality reporting systems.[1] This will further protect consumers against an inadequate network of providers.

We recommend that the Departments prohibit the application of reference pricing to certain services that could result in a selection bias. Because reference pricing has the potential to shift consumers from particular high-cost providers to other low-cost providers, there is a threat that if certain providers attract a disproportionate share of sicker and more expensive patients, then plans could intentionally set pricing levels to exclude providers serving these patients in an effort to discourage these patients from selecting their plan. We think it is important to safeguard against underwriting-like practices that would undermine the ACA's protections.

We recommend a requirement that reference-pricing programs implement a robust consumer education and support system. Transparency is a key to providing consumers meaningful access to care in a reference-based pricing structure. Programs should have in place broad communications with targeted outreach and education strategies to inform consumers about how reference-pricing programs work. Notices written in plain language should be sent to all plan members along with targeted outreach to members who may require a health service that is subject to reference pricing. Communications should include general education materials, a list of services that have a reference price, the scope of services a reference price is meant to cover (i.e. some programs only pay the hospital facility fee, others cover all billed services during the procedure), a list of the plan's providers who fall within the reference price limit, and a clear explanation of the cost implications for consumers who choose a provider that doesn't accept the reference price. These communications should be presented to consumers in formats that are easy to read and use. Also, consumer-friendly tools such as a comparison tool that allows consumers to compare providers based on price, quality and other factors should be required.

We recommend that reference-pricing programs include an appeals process. A health plan should be required to demonstrate to the Departments that it has an appeals process for consumers who believe they were wrongfully required to cover excess costs due to a reference-pricing structure. Additionally, plans should have a process for granting exceptions to the reference price, dependent on the type of procedure, for enrollees who might have a specialized need requiring a provider outside of the reference price. Providers and consumers should be educated about the appeals and exceptions processes, and they should be clearly stated on all consumer notices.

The Departments should require a reference-pricing program to be independently evaluated annually. Annual evaluation will be important to determine if the reference price is actually encouraging consumers to seek care for lower-cost providers and to measure the effect of the reference price on provider pricing, consumer out-of-pocket spending, access to services, and health outcomes. Also, the program should evaluate the program's affect on utilization of care to make sure that the reference price does not inadvertently create barriers to care. Consumer surveys would be a way for

[1] James C. Robinson and Timothy T. Brown, Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery, *Health Affairs*, 32, no.8 (2013): 1392-1397.

programs to understand how the reference price is affecting individual enrollees and the insured group as a whole.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Ashley Blackburn, Policy Analyst, at ablackburn@communitycatalyst.org or 617-275-2943.

Respectfully submitted,

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