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President and CEO

January 29, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Transparency in Coverage (CMS-9915-P)

Dear Administrator Verma:

Transparency in Coverage

The FAH has frequently expressed its support for efforts to ensure that consumers have access to clear, accurate, and actionable information concerning their copayment, coinsurance, and deductible obligations (collectively “cost-sharing obligations”) and emphasized the importance of payer-focused price transparency efforts that promote meaningful, consumer-friendly price transparency while minimizing the risks to competition. The FAH appreciates that the disclosure of personalized cost-sharing information by group health plans and issuers as described in the Proposed Rule would help further this objective, and we look forward to working collaboratively with the Departments on this shared goal. The FAH strongly disagrees, however, with the additional proposal to require plans and issuers to publicly disclose their negotiated provider rates because the agencies lack statutory authority to mandate the public disclosure of pricing data and the policy could have significant adverse market impacts. ***The FAH, therefore, urges the Departments to focus their efforts on assuring that consumers have access to clear, accurate, and actionable cost-sharing information in collaboration with stakeholders rather than exceeding the bounds of its legal authority and jeopardizing market dynamics by requiring the public disclosure of competitively sensitive information.***

Disclosure of Personalized Cost-Sharing Information

As the FAH has previously noted, it is critically important that payers be included in efforts to promote meaningful, consumer-friendly price transparency while minimizing the risks

to competition. Payer-based price estimator tools are becoming more prevalent among insurers and self-funded employers. Payers can provide this information to their members and beneficiaries without disclosing data more broadly among competing providers or disclosing this data to competing payers. In addition, payers are uniquely qualified to provide patients with precise information concerning any limitations on their coverage, the scope of patient cost-sharing obligations (including out-of-pocket spending limits, deductibles, coinsurances, and any reference-based pricing strategies used by the plan). And, because an episode of care typically involves multiple providers and professionals rather than hospital care alone, the payer is uniquely situated to provide patients with accurate and actionable estimates of their potential financial exposure for an entire episode of care.

The Proposed Rule would require group health plans and issuers to disclose information relevant to an enrollee's cost-sharing liability, including an estimate of the enrollee's expected cost-sharing liability, the accumulated deductible and out-of-pocket amounts incurred by the enrollee to date, and any prerequisites to coverage for the item or service. The FAH supports initiatives designed to provide patients with better access to timely, accurate and personalized information on their expected cost-sharing and other important coverage details, although the FAH opposes the unnecessary disclosure of competitively sensitive provider rates to enrollees. In addition, the FAH supports the Departments' proposal to make patient-specific cost-sharing information available to authorized representatives—which may include health care providers—as well as participants, beneficiaries, and enrollees.¹ Without this information, providers may not have adequate information to fully discuss cost-sharing considerations with patients, and access to this information will enable providers to address patients' interests in reducing and/or planning for out-of-pocket expenditures.

The FAH also supports the inclusion of the plain-language statements concerning the limitations of cost-sharing estimates.² Cost-sharing estimates made before the delivery of care are just that—estimates. The course of care can be unpredictable, and the proposed notices help to ensure that patients are aware of the limitations of estimates provided prior to the delivery of care and can plan accordingly.

Public Disclosure of Negotiated Rates and Allowed Amounts

Although the FAH supports the provision of personalized cost-sharing estimates under the first part of the Proposed Rule, the FAH strongly objects to the Department's proposal to require group health plans and issuers to make their negotiated provider rates publicly available and urges the Departments to not finalize subsection (c) of the proposed transparency in coverage regulations.³ The public disclosure of such competitively sensitive information would confuse rather than assist patients in understanding their potential cost-sharing exposure, and it would unnecessarily disrupt private contract negotiations between providers and health plans. Moreover, the proposal is not permissible as the Departments lack the statutory authority to require the publication of machine-readable data files on negotiated provider rates and the Departments have not articulated a reasoned justification for this onerous and destabilizing

¹ *E.g.*, 84 Fed. Reg. at 65,521 (proposed 45 C.F.R. § 147.210(b)).

² 45 C.F.R. § 147.210(b)(1)(vii).

