



The
ERISA
Industry
Committee

July 31, 2014

U.S. Department of Labor
U.S. Department of Health and Human Services
U.S. Treasury Department

RE: FAQs About Affordable Care Act Implementation (Part XIX)

Ladies and Gentlemen:

The ERISA Industry Committee (“ERIC”) is writing in response to the request of the U.S. Department of Labor, U.S. Department of Health and Human Services, and U.S. Treasury Department (collectively, the “Departments”) for comments regarding guidance on annual cost-sharing limits under section 1302 of the Affordable Care Act (“ACA”), which was published in FAQs About Affordable Care Act Implementation (Part XIX) on May 2, 2014 (the “May 2014 FAQs”).¹

ERIC submitted comments on the Departments’ prior FAQs on annual cost-sharing limits under ACA section 1302 on April 25, 2013.²

ERIC’S INTEREST IN THE ACA

ERIC is a nonprofit association committed to the advancement of the employee retirement, health, and other welfare benefits of America’s largest employers. ERIC’s members sponsor some of the largest private group health plans in the country. These plans provide health care to millions of workers and their families.

ERIC’s members devote considerable time and resources to their benefit plans. However, they must balance the desire to provide high quality, affordable health care with the need to contain the costs for these programs. Any additional burdens placed on plans could adversely affect the ability of these employers to continue to provide generous benefits and could result in increased costs for participants.

SUMMARY OF COMMENTS

ERIC makes the following recommendations with respect to the FAQs:

- The Departments should provide that the ACA cost-sharing limits do not apply to any additional amounts incurred by participants because they choose not to adhere to the plan’s reasonable medical management techniques.

¹ U.S. Dep’t of Labor, U.S. Dep’t of Health and Human Services, and U.S. Treasury Dep’t, *FAQs About Affordable Care Act Implementation (Part XIX)* (May 2, 2014).

² The ERISA Industry Committee, *Letter regarding FAQs About Affordable Care Act Implementation (Part XII)* (Apr. 25, 2013), available at <http://www.eric.org/uploads/doc/health/ERIC%20Comment%20Letter%20-%20FAQs%20Part%20XII.pdf>.

- The Departments should issue guidance confirming that reference-based pricing is acceptable as a reasonable medical management technique.

OVERVIEW

Pursuant to the ACA, non-grandfathered group health plans may not impose cost-sharing limits that exceed certain dollar amounts. For plan years beginning in 2014, any cost sharing for essential health benefits may not exceed the dollar amounts in effect under the Internal Revenue Code for high deductible health plans.³ For plan years beginning in 2015 or later, the limit for self-only coverage is equal to the 2014 limit plus the premium adjustment percentage. The premium adjustment percentage is the cost of the average per capita premium for health insurance coverage in the United States for the preceding calendar year less the average per capita premium for 2013.⁴ The limit for family coverage for plan years beginning in 2015 or later is twice the amount for self-only coverage.

Under the ACA, the term “health plan” includes health insurance coverage and group health plans, but generally does not include self-insured group health plans unless specifically provided in the statute.⁵ The Departments have interpreted section 2707(b) of the Public Health Service Act as extending this requirement to self-insured plans.

The term “cost-sharing” includes “(i) deductibles, coinsurance, copayments, or similar charges; and (ii) any other expenditure required of an insured individual which is a qualified medical expense...with respect to essential health benefits covered under the plan.”⁶ Cost-sharing does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.⁷

Thus, while the ACA provides that certain items must be counted toward the cost-sharing limit, and conversely excludes others from its application, the scope of the cost-sharing limit is not precisely delineated. Indeed, such parameters are probably not capable of being firmly specified because of the myriad of medical services and devices that could potentially be affected and the ever-evolving nature of these services and procedures themselves.

For companies that wish to pursue cost-effective design strategies as well as for plans that must keep track of, and closely monitor, these limits, uncertainty as to whether the cost of a particular service or device is properly charged to the ACA cost-sharing limit creates a significant impediment to a plan’s ability to determine whether a participant has exceeded his or her cost-sharing limit. Although the Departments have issued some helpful guidance in the form of FAQs, clearly this type of guidance is not capable of addressing in a timely fashion all situations that may occur, leaving plans in an untenable situation and creating uncertainty for companies, who may not be able to determine the viability of some aspects of their plan design.

