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HHS Seeks Comments on Reference Pricing

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In a recent answer to a frequently asked question (FAQ), the Departments of Labor, Treasury and Health & Human Services (the Departments) have temporarily indicated that large group health plans may be able to use reference-based pricing strategies without violating the Affordable Care Act (ACA).[2] Reference pricing is a relatively new benefit design approach to reducing plans' claim expenditures. Because reference-based pricing limits the plan exposure through price-based coverage limitations, this approach threatens to reduce provider reimbursement without the plan engaging in provider negotiations. It is thought by some that reference pricing might implicate the ACA's beneficiary protections, particularly the limit on out-of-pocket spending by beneficiaries. The FAQ, however, indicates that the Departments will not enforce the out-of-pocket limit requirements in a way that precludes health plans from using reference-based pricing for the time being. At the same time, the FAQ acknowledges that the practice may be harmful to patients and announces that the Departments may issue guidance on the issue in the future.[3] To that end, the Departments seek comment on the permissibility of the practice and potential standards that might apply to reference pricing strategies. ***Comments are due to E-OHPSCA-FAQ.ebsa@dol.gov by August 1, 2014.***

What is Reference Pricing?

A plan that uses reference pricing defines the maximum amount it will cover for a particular service (e.g., facility fees for hip replacement surgery or imaging), regardless of the allowed amount it may have negotiated with each provider. This is the "reference price" above which enrollees are responsible for any additional costs. If, for example, a plan imposes a 20 percent coinsurance obligation on enrollees and restricts coverage for hip surgery to a reference price of $30,000, an enrollee would be liable for his or her coinsurance obligation based on the reference price ($6,000), up to the plan's out-of-pocket maximum *in addition to* any amount between the reference price and the hospital's allowed amount. A hospital that has negotiated an allowed amount of $40,000 would thus only receive $24,000 from the plan, and the remaining $16,000 would be the enrollee's responsibility. The health plan's enrollees are thus encouraged to seek treatment from a provider who will accept the reference price, and the provider is in turn pressured to adopt the reference price as its allowed amount.

To date, reference pricing has been primarily explored by large, self-funded plans for drugs, imaging, and certain procedures (e.g., colonoscopies and hip and knee replacements). In 2011, the California Public Employees' Retirement System

(CalPERS) adopted reference pricing for hip and knee procedures. CalPERS is the second-largest employer purchaser of health care after the federal government. Over two years, the program reportedly saved $5.5 million dollars, and 85 percent of the savings came from hospitals that cut their prices in order to remain competitive. Safeway Inc., a California-based supermarket chain, has used reference pricing for pharmaceuticals since 2008, and Kroger Co., the nation's largest grocery store chain, uses reference pricing for certain imaging scans. An estimated 12 percent of the nation's largest employers were using reference pricing in 2013. In some instances, plans have asserted that they have taken quality measures into account when developing reference-based pricing strategies. Other plans, however, may exclusively rely on cost data.

Reference Pricing under the Affordable Care Act

The ACA establishes a number of requirements intended to make health insurance affordable and limit patients' cost-sharing obligations. For example, the ACA bans lifetime and annual limits, imposes actuarial value requirements, and limits out-of-pocket spending. Health plans' use of reference pricing may undermine these financial protections in general and raise particular concerns with regard to the ACA's out-of-pocket limits. The ACA places dollar limits of $6,350 (individual) and $12,700 (family) on enrollees' out-of-pocket expenses, even for non-grandfathered, large group and self-funded ERISA plans. Once an enrollee meets the out-of-pocket maximum, the enrollee receives any further covered services without any cost sharing. The Departments' regulations, however, permit health plans to exclude enrollee spending on out-of-network providers from those limits.

The Departments' recent FAQ acknowledges the practice of reference pricing and notes that the Departments intend to issue guidance on reference-based pricing strategies. In the interim, however, the FAQ states that the Departments will not at this time apply the ACA to broadly prohibit reference-based pricing strategies. For now, the FAQ says that plans can treat "providers that accept the reference price as the only in-network providers, provided that the plan uses a reasonable method to ensure that it provides adequate access to quality providers." In other words, if enrollees are responsible for any provider charges above the reference price, those payments need not be counted toward the out-of-pocket limit. The Departments currently do not require that plans limit out-of-pocket spending for care provided by non-network providers. As a result, treating amounts in excess of the reference price as out-of-network costs exposes enrollees to potentially significant cost sharing. Likewise, contracted providers with allowed charges above a reference price face decreased utilization and reimbursement below negotiated amounts.

The FAQ's current approach only applies to large group and self-funded group plans. Non-grandfathered individual and small group health plans, including those offered on the new health insurance exchanges (also known as Marketplaces), are subject to a broader set of consumer financial protections in the ACA. In particular, these non-grandfathered individual and small group plans must cover essential health benefits and cannot impose additional limitations on coverage beyond those set forth in

the benchmark plan. Though it appears that these restrictions would preclude the use of reference pricing by these plans, the Departments have not yet addressed this issue, except to note that these plans are subject to additional requirements.

The FAQ acknowledges that this payment strategy may shift significant costs to patients, undermining the law's broad goals of affordability and access and exposing providers to the risk of non-payment. These concerns are heightened if the health plans fails to ensure that an adequate number of high-quality providers will accept the reference price for a particular procedure. The FAQ currently requires a plan employing reference-based pricing strategies to use a "reasonable method to ensure that it provides adequate access to quality providers." But the FAQ does not explain how the Departments would enforce this broad standard. With these risks in mind, the Departments indicate that they will issue future guidance on the application of out-of-pocket limits to reference pricing arrangements and seek comment on specific standards to protect patients in these circumstances.

At present, the FAQ provides minimal, interim, sub-regulatory guidance on reference-based pricing strategies. Thus, there is an opportunity for stakeholders, including health care providers, to offer comments reflecting the potential impact that reference-based strategies will have on providers and patients.

Even if the Departments' anticipated guidance ultimately attempts to limit the ACA's protections so as to broadly permit reference pricing, plans that employ such strategies may violate the terms of managed care agreements, depending on the contractual language.

Furthermore, the Departments' non-enforcement of the out-of-pocket maximum requirements and any final guidance on this issue may itself be subject to judicial challenge.

We are available to provide advice and counsel concerning the impact of reference-based pricing strategies on clients' managed care relations and to assist clients in supplying comments in response to the FAQ by August 1, 2014.

For additional information, please contact John Hellow or Glenn Solomon in Los Angeles at 310.55.8111; Katrina Pagonis or Felicia Sze in San Francisco at 415.875.8500; or Marty Corry or Keith Fontenot in Washington, D.C. at 202.580.7700.

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[2] Center for Consumer Information & Insurance Oversight, Department of Health & Human Services, FAQs About Affordable Care Act Implementation—Part XIX, p.5 (May 2, 2014), *at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html.

[3] The Departments have not committed to engaging in notice-and-comment rulemaking when issuing future guidance on reference-based pricing strategies. FAQs and other types of subregulatory guidance do not constitute official regulations and are not binding authority.