³ Proposed 26 C.F.R. § 54.9815-2715A(c), 29 C.F.R. § 2590.715-2715A(c), and 45 C.F.R. § 147.210(c).

requirement. Lastly, the proposed public disclosure requirement for negotiated rates is impermissible under the First Amendment as improper, compelled commercial speech.

The Departments Lack Statutory Authority. The Proposed Rule purports to implement section 2715A of the Public Health Service Act, 42 U.S.C. § 300gg-15A, and section 1311(e)(3) of the Affordable Care Act, 42 U.S.C. § 18031(e)(3), but neither statute provides the Departments with the statutory authority to require plans and issuers to make data on negotiated provider rates public. As a preliminary matter, 42 U.S.C. § 300gg-15A “simply extends the transparency provisions set forth in section [18031(e)(3)] to group health plans and health insurance issuers offering group and individual health insurance coverage.”⁴ It does not provide the Departments with any authority to impose *additional* transparency requirements. Instead, the Department of Health and Human Services (HHS) is responsible for implementing coverage transparency requirements for qualified health plans in accordance with 42 U.S.C. § 18031(e)(3), and the Departments’ regulatory authority under 42 U.S.C. § 300gg-15A is confined to requiring group health plans and issuers to comply with those requirements.⁵ On March 27, 2012, HHS adopted 42 C.F.R. § 155.220 as part of the Exchange Establishment final rule, implementing the coverage transparency provisions at 42 U.S.C. § 18031(e)(3)(A) through (C). The Proposed Rule would not amend this coverage transparency regulation⁶ (nor could it in light of the limitations in 42 U.S.C. § 18031(e)(3), described below), but would instead impermissibly add price transparency requirements in separate regulations.

The Departments further lack the statutory authority to adopt the proposed public disclosure requirements under 42 U.S.C. § 18031(e)(3). Section 18031(e)(3) is entitled “Transparency in Coverage” and sets forth types of information that must be publicly disclosed in “plain language” and requires the provision of personalized cost-sharing information to enrollees upon request. Under subparagraph (A) of the provision, plans are required to “make available to the public” eight statutorily enumerated types of information related to coverage (*e.g.*, claims payment policies and practices and enrollment data) and “[o]ther information as determined appropriate by the Secretary.” Subparagraph (B) clarifies that these disclosures must be made in “plain language” that follows “best practices of plain language writing.” Subparagraph (C) sets forth requirements with respect to personalized cost-sharing estimates rather than public disclosures.

In the Proposed Rule, however, the Departments are seeking to require payers to publish a machine-readable data file containing negotiated provider rates. As a threshold matter, the proposed requirement that payers publicly disclose negotiated provider rates does not further the statutory objective of promoting “transparency in *coverage*”—the exclusive focus of section 1311(e)(3). Plans and issuers currently disclose critical information concerning coverage to the public, including their claims payment policies, claims denial data, rating practices, and practices

⁴ 80 Fed. Reg. 10,750, 10,829 n.62 (Feb. 27, 2015).

⁵ Under 42 U.S.C. § 18031(e)(3)(D), the Secretary of Labor “shall update and harmonize” its rules “concerning accurate and timely disclosure to participants . . . with the standards established” for qualified health plans. Like 42 U.S.C. § 300gg-15A, however, this provision confers no additional statutory authority on the Secretary of Labor to impose price transparency requirements.

⁶ 84 Fed. Reg. at 65,483.

and information on cost-sharing and payments with respect to any out-of-network coverage.⁷ This information, unlike the competitively sensitive price information at issue in the Proposed Rule, is properly focused on coverage information relevant to consumers writ large. Moreover, 42 U.S.C. § 18031(e)(3) provides authority to require only “plain language” coverage disclosures. By definition, a machine-readable file does not consist of “language that the intended audience . . . can readily understand and use.”⁸ Rather, per the Proposed Rule, a machine-readable file is “a digital representation of data . . . that can be imported or read by a computer system for further processing without human intervention.”⁹ Machine-readable file formats might include JSON, XML, or CSV,¹⁰ file formats that readily allow competing payers and providers to access the data but that are not accessible or understandable to typical consumers. Because Congress has expressly restricted coverage transparency disclosure to “plain language” disclosures, the Departments lack authority to require the disclosure of machine-readable provider rate data.

