



Charles N. Kahn III
President & CEO

August 1, 2014

Ms. Phyllis C. Borzi
Assistant Secretary
Employee Benefits & Security Administration
Department of Labor
200 Constitution Ave, NW, Suite S-2524
Washington, D.C. 20210
Sent by e-mail to E-OHPSCA-FAQ.ebsa@dol.gov

Ms. Mandy Cohen
Acting Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable John A. Koskinen
Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, D.C. 20224-0002

Re: FAQs about Affordable Care Act Implementation (Part XIX); Question 4 on Reference Pricing (May 2, 2014)

Dear Assistant Secretary Borzi, Acting Deputy Administrator and Director Cohen, and Commissioner Koskinen:

The Federation of American Hospitals (“FAH”) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the

United States. Our members include teaching and non-teaching, short-stay rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to comment on the application of out-of-pocket limits to reference-based pricing strategies used by non-grandfathered large group or self-insured group health plans, as requested in the Frequently Asked Questions (“FAQ”) document released by the Departments of Labor, Treasury and Health and Human Services (“the Departments”) on May 2, 2014.

Under the Departments’ current view, as described in the FAQ, non-grandfathered large group and self-insured health plans may simultaneously implement a reference pricing strategy and comply with the out-of-pocket maximum requirements of section 1302(c) of the *Patient Protection and Affordable Care Act* (“ACA”) and section 2707(b) of the Public Health Services Act (“PHSA”). As the FAQ explains, providers that do not accept the reference price for a particular service may be considered “out-of-network” such that the out-of-pocket maximum does not apply to out-of-pocket spending by the patient for the treatment. The FAH believes the Departments’ current view does not adequately take into account the consumer protections included in the ACA and, thus should be reconsidered.

Also, the FAH is concerned with the process by which the Departments are considering reference pricing. We believe that an FAQ is an inappropriate vehicle to establish policy on such an important topic. Reference pricing likely will have an enormous adverse impact on consumers, and could create the very access and affordability problems that the ACA seeks to eliminate. Indeed, we agree with the Departments’ position in the FAQ expressing concern that some reference pricing structures might be a “subterfuge” for “otherwise prohibited limitations on coverage,” without assuring adequate access. Therefore, at a minimum, we believe a more formal process is appropriate to consider policy in this area.

There are many factors to be considered in determining whether reference pricing strategies are permissible under the ACA. In the absence of any discussion of these factors, as well as the Departments not having the benefit of having heard from all affected stakeholders, especially those most impacted, *i.e.*, consumers, **we believe the Departments should direct that all plans that utilize reference-based pricing programs – including large group health plans and self-insured group health plans – may not comply with the ACA’s enrollee out-of-pocket maximum cap. This directive should remain in place until the Departments have an opportunity to set policy on reference pricing through notice and comment rulemaking,** which would allow a thorough discussion of the issue, and most notably, consideration of reference pricing within the context of the ACA’s consumer protection provisions.

CONSIDERING REFERENCE PRICING WITHIN THE CONTEXT OF THE ACA

The purpose of the ACA is to provide access to health insurance coverage for millions across the country who are under-insured or uninsured. To ensure that access to medical care is meaningful, and not in name only, the law simultaneously implements many consumer protection provisions intended to facilitate access to affordable coverage.

The law also promotes care coordination and value-based purchasing strategies to transform our health care delivery structure into a system that furnishes care with increased efficiency, better value and lower costs. While the FAH supports this transformation and recognizes the benefits of appropriate value-based purchasing strategies, we also share the Departments' concern that these strategies should not undermine fundamental ACA consumer protections.

To this end, we are concerned that the concept of reference pricing is at odds with many ACA consumer protections, and believe that the permissibility of reference pricing should be considered within the larger context of the ACA. Such consideration brings into play several critical ACA provisions, particularly the cap on out-of-pocket spending for insured individuals.

Section 1302(c) of the ACA (under section 2707(b) of the Public Health Services Act ("PHSA")), places dollar limits on health plan enrollees' out-of-pocket spending (\$6,350 for individuals and \$12,700 for families in 2014), with respect to all health plans. Once an enrollee meets the out-of-pocket maximum, the enrollee receives any further covered services without incurring any additional cost sharing obligations. Reference pricing raises particular concerns with regard to these limitations because patients may end up spending significantly more out-of-pocket if they see providers who do not offer services at the reference price, and because plans are offering a benefit and then limiting it through the creation of a "reference price network." In essence, these types of arrangements could be more of a "bait and switch" scheme rather than a strategy to increase the value of the care offered.

