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August 1, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Re: Request for Comment on Reference Pricing in Online FAQs about Affordable Care Act Implementation (Part XIX)

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (AHA) appreciates the opportunity to comment on a Frequently Asked Question (FAQ) posted on the Centers for Medicare & Medicaid Services' (CMS) [website](#) and the question raised by CMS, the Department of Labor (DOL) and the Treasury Department (Treasury) regarding the implications of reference pricing on network design and adequacy.

The FAQ states that it is permissible for health plans to consider only those providers that accept a pre-determined reference price as in-network providers. Reference pricing is a relatively recent cost reduction tactic whereby an insurer or employer sets a price ceiling for a particular service, and any amount charged by a provider above that price ceiling is paid by the enrollee. The implication of the FAQ is that all providers who price their services above the pre-determined reference price would be considered out-of-network, and, therefore, any out-of-pocket costs paid by the enrollee to those providers would not be included in the calculation of the enrollee's annual out-of-pocket maximum.

The AHA shares the agencies' stated concern 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." We believe it is imperative to set reference prices at levels that ensure an adequate number of high-quality providers will accept the reference price and are, therefore, considered to be in-network. **For health plans that use reference pricing, the AHA recommends that the network of providers that agree to accept**



the reference payment meet all of the network adequacy requirements applicable to non-grandfathered plans under the Affordable Care Act (ACA) and state law.

Further complexity arises when plans combine tiered provider networks with reference pricing. Under a tiered provider network, enrollees pay different cost-sharing rates for each tier of providers. **The AHA recommends that, when a health plan has multiple network tiers and uses reference pricing, the lowest cost-sharing tier must include only those providers that accept the reference rate, and it should be required to meet network adequacy standards in the first tier alone.** This ensures enrollees are not compelled to seek services from a higher cost-sharing tier in order to gain access to needed services, and is consistent with recommendations the AHA previously made with respect to tiered networks and network adequacy requirements for Qualified Health Plans.

Moreover, this recommended approach is consistent with the agencies' interpretation of required coverage of generic versus brand name drugs in Question 3 of this same set of FAQs. In that FAQ, the agencies reiterated previous interpretations that higher cost sharing for brand name drugs can be imposed only when an equally effective and medically appropriate generic drug is available to the patient. With regard to reference pricing, we support requirements where higher-cost services can be made available as long as there are sufficient services available in-network and at the lowest cost-sharing level. If the reference prices are set at a reasonable level, the plan will be able to contract with an adequate number of providers at those prices.

The AHA has long expressed its disagreement with the agencies' decision allowing plans to not count out-of-network cost sharing toward the out-of-pocket limit. Thus, we also disagree with allowing the difference between reference prices and other in-network negotiated prices (such as those for second-tier providers) to not be counted toward out-of-pocket limits. However, rather than change the rules at this time when so many changes are being implemented, **the AHA recommends the agencies revisit this policy as premiums stabilize, and consider establishing a separate out-of-pocket maximum for payments to out-of-network providers for medically necessary essential health benefits.**

Finally, we are concerned that enrollees do not fully understand network coverage limitations or how different levels of cost sharing might be charged within networks, often resulting in surprise medical bills after services have been received. In many cases, adequate information on network composition has been not made available by health plans during or after the initial ACA enrollment period, resulting in confusion for consumers and providers. The AHA also is concerned that the public does not understand exceptions to what counts toward their out-of-pocket limit, or even that there could be exceptions. **The AHA recommends that the agencies devote substantially more energy to public education on health coverage, particularly for those who have recently gained access to health insurance.**

We appreciate the opportunity to provide comments on this issue, although we were surprised that such an unconventional vehicle was utilized for this request. Requests for comment conveyed through FAQs are not seen by many interested parties who would want to comment. We recommend that more conventional channels, such as the Federal Register, be used for any further regulatory interpretation or actions in this area.

Ms. Marilyn B. Tavenner

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If you have any questions about our comments, please contact me, Jeffrey Goldman, vice president for coverage policy, at jgoldman@aha.org or (202) 626-4639, or Ellen Pryga, policy director, at epryga@aha.org or (202) 626-2267.

Sincerely,

/s/

Linda E. Fishman

Senior Vice President

Public Policy Analysis & Development