American Federation of Labor and Congress of Industrial Organizations

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Submitted electronically to E-OHPSCA-FAQ.ebsa@dol.gov

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

Re: Affordable Care Act Implementation FAQ Part XIX

Ladies and Gentlemen:

These comments on the standards that large group market or self-insured plans using reference-based pricing structures should meet to ensure meaningful access to medically appropriate quality care are submitted by the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO") and its 56 affiliated unions.[1] The AFL-CIO, together with its community affiliate, Working America, represents more than 12.5 million workers across the country in all sectors of our economy, including those working in manufacturing, construction, transportation, grocery and retail stores, food processing and meatpacking, health care, education, hospitality, entertainment and state and local governments. Our affiliated unions negotiate health care benefits for millions of workers, retirees, and their family members, and these benefits are provided through single employer and multiemployer plans, both insured and self-funded.

[1] In Q4 of Affordable Care Act Implementation FAQ Part XIX ("FAQ XIX") issued by the Departments of Labor, Health and Human Services and Treasury (the "Departments") on May 2, 2014 (*available at* http://www.dol.gov/ebsa/pdf/faq-aca19.pdf) , the Departments invited comment on the application of the out-of-pocket limitation to the use of reference based pricing and indicated their interest in standards that plans using such structures should meet.

Reference pricing, as the Departments note in FAQ XIX, Q4, is an approach "… to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs." As a cost reduction strategy, reference pricing is appropriately targeted at the primary source of ever-increasing health care costs—the providers of care. But, to the extent reference pricing is designed and operated as a cost-shifting strategy, imposing additional health care costs on workers and their families, it does nothing to address our national challenge to reduce health care costs. We spend more than any other country on health care, and our outcomes are among the worst.[2] We need to address this problem now and at a systemic level, not only plan by plan using tools like provider contracting, reference pricing and the other payment reforms fostered by the Affordable Care Act.

The leading articles discussing reference pricing[3] report on programs adopted by the California Public Employees' Retirement System ("CalPERS"), the second largest public health purchaser in the country, and Safeway, a national chain of grocery stores, each of which have been in effect for relatively short periods of time.[4] According to Robinson and Brown, CalPERS saved almost $3 million during the first two years of its program and participants saved $300,000 through lower out-of-pocket cost sharing.

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[2] In the most recent international comparison of 11 nations from the Commonwealth Fund, health expenditures in the United States were $8,508 per capita well above the next highest, Norway at $5,669. The overall rank for the US was last in large part due to poor rankings on efficiency, equity and mortality and life expectancy. Karen Davis, et al., *Mirror, Mirror On The Wall 2014 Update* (Commonwealth Fund June 2014) *available at* http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf. While national health expenditure growth has slowed in 2012 and the three previous years, these expenditures still amounted to 17 percent of GDP, and they are projected to rise to 20 percent of GDP in 2022. *See*, Anne B. Martin, et al., *National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year*, 33 Health Affairs No. 1: 67-77 (January 2014) *available at* http://content.healthaffairs.org/content/33/1/67.full.pdf+html and Gigi A. Cuckler, et al., *National Health Expenditure Projections, 2012-2022: Slow Growth Until Coverage Expands and Economy Improves*, 32 Health Affairs No. 10: 1820-1831 (October 2013) *available at* http://content.healthaffairs.org/content/32/10/1820.full.pdf+html.

[3] James C. Robinson and Timothy T. Brown, *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery*, 32 Health Affairs No. 8: 1392-1397 (August 2013) *available at* http://content.healthaffairs.org/content/32/8/1392.full.pdf+html; James C. Robinson and Kimberly MacPherson, *Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers*, 31 Health Affairs No. 9: 2028-2036 (September 2012*) available at* http://content.healthaffairs.org/content/31/9/2028.full.pdf+html.

[4] CalPERS initiated its reference pricing policy for the facility charges related to hip and knee replacement procedures in January 2011 while Safeway's pilot program for colonoscopy began in 2009.

According to the Employee Benefit Research Institute, the potential savings from using reference pricing for hip and knee replacements and variety of medical tests, including colonoscopy, CT scans of the head or brain and echocardiograms, could reach $9.4 billion if adopted by all employers for covered workers and dependents under age 65.[5] Those savings represented a small percentage—1.6 percent—of the total health care spending for those covered by workplace plans in 2010.

While plans may potentially reduce costs and lower participant cost-sharing expenses through the use of reference pricing, the design of any program and its communication to participants are critical. As the reviews of the CalPERS program indicate, key components of any reference pricing program include the selection of the procedures and services to be covered, the setting of the reference price and the availability of a sufficient number of providers considered to be quality providers that are easily accessible to participants. Communications with, and the provision of information to, plan participants are also critical.

The standards for plans using reference-based pricing structures should, at a minimum, include the following:

1. Reference-based pricing should be limited to specific procedures and services covered under the plan. It should not apply to all covered services under a plan. The particular procedures and services should be ones, like those included in the CalPERS and Safeway programs, that do not involve emergency care, have uniform protocols and little difference in quality.[6]

2. The reference price set for covered procedures and services must be sufficient to assure that access to quality providers is readily available and geographically accessible to plan participants. Price cannot be the only consideration as participants must have access to providers offering quality care without facing the potential of additional expenses through using a non-designated provider.

3. The reference price should not apply to emergency or complicated procedures that might require additional services or longer hospital stays.[7] In addition, the reference

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[5] Paul Fronstin and M. Christopher Roebuck, *Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits*, Issue Brief No. 398 (Employee Benefits Research Institute, April 2014) *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_398_Apr14.RefPrcng.pdf.

[6] Id. at 5.

[7] This feature was part of the CalPERS program for hip and knee replacements. *See* Amanda E. Lechner, et al., *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer* (Center for Studying Health System Change December 2013) at 2-3 *available at* *http://www.hschange.org/CONTENT/1397/1397.pdf*.

price should not serve as an upper limit if complications arise in any individual situation if the participant uses a designated provider.

4. Any reference-based pricing program must include comprehensive communications with, and the provision of information to, plan participants. Advance information about the program, its operation and the potential financial impact of using a provider charging more than the reference price, are critical. Clear and understandable descriptions of the services and procedures covered and the identity of the providers and facilities accepting the reference price must be provided when the program is first effective.[8]

The suggested minimum standards will provide some assurance that any reference-based pricing structure is not being used solely as means to shift unreasonable costs to working families. In our view, the provision and availability of clear and understandable information about the structure, the designated providers and the impact of selecting non-designated providers are necessary to assure that participants can easily make informed choices and minimize the potential of incurring unexpected health care expenses.

Reference-based pricing structures can be useful tools for addressing high health care prices and offering quality health care services to workers at a lower cost, providing savings to them and the benefit plans that cover them. But, unless adequate protections are included in the reference-based pricing structure, individuals could be at risk of incurring significant expenses that may well be unaffordable. Designing reference-based pricing structures requires careful thought and consideration of a multitude of interacting concerns, and we look forward to working with the Departments as they consider the standards to apply these structures.

The AFL-CIO appreciates the opportunity to submit these comments on the standards that reference-based structures should be required to meet. If you have any questions about these comments or need any additional information, please do not hesitate to contact me.

Very truly yours,

/s/ Karin S. Feldman
Karin S. Feldman
Benefits and Social Insurance Policy Specialist

[8] In addition, this information must be readily available in benefit booklets, summary plan descriptions and other communications about the benefit program so that participants know where to go as they consider a scheduled procedure or test covered by the reference-based pricing structure.