The Requirement Would Impermissibly Mandate Disclosure of Competitively Sensitive Rate Information. In addition, the proposed provider rate disclosure requirement is untenable and unreasonable because it is wholly inconsistent with other laws that protect negotiated rates from disclosure. Congress has previously protected the disclosure of trade secrets and confidential commercial or financial information against broad public disclosure under the Freedom of Information Act (FOIA), and the Department’s proposal impermissibly circumvents this statutory protection. Exemption 4 of the FOIA protects “trade secrets and commercial or financial information obtained from a person [that is] privileged or confidential.”¹¹ Negotiated provider rates are a paradigmatic example of confidential commercial or financial information.¹² If Congress intended to authorize disclosure of confidential commercial information protected from disclosure under FOIA, it would have said so plainly, and the Departments’ proposed disclosure requirement for negotiated provider rates is unreasonable. Moreover, the Departments may not compel third parties to do indirectly what the Departments themselves may not do directly.¹³

The Departments’ proposed disclosure requirement is also inconsistent with the Sherman Act, which has protected competition since 1890 and has been interpreted for at least two decades to prohibit health care plans and providers from making fee-related information

⁷ See CMS, Qualified Health Plan Issuer Application Instructions, Appendix C, Transparency in Coverage Template (May 2019), at https://www.qhpcertification.cms.gov/s/Version1.1_FINAL_2020QHPIIssuerInstructions_TransparencyInCoverage.pdf?v=2.

⁸ 42 U.S.C. § 18031(e)(3)(B).

⁹ 84 Fed. Reg. at 65,520 (proposed 45 C.F.R. § 147.210(a)(2)(xi)).

¹⁰ *Id.* at 65,481.

¹¹ 5 U.S.C. § 552(b)(4).

¹² Information is confidential for FOIA purposes if disclosure of the information is likely “to cause substantial harm to the competitive position of the person from whom the information was obtained.” *Nat’l Parks & Conservation Ass’n v. Morton*, 498 F.2d 765, 770 (D.C. Cir. 1974).

¹³ *Cf. Cummings v. Missouri*, 71 U.S. 277, 288 (1867) (“[T]hat what cannot be done directly cannot be done indirectly.”); 82 Fed. Reg. 37,990, 38,499 (Aug. 14, 2017) (withdrawing a proposal to require third parties to disclose confidential survey reports because the proposal “may appear as if [the Centers for Medicare & Medicaid Services] was attempting to circumvent the [statutory] provision” that prohibits the agency from directly disclosing such reports).

available to competing plans and providers. Because the data files of negotiated provider rates that would be required under the Proposed Rule would be publicly available, they would be available to competing plans' providers. The Federal Trade Commission and the Antitrust Division of the Department of Justice have concluded that the disclosure of prospective negotiated rates is "very likely to be considered anticompetitive" under the Sherman Act. In fact, the narrow safety zone for exchanges of price information among providers only applies to third-party surveys based on data at least three months old and where the data is aggregated such that it would not allow viewers to identify any particular provider's negotiated rates. In short, if Congress intended to compel the disclosure of negotiated provider rates when it required disclosure of group health plan and issuer coverage information, it would have done so explicitly because such a policy stands in sharp contrast to long-standing policies and congressional enactments.

The Departments Lack a Reasoned Justification for Requiring the Disclosure of Negotiated Provider Rates. Even if the Departments had the statutory authority to require the public disclosure of negotiated rates, the Proposed Rule fails to provide a rational justification for this proposal and instead relies on flawed reasoning. The Departments assert that (1) uninsured consumers will use payer-negotiated rate information to select their health care providers,¹⁴ (2) consumers will use the information when "evaluat[ing] available options [in the] group or individual market,"¹⁵ (3) public disclosure "is necessary to enable consumers to use and understand price transparency data in a manner that will increase competition, reduce disparities in health care prices, and potentially lower health care costs,"¹⁶ (4) employers that sponsor group health plans will benefit from this information in rate negotiations,¹⁷ and (5) the public information will "assist health care regulators in . . . oversee[ing] health insurance issuers."¹⁸ None of these assertions provides a reasoned justification for the proposal. Rather, each asserted rationale relies on statutorily improper considerations or is otherwise indefensible.