³ Pub. L. No. 111-148, § 1302(c)(1)(A) (2010).

⁴ *Id.* at §§ 1302(c)(1)(B), 1302(c)(4).

⁵ *Id.* at § 1301(b).

⁶ *Id.* at § 1302(c).

⁷ *Id.*

At the same time, it is vital that plans be permitted to continue to exercise cost restraint through the employment of reasonable medical management techniques. To the extent that the ACA cost-sharing limits must be applied to expenses that otherwise would be excluded through use of these techniques, these cost-management tools become correspondingly less effective as participants have no incentive to choose lower-cost care (and providers become similarly less willing to limit their charges).

It is important to remember also that sponsors of self-insured plans need not cover all essential health benefits; where a benefit is not provided under a plan at all, cost-sharing limits obviously cannot apply. Thus, plan sponsors can be faced with a choice between counting certain participant expenses against the cost-sharing limit and not covering the benefit at all. If plan sponsors are not allowed to use reasonable medical management techniques, they may feel obligated to reduce the benefits provided to participants in order to manage plan costs.

DETAILED COMMENTS

I. The Departments should provide that the ACA cost-sharing limits do not apply to any amounts incurred by participants because they choose not to comply with the plan's reasonable medical management techniques.

One goal of the ACA is to seek to provide individuals with meaningful access to medically appropriate, high-quality care through mandates such as those regarding preventive services, coverage of adult children, and restrictions on annual and lifetime limits. At the same time, both Congress and the Departments have acknowledged the need for cost control measures by recognizing and legitimizing the use of appropriate medical management techniques in their guidance. Hence, the ACA (and the FAQs issued by the Departments) provide that the term “cost-sharing” excludes amounts incurred by failure to adhere to certain medical management techniques and spending for non-covered services.⁸

Furthermore, the Departments indicate in the interim final regulations for preventive services that they “recognize the important role that value-based insurance design can play in promoting the use of appropriate preventive services.”⁹ The Departments also comment in FAQs that the preventive care section of the ACA and corresponding regulations “allow plans to use reasonable medical management techniques to control costs.”¹⁰

Thus, plans are permitted to constrain costs by negotiating for quality care at competitive prices with a group of providers who agree to accept these payments. Some plans allow participants to see out-of-network providers, although they will be responsible for any additional costs in excess of the in-network rate for those services (known as “balance billing”), a practice recognized by both

⁸ U.S. Dep't of Labor, U.S. Dep't of Health and Human Services, and U.S. Treasury Dep't, *FAQs About Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation*, Q&A-5 (Jan. 9, 2014); U.S. Dep't of Labor, U.S. Dep't of Health and Human Services, and U.S. Treasury Dep't, *FAQs About Affordable Care Act Implementation (Part XIX)* (May 2, 2014).

⁹ U.S. Dep't of Labor, U.S. Dep't of Health and Human Services, and U.S. Treasury Dep't, *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act*, 75 Fed. Reg. 41726, 41729 (Jul. 19, 2010).

¹⁰ U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation* (Dec. 22, 2010).

Congress and the Departments. In this manner, plans may control costs by specifying the types of services that are covered under the terms of the plan. At the same time, participants are protected because they are not prevented from seeking services that are not covered by the plan, although the additional costs will not apply against the cost-sharing limit.

Plans use a variety of methods to manage costs in addition to those techniques described by the Departments in the FAQs. For example, plans may seek to control costs by using preferred providers, by using a mail-order pharmacy or preferred pharmacy network, and by requiring a participant to obtain a “pre-certification” before undergoing inpatient surgery. A plan sponsor may make available a disease management program where co-payments and cost-sharing under the health plans are waived for employees who participate in the program.

Plan sponsors strive to balance the needs of individuals with the interests of all of the participants in the plan as a whole through the use of these reasonable medical management techniques. This allows companies to minimize plan costs while maximizing benefits for participants.

Despite the essential role played by reasonable medical management techniques, and given the ever-evolving nature of medical care, it clearly is not possible for the Departments to issue guidance in a timely fashion that could address each technique. Plans, however, must know in advance of the implementation of any particular approach whether any costs associated with that technique will be applied against an individual’s cost-sharing limit; individuals also need this information in advance in order to determine which course of medical care they wish to pursue.