Further, the ACA does not differentiate between types of plans with regard to application of many of its consumer protections, including the enrollee out-of-pocket maximum cap. Thus, there is no support for treating large group and self-insured group health plans differently from individual and small group health plans, as expressed in the Departments' interim position.

Additionally, under section 1001 of the ACA, which establishes PHSA section 2711, all insurers and group health plans are prohibited from imposing annual dollar limits for services that are essential health benefits. Coupled with this provision, the law also requires individuals to maintain "minimum essential coverage" under ACA section 1501. CMS determined, however, that fixed-dollar indemnity plans do not qualify as "minimum essential coverage" primarily because these plans place a dollar limit on per-service payments in violation of PHSA 2711 annual dollar limits, which conceptually is similar to reference pricing strategies.

Finally, the ACA contains provisions for direct access to emergency, pediatric, and obstetric and gynecological care. Reference pricing strategies should not limit these access provisions, nor should they undermine the ACA's consumer protection requirements as to actuarial value, essential health benefits and network adequacy.

Each of these ACA provisions is intended to protect consumers and ensure appropriate access to affordable care. Because of the propensity for reference pricing to completely turn these provisions on their head, there should be an opportunity to consider reference pricing within the overall context of the ACA to ensure that these consumer protections remain clearly intact.

THE DEPARTMENTS SHOULD SET REFERENCE PRICING POLICY THROUGH NOTICE AND COMMENT RULEMAKING

The FAH believes that setting reference pricing policy through an FAQ is not an appropriate forum for such a complex issue, and we urge the Departments to develop policy through a notice and comment rulemaking. The development of reference pricing policy needs the benefit of a thorough discussion among all affected stakeholders before establishing policy. In the meantime, until a regulatory process is finalized, the Departments should reverse their interim position, as stated in the May 2, 2014 FAQ, to direct that all plans (including large group health plans and self-insured group health plans) that utilize reference-based pricing programs may not comply with the ACA's enrollee out-of-pocket maximum cap. Alternatively, at a minimum, the Departments should withdraw the FAQ.

Reference pricing involves many multi-faceted issues that threaten to undermine meaningful access to health care for consumers. For example, reference pricing schemes can be misleading and result in an inadequate number of providers in a network or deprive patients of access to high quality providers. Further, these strategies often lack transparency, such that patients could experience confusion and be subjected to unexpected limitations on the use of in-network providers and undisclosed, material out-of-pocket costs. Because reference pricing also does not lend itself to many types of procedures, especially emergency procedures, patients may not have the opportunity to easily compare prices and quality among providers, thereby creating an additional challenge to informed plan selection.

The FAH recognizes the importance of allowing marketplace strategies to develop that promote stable insurance premiums, yet caution is needed to ensure that these strategies do not inappropriately undermine consumer access. For example, consumers grapple with marketplace strategies such as narrow networks and tiered networks, but nevertheless have some familiarity with these concepts. With proper federal and state oversight to ensure transparency and fairness for consumers, these strategies may be an adequate alternative to offer more affordable coverage while achieving the same goals as reference pricing.

Reference pricing, however, should not be viewed through the same lens as narrow networks or tiered networks. Reference pricing is an extreme form of narrow networks that is not transparent and should be differentiated from these other types of strategies. Consumers have no familiarity with this concept when choosing medical services, which likely will cause substantial confusion on top of the confusion they are already experiencing simply from encountering the health insurance marketplace for the first time, considering many different types of health plans, and navigating insurance strategies such as narrow networks. With reference pricing, consumers may choose a plan believing a certain provider is in a plan's network only to find out after the fact that the provider is considered out-of-network for certain procedures. A provider's in-network status should be determined by its contracting status and should not fluctuate on a per-service, per-enrollee basis. These distinctions threaten to disrupt patient-provider relationships and coordination of care. Consumers need clarity to determine easily whether a provider is in-network or out-of-network. Notice and comment rulemaking is

necessary to sort through these issues and consider whether other marketplace strategies may achieve the same goals as reference pricing, and be better alternatives for consumers.

Each of the foregoing issues deserves full consideration before the Departments set forth reference pricing policy. Notice and comment rulemaking would ensure that such consideration occurs with meaningful stakeholder input, and we urge the Departments to initiate a rulemaking at the earliest opportunity.

We appreciate the opportunity to provide these comments and look forward to working with the Departments on this important issue. In the meantime, if you have any questions, please contact me or Jeff Micklos, Liz Ward or Katie Tenover of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Rosen". The signature is fluid and cursive, with a large initial "A" and "M".