The first four justifications offered by the Departments each focus on altering the market for health care services and are wholly untethered from any interest in furthering "[t]ransparency *in coverage*" under 42 U.S.C. § 18031(e)(3).¹⁹ As discussed above, the Departments have not cited any statutory authority permitting them to mandate the public disclosure of competitively sensitive information for the purpose of interfering in the negotiation of provider rates. Moreover, the disclosure of negotiated provider rates—in contrast to the coverage disclosures

¹⁴ 84 Fed Reg. at 65,477. Notably, the negotiation of rates between hospitals and health plans does not provide much information of use to an individual uninsured consumer. Most uninsured consumers are eligible for financial assistance, and an assessment of the consumer's eligibility for such assistance will be of the greatest value in understanding the consumer's potential financial obligations.

¹⁵ *Id.*

¹⁶ *Id.* at 65,478.

¹⁷ *Id.*

¹⁸ *Id.* at 65,479.

¹⁹ In addition, these four justifications are also unrelated to the needs of consumers of *qualified health plans*. Section 18031(e) sets forth certification requirements for qualified health plans, and as the Departments have previously observed, 42 U.S.C. § 300gg-15a "simply extends the transparency provisions set forth in section [18031(e)(3)] to group health plans and health insurance issuers offering group and individual health insurance coverage." 80 Fed. Reg. 10,750, 10,829 n.62 (Feb. 27, 2015). Thus, any transparency regulations should be based on the needs and interests of qualified health plan consumers and regulators.

required under 45 C.F.R. § 155.220 and the enrollee cost-estimator tool—is likely to confuse consumers instead of promoting informed decision making, as discussed in more detail below.

The Departments’ fifth proffered rationale, which focuses on regulators’ interests, is invalid as well because it does not justify *public* disclosure of highly sensitive and confidential pricing information on the grounds that state insurance regulators might find such information helpful. As a preliminary matter, state insurance regulators already have access to this information,²⁰ making further disclosures unnecessary. In addition, any interest regulators may have in accessing pricing data cannot justify the broad public disclosure of this sensitive data. In other words, the Departments have not presented a reasoned justification for the *public* disclosure of negotiated provider rates.

First Amendment Violation. The compelled disclosure of highly confidential and commercially sensitive provider rate information also violates the First Amendment rights of group health plans and issuers. The First Amendment “imposes stringent limits on the Government’s authority to either restrict or compel speech by private citizens and organizations.”²¹ Under the *Central Hudson* test, government regulation of non-misleading commercial speech is unlawful unless it “directly advances” a “substantial” government interest and is no “more extensive than necessary to serve that interest.”²² Here, the Departments’ proposal to mandate public disclosure of negotiated provider rates does not advance any substantial governmental interest, much less in a narrowly tailored way. First, the Departments can identify no substantial government interest in the disclosure of all negotiated provider rates. It is widely acknowledged that consumers’ interests in provider prices is focused on the consumer’s out-of-pocket costs, not the cost to their health plan. As HHS has recently noted, “consumers of health care services simply want to know where they can get a needed health care service and what that service will cost them out-of-pocket.”²³ The disclosure of negotiated provider rates, on the other hand, is more likely to confuse consumers because their cost-sharing obligations will often be markedly different from the disclosed rates and the disclosed rates shown may by necessity reflect inconsistent assumptions necessary to reduce payment methodologies to set dollar amounts. Moreover, as explained above, the Departments’ proffered justifications for the public disclosure requirement do not provide a cognizable rationale for that requirement, much less articulate a “substantial” government interest. Likewise, even if the government’s interest in the disclosures was substantial, the public disclosure proposed here is not narrowly tailored to that interest because it is extraordinarily broad and burdensome. As the FAH has previously noted, providers and private payers alike rely heavily on the confidentiality of negotiated rates to permit them to negotiate arm’s length rates with other payers and providers. The resulting rates are confidential

²⁰ 84 Fed. Reg. at 65,479 (“The Departments understand, however, that some government agencies may already have access to the information proposed to be made public.”).

²¹ *Am. Meat Inst. v. U.S. Dep’t Agric.*, 760 F.3d 18, 30 (D.C. Cir. 2014) (Kavanaugh, J., concurring).