Thus, ERIC strongly encourages the Departments to confirm, as a general principle, that if a plan utilizes reasonable medical management techniques to manage their health costs, any amounts incurred by a participant because he or she chooses not to adhere to the plan’s reasonable medical management techniques will not apply against the ACA limits on cost-sharing for that individual.

II. The Departments should issue guidance confirming that reference-based pricing is acceptable as a reasonable medical management technique.

The ACA has provisions that are designed to minimize the cost of health care to participants as well as provisions to address the type of coverage to be offered. As the Departments noted in the May 2014 FAQs, the ACA provisions are designed to minimize costs to participants by ensuring that any annual cost-sharing imposed by the plan does not exceed the out-of-pocket limits. In these FAQs, the Departments recognized the value of reference-based pricing in minimizing costs to participants. The FAQs acknowledge that “Reference pricing aims to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs.”

Reference-based pricing refers to arrangements whereby a health plan agrees to pay no more than a set, pre-determined price for a medical service, device, drug, or procedure. Plans that use this medical management technique have agreements with providers who will accept that amount as payment in full. While a participant may choose to use a provider that charges more than the reference price, the plan does not reimburse the participant for amounts in excess of the reference-based price.

Plans often adopt reference-based pricing for non-urgent procedures in a given geographic area where considerable variation exists as to price, but there is little variation in the quality of the service. This type of pricing structure can be a useful tool for encouraging the utilization of cost-efficient drug therapies and is becoming more widely used as well for specific bundled packages such as hip and knee replacement. CalPERS, for example, found that its use of reference-based pricing for hip and knee replacements not only reduced costs, but it also resulted in improved clinical quality; CalPERS has expanded its use of reference-based pricing to inpatient procedures for cataract surgery, colonoscopies, and arthroscopies.¹¹

The Departments state in the May 2014 FAQs that they “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.” Furthermore, the Departments state that they “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.”

The provision of group health plan coverage by employers is still voluntary, despite the ACA shared responsibility requirements; plan sponsors retain the flexibility to pursue benefit designs that are intended to keep their participants healthy and productive, while attempting to control plan costs. Thus, for instance, while self-insured plans are not required to have “an adequate network of providers”, these plans generally do, nonetheless, offer robust networks to their participants in order to provide high-quality, cost-effective care.

Plans rely on the use of reference-based pricing for a similar reason. Adherence to an appropriate reference-based price structure can hold the line on increasing medical costs while enhancing the quality of the specified service. Often this will result in reduced costs for participants, while still affording them significant flexibility in the selection of their medical services and drugs. Restrictions placed by the Departments on reference-based pricing, except where there is clear and obvious evidence of abuse, could result in participants having to pay more to receive services of a lesser quality.

ERIC urges the Departments not to impose specific restrictions on the “reasonable” use of reference-based pricing but, rather, to treat it as any other type of “reasonable medical management technique”. As noted above, pursuant to the ACA, the Departments have imposed a number of rules and regulations to ensure meaningful access to medically appropriate, quality care. Imposing additional constraints on reference-based pricing, where its use is “reasonable”, will not further this goal.

Given the rapidly changing nature of medical plans, the Departments do not have the necessary resources or capacity to timely and effectively regulate a plan’s use of reasonable medical management techniques; indeed, any attempt to do so is likely to have the perverse effect of driving up costs and lowering quality. Rather than creating an overly complex regulatory structure that discourages innovation and limits success in this area, the Departments should address perceived

¹¹ *Reference-Pricing Policy for Hip/Knee Replacements Generates Significant Savings by Encouraging Enrollees To Choose High-Value Facilities*, U.S. Dep’t of Health & Human Services, Agency for Healthcare Research and Quality (May 21, 2014), available at <http://www.innovations.ahrq.gov/content.aspx?id=4069>.

abuses as they are brought to their attention and not attempt to second-guess which techniques could lead to abuse before it has actually occurred.

ERIC appreciates the opportunity to provide comments on the May 2014 FAQs. If the Departments have any questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,



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