MY BENEFIT ADVISOR

FAQ Issued on ACA: Annual Limits and Referenced-Based Pricing

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Another single frequently asked question ("FAQ"), prepared jointly by the Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, the "Departments"), was issued on October 10, 2014 (the 21st set of FAQs), with respect to the Affordable Care Act ("ACA") requirement of annual limitations on out-of-pocket maximums and referenced-based pricing plan structures.

This FAQ provides additional information in response to the nineteenth set of FAQs issued on May 2, 2014, in which the Departments invited comments from large group market coverage or self-insured group health plans on the application of the out-of-pocket limitation with respect to reference-based pricing structures. The FAQ provides additional detail as to what the Departments will consider to be a reasonable method of reference-based pricing that would not fail to comply with the out-of-pocket maximum requirements.

Background

Effective the first plan year that begins on or after January 1, 2014, all non-grandfathered group health plans must comply with annual cost-sharing limitations on out-of-pocket maximums (also referred to as an annual limitation on cost-sharing – for plan/policy years beginning in 2015, this limitation is $6,600 for self-only coverage and $13,200 for all other coverages).

With respect to an out-of-network provider, the amount in excess of the allowed amount (also known as balance billing) does not have to count toward the out-of-pocket maximum.

Reference-Based Pricing Structures

Reference-based pricing structures refer to a plan payment mechanism where the plan pays a fixed amount for a particular procedure (for example, a knee replacement surgery), which certain providers (who are treated as in-network) accept as payment in full. All others would be treated as out-of-network providers. This type of structure may exist under self-insured group health plans.

An example of a referenced-based pricing structure that exists in the market is the Cost Plus pricing model. The Cost Plus pricing model eliminates the PPO provider network and instead uses an agreed-upon plan pricing structure that may range from 15% to 20% above Medicare reimbursement rates. Participants are allowed the agreed-upon pricing structure for services under the plan, which references the Medicare reimbursement rate. Any cost billed by a provider in addition to this reference-based pricing structure is not paid by the plan and may be balanced billed to the participant.

When will a Reference-Based Pricing Structure not Run Afoul of the Out-of-Pocket Maximum Requirements?

The FAQs provide that, pending issuance of future guidance and for purposes of enforcing the out-of-pocket maximum requirements, the Departments will consider "all the facts and circumstances" when evaluating whether a plan's reference-based pricing design (or similar network design) that treats providers that accept the reference-based price as the only in-network providers and excludes or limits cost-sharing for

services rendered by other providers as using a "reasonable method" to ensure adequate access to quality providers at the reference price.

The FAQ specifies the following factors to be considered as to whether the reference-based price structure is a reasonable method:

1. **Type of service.** Plans should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs. For this purpose:

    a. In general, reference-based pricing should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider.

    b. Limiting or excluding cost-sharing from counting toward the Maximum Out-of-Pocket is not reasonable with respect to emergency services.

2. **Reasonable access.** Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries.

3. **Quality standards.** Plans should have procedures to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

4. **Exceptions process.** Plans should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:

    a. Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time or travel distance).

    b. The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues).

5. **Quality standards.** Plans should provide the following disclosures regarding reference-based pricing (or similar network design) to plan participants free of charge.

    a. Automatically. Plans should provide information regarding the pricing structure, including a list of services to which the pricing structure applies and the exceptions process. (This should be provided automatically, without the need for the participant to request such information, for example through the plan's Summary Plan Description or similar document.)

    b. Upon Request. Plans should provide:

        i. A list of providers that will accept the reference price for each service;

        ii. A list of providers that will accept a negotiated price above the reference price for each service; and

        iii. Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

Employer Action

An employer utilizing a reference-based pricing structure should consult with its TPA to ensure that the plan may satisfy the factors the Departments will use to determine if the reference-based pricing structure uses a reasonable method. Specifically, plans using a reference-based pricing structure must be able to prove that there is access to providers, for all services under the plan, that will accept the reference-based pricing structure.

Employers should also be prepared for additional guidance regarding reference-based pricing structures. The FAQ stated that the Departments will continue to monitor reference-based pricing structures and may provide additional guidance in the future.