ERIC

The ERISA Industry Committee

September 22, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6074-NC
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Request for Information – Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans (CMS-6074-NC) (RIN 0938–ZB31)

To Whom It May Concern:

The ERISA Industry Committee ("ERIC") is pleased to respond to the request for information issued by the Department of Health and Human Services ("HHS") Centers for Medicare and Medicaid Services (CMS) on August 23, 2016, requesting public comments on inappropriate steerage of public health insurance program beneficiaries. ERIC appreciates that HHS is looking into this important issue in the health care sector, and urges CMS to recognize that this is also occurring in the private sector, and to consider how patients enrolled in, and plan sponsors of, private sector group health plans are also adversely affected by similar inappropriate activity.

ERIC'S INTEREST IN THE STEERAGE AND 3RD PARTY PAYER ISSUE

ERIC is a nonprofit organization representing the Nation's largest employers that maintain health care, retirement, disability, and other employee benefit plans covered by the Employee Retirement Income Security Act of 1974 (ERISA). ERIC is the only national association that advocates for large employers on health, retirement and compensation public policies at the federal, state and local levels. ERIC seeks to enhance the ability of its members to provide high-quality health care benefits to millions of active employees, retired employees, and families. These benefits help ERIC members to attract and retain talent and maintain a healthy and productive workforce.

ERIC member companies are on the forefront of efforts to improve health care quality, control costs for plan sponsors and beneficiaries, and protecting the ability of employers to offer health insurance options to employees. ERIC members sponsor self-insured health plans, meaning that while a health insurance company may be contracted with to process claims or manage a provider network, it is ultimately our member companies that are responsible for the costs of the care provided to employees, retirees, and their dependents. Likewise, ERIC member companies pay the majority of plan enrollees' health insurance premiums and health care costs.[1]

It is ERIC's hope that efforts to curb inappropriate steerage of patients in the health care sector will accrue to the benefit of all Americans, including those enrolled in employer-sponsored health insurance plans, those on public programs, and those within the individual and small group markets. Decisions about which health insurance plan to enroll in, or where to obtain medical care, should always center on the best interests of the patient – not on the highest reimbursement

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[1] See Kaiser Family Foundation, "2016 Employer Health Benefits Survey." 14 September 2016. http://kff.org/health-costs/report/2016-employer-health-benefits-survey/ [Sections 6 and 7 speak directly to the high percentage of costs covered specifically by large employers]

for providers. ERIC is committed to preserving the employer-sponsored insurance system, and just as steerage of additional risk can threaten the sustainability of exchange plans, the practice also poses a threat to employer plans' risk pools.

Although this request for information is focused on the Medicaid and Medicare programs, we believe that similar practices and problems are adversely affecting those enrolled in, and sponsoring, plans outside of Medicare and Medicaid. As such, we request that HHS considers what policies and strategies might provide relief to those individuals outside of public programs as well – CMS' leadership often has significant effect outside public programs, and there may also be levers available to curb inappropriate practices across all markets. These comments will detail several examples of situations in which we believe increased oversight and possibly new regulations are needed to protect the rights and care of beneficiaries in both public programs and private health insurance.

COMMENTS

I. CHALLENGES DUE TO THIRD PARTY PAYMENT OF HEALTH CARE COSTS

ERIC members have provided high quality health insurance benefits for employees and their families since long before the Affordable Care Act (ACA). They did so for a variety of reasons including to maximize workforce productivity, reduce employee stress and increase peace of mind, attract and retain the most talented human capital, supplement employee compensation in a way more customizable than salary, reduce turnover, and many other reasons. Major employers also have a desire to make sure employees, retirees, and their families are taken care of.

However, when third parties intervene in the provision of health insurance benefits in a manner that changes the financial balance inherent in the relationship between payers and plan beneficiaries, to the detriment of the health care system, the results can be adverse for the individual being assisted, for other plan beneficiaries, and for the sustainability of the group health plan as a whole. What may appear to be innocent assistance to a patient, may in fact be an effort to change that individual's coverage and caregiving in a way that benefits the third party or others, and not the patient. We know CMS is actively monitoring situations in which providers have funded organizations, and those organizations have steered individuals away from public programs, where provider reimbursement is lower, instead to ACA marketplace plans, where provider reimbursement is higher.[2] But we ask CMS to also consider that the same type of schemes, in which providers and their proxies attempt to steer individuals away from public programs, threaten employer plans as well. Since employer-sponsored health insurance covers well over 100 million Americans, the negative impact of these schemes could have a significant effect on the overall health care system.

