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FAQ Offers Additional Guidance on Reference-Based Pricing and Out-of-Pocket Maximums

The Departments of Labor, Health & Human Services, and Treasury recently issued an FAQ that provides clarification on how sponsors of non-grandfathered plans that use reference-based pricing may comply with ACA's limits on out-of-pocket maximums. Group health plans that use reference-based pricing, or similar network designs, should review those plans for compliance with this guidance.

Background

For plan years beginning in 2014, non-grandfathered group health plans may not have annual out-of-pocket (OOP) maximums on essential health benefits (EHB) for in-network benefits greater than $6,350 for self-only coverage and $12,700 for coverage other than self-only coverage. These limits are increased to $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage for plan years beginning in 2015.

Prior guidance issued made it clear that plans must apply cost-sharing such as deductibles, coinsurance, copayments, or similar charges for EHB towards the in-network, OOP maximum. It also confirmed that a plan is not required to take into account premiums, non-covered services, balance billed amounts from non-network providers or out-of-network cost-sharing or expenses for non-EHB. (See our March 11, 2014 *For Your Information*.)

Last spring, the Departments of Labor, Health & Human Services, and Treasury (departments) issued FAQs that, among other things, offered guidance on whether and when a plan would be permitted to exclude additional expenses incurred by an individual due to certain medical management techniques from the OOP maximum. In addition to discussing programs that impose additional cost-sharing when an individual uses brand drugs instead of generics and the treatment of amounts balanced-billed by an out-of-network provider, the FAQs also addressed reference-based pricing. (See our June 10, 2014 *For Your Information.*)

Reference-Based Pricing

Reference-based pricing is a medical management technique in which a plan pays a fixed amount for a particular procedure, such as knee replacement, and contracts with providers who agree to accept the fixed amount as full payment. An individual who uses a provider who does not accept it as payment in full will incur additional out-of-pocket expenses.

Although concerned that plans could use reference-based pricing as a subterfuge for imposing limitations on coverage, the FAQ stated that until guidance was issued and effective, a plan would not be deemed to

violate the OOP maximum because it treated providers that accept the reference amount as the only in-network providers, as long as the plan uses a reasonable method to ensure that it provides adequate access to quality providers. Recently, the departments issued FAQs, *About Affordable Care Act Implementation (Part XXI),* offering additional guidance on reference-based programs. This guidance is effective immediately.

Reference-Based Pricing

The FAQ states that pending issuance of future guidance, the departments will consider all facts and circumstances in determining whether a plan that treats providers that accept the reference-based price as the only in-network providers ("accepting providers") and excludes or limits cost-sharing for services rendered by other providers from the OOP maximum is using a reasonable method for ensuring adequate access to quality providers at the reference price. Factors taken into account in the evaluation include whether:

- **The types of services to which reference-based pricing applies are those for which a patient will generally have sufficient time in which to make an informed choice of provider.** The FAQ notes, for example, that it would not be reasonable to limit or exclude cost-sharing from counting toward the OOP maximum with respect to emergency services.
- **Patients will have reasonable access to accepting providers.** Plans should have procedures to ensure that there are an adequate number of accepting providers available. Plans should consider network adequacy approaches developed by states, as well as reasonable geographic distance measures and patient wait times.
- **An adequate number of accepting providers meet reasonable quality standards.**
- **The plan has an easily accessible exceptions process for allowing services rendered by providers that do not accept the reference price to be treated as accepting providers.** An exception might be warranted if a patient cannot access an accepting provider within a reasonable wait time or within a reasonable travel distance, or when the quality of services with respect to a particular individual could be compromised if delivered by an accepting provider.
- **The plan provides certain disclosures on reference-based pricing (or similar network design) to plan participants free of charge.** Information regarding the pricing structure, the services to which it applies, and the exceptions process must be provided automatically to participants — and not just upon request. The FAQ notes that it could be provided through the plan's summary plan description or similar document. Plans also should provide the following upon request:
  - A list of providers that will accept the reference price for each service
  - A list of providers that will accept a negotiated price above the reference price for each service
  - Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards

    Comment. Although the guidance does not limit the use of referenced-based pricing, the fairly prescriptive standards will likely require many plans that use reference-based pricing to credit any employee cost-sharing for non-accepting providers to the in-network OOP maximum. This could limit the effectiveness of these programs in controlling benefit costs.

Similar Network Designs

The FAQ states that the departments will apply the same type of evaluation to "similar network designs." Regulators have confirmed informally that this would include certain types of multi-tiered-network plans. For example, if a medical plan has a narrow first tier of preferred, high efficiency providers, a broader second tier of in-network providers and a third tier of out-network providers, the employee cost-sharing for EHB in the first and second tiers would need to apply towards the in-network, OOP maximum unless the requirements outlined above were satisfied. Hospital network designs that have a first tier of network providers using that hospital and its providers, a second tier that includes the broader carrier network, and a third tier of out-network providers would be similarly affected.

In Closing

Sponsors of plans using reference-based pricing, or similar network designs, should review their programs for compliance with this guidance and either take any needed actions to comply or credit the employee cost-sharing to the plan's OOP maximum.

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