²² *Central Hudson Gas & Electric Corp. v. Public Service Comm’n of New York*, 447 U.S. 557, 566 (1980). The alternative test articulated in *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985), does not apply in lieu of the *Central Hudson* test. *Zauderer* applies to disclosure requirements reasonably related to the State’s interest in preventing deception of consumers, an interest that is not applicable here. In fact, a machine-readable file of negotiated provider rates is more likely to confuse than inform consumers. In addition, even under *Zauderer*, a disclosure requirement cannot be “unjustified or unduly burdensome,” *id.* at 651, but there is no reasoned justification for the compelled disclosure requirement proposed by the Departments.

²³ 84 Fed. Reg. 39,398, 39,574 (Aug. 9, 2019).

trade secrets that derive value from not being known to competing providers and payers, and the proposed disclosure requirement for payer-specific negotiated rates would infringe upon trade secret protections recognized by Congress, the common law, and many states.²⁴

Medical Loss Ratio (Proposed 42 C.F.R. § 158.221(b)(9))

Lastly, the FAH strongly opposes the proposed amendment to the medical loss ratio (MLR) regulation to permit group health plans and carriers to treat payments to enrollees that obtain care from lower-cost providers as if those dollars had been spent on health care services or activities to improve the quality of care. Proposed 42 C.F.R. § 158.221(b)(9) fails to ensure that consumers' premium dollars are appropriately devoted to the provision of health care services and quality-improvement efforts and is wholly impermissible under the MLR statute.

The rebates required under 42 U.S.C. § 300gg-18 (the "MLR statute") compensate enrollees when their premium dollars are not adequately devoted to "reimbursement for clinical services" and "activities that improve health care quality."²⁵ This is accomplished by calculating a ratio that compares the sum of these expenditures to the "total amount of premium revenue . . . for the plan year," after certain adjustments. If that ratio falls below 85% (in the large group market) or 80% (in the small group market or the individual market), enrollees are entitled to a rebate on a pro-rata basis.²⁶

The proposal to amend 45 C.F.R. § 158.221 would expand the scope of activities an issuer may include in the MLR "numerator" in a manner that is directly contrary to the statutory scheme. In particular, the proposed rule would allow an issuer to count "savings they share with enrollees" in the MLR numerator.²⁷ As examples, the Proposed Rule points to plan designs by which an enrollee can share in the health plan's savings if the enrollee selects a lower-cost provider; these are commonly referred to as reference-based pricing schemes, because the enrollee is encouraged to choose a provider that will accept less than the plan's "reference" price for a particular procedure or service.²⁸ The Proposed Rule indicates that "HHS is of the view that such unique plan designs would motivate consumers to make more informed choices by providing consumers with tangible incentives to shop for care at the best price."²⁹

²⁴ These rates constitute trade secrets under 18 U.S.C. § 1839(3) (defining trade secret to include "all forms and types of financial, business, scientific, technical, economic, or engineering information, including . . . compilations, . . . formulas, [or] methods . . . , whether tangible or intangible, . . . if (A) the owner . . . has taken reasonable measures to keep such information secret; and (B) the owner derived independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable through proper means, by another person who can obtain economic value from the disclosure or use of the information"), under the Uniform Trade Secrets Act (defining trade secret as "information, including a . . . compilation [or] method . . . that: (i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use, and (ii) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy"), and the Restatement of Torts sec. 757, cmt. b (setting forth various factors to determine whether a trade secret exists, including the extent to which the information is known outside the business, the measures taken to guard the secrecy of the information, the value of the information to the business and its competitors, and the ease or difficulty with which the information could be properly acquired or duplicated by others).

²⁵ 42 U.S.C. § 300gg-18(a).

²⁶ 45 C.F.R. part 158.

²⁷ 84 Fed. Reg. at 65,489.

²⁸ *Id.*

²⁹ 84 Fed. Reg. at 65,489.

Inclusion of these “shared savings” in the MLR numerator, however, runs contrary to the text and purpose of the statutory MLR requirement, and the statutory MLR scheme cannot be subverted to incentivize these plan designs. The MLR requirement is “intended to help ensure policyholders receive value for