II. STEERAGE FROM PUBLIC PROGRAMS TO EMPLOYER-SPONSORED PLANS

One example of how inappropriate third party steerage can threaten employer-sponsored plans is through the COBRA program. As required by law, ERIC members offer COBRA coverage to employees or dependents who have a qualifying life event. In most cases, the costs of COBRA coverage are much higher than the other options an individual might have – enrolling in a public plan, purchasing a plan on an ACA exchange, enrolling in a plan where another member of the family is the primary insured, etc. As such, when an individual's employment status changes, so

[2] Mangan, Dan. "Health providers may be steering people to Obamacare to get higher reimbursement," 18 August 2016, CNBC. http://www.cnbc.com/2016/08/18/health-providers-may-be-steering-people-to-obamacare-to-get-higher-reimbursement.html

too do the incentives to choose a given source of insurance coverage.

ERIC is concerned that some third parties are urging individuals to elect COBRA coverage rather than consider other options, in order to maintain the generous provider reimbursements offered by employer plans. These third parties may then either make COBRA premium payments on behalf of the beneficiary, or "reimburse" the beneficiary for some portion of the costs of the premiums. This drastically changes an individual's incentives to enroll in other coverage, when other coverage might in fact be a better fit for the individual. In some cases, this would cause an individual not to enroll in a public program specifically crafted to provide the right care, in a cost-effective manner, to similarly situated individuals. This can also result in increased risk in the employer plan's risk pool – ultimately increasing costs for all plan beneficiaries.

It's important to consider the source of funding for these arrangements as well. A given third party may indeed have the best interests of patients in mind, while the flow of funds could reveal that the primary driver behind the resources was in fact a change in provider reimbursement.[3] If and when that is the case, CMS should consider consequences for the underlying funders of these schemes, not just the direct participants.

As CMS acts to crack down on third parties steering individuals away from public programs and into the ACA exchanges, ERIC urges that similar practices taking place with employer-sponsored plans be taken into account.

III. SELF-DEALING AND OUT-OF-NETWORK STEERAGE

Another example of the dangers posed by third parties using financial incentives to steer plan beneficiaries is a recent spate of cases in which providers are reducing or eliminating plan beneficiaries' portion of cost-sharing in order to entice them out of network. In recent months, ERIC has been made aware of various instances of providers referring employer-sponsored plan beneficiaries to out-of-network medical facilities, including cases in which the provider has an ownership stake in said facility.[4] Normally this practice would be mitigated by the increased out-of-pocket costs to patients choosing out-of-network facilities. However, it has been demonstrated that the providers or facilities are actually reimbursing patients' out-of-pocket costs, or waiving their costs, in order to make the out-of-network facility a more affordable option to patients than staying in-network.

As CMS is no doubt aware, crafting networks in which providers have agreed to negotiated reimbursement rates is crucial to the operation of group health plans. The existence and integrity of networks is not only a key factor in preserving the affordability of a plan, but is also important for quality-improvement activities, care coordination, data tracking and analysis, and other critical functions of a modern employer-sponsored plan. Preserving the ability of employer plans to craft and utilize provider networks is crucial, and arrangements by which providers can use financial incentives to steer plan beneficiaries to out-of-network facilities severely undermine a plan's ability to use a network.

As employer plans attempt to deal with these schemes, no doubt plans participating in the ACA

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[3] Wilde Matthews, Anna. "UnitedHealth Sues American Renal Associates, Alleging Fraud" 01 July 2016, Wall Street Journal. http://www.wsj.com/articles/unitedhealth-sues-american-renal-associates-alleging-fraud-1467409671 [Nonprofit funded exclusively by dialysis providers, reimbursement for a session $300 under public programs, $4,000 billed to private payer]

[4] Mata, Emma. "The Out-of-Network Battle Heats Up," September 2015, American Bar Association Health Law Section. http://www.americanbar.org/publications/aba_health_esource/2014-2015/september/out_of_network.html

exchanges are also experiencing similar activity. For a given patient, having a reduced or even no copay or coinsurance is very attractive – but for the plan as a whole, an increase in out-of-network utilization means an increase in costs that will ultimately lead to higher premiums or reduced benefits for all enrollees. Further, some plan beneficiaries are likely to experience a reduced quality of care, as one factor plans use in crafting a network is including providers and facilities rated highly in quality metrics.

While CMS is primarily focused on steerage of individuals relating to insurance coverage, we urge that steering of plan beneficiaries to out-of-network providers and facilities also be considered.

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

Sincerely,

Annette Guarisco Fildes
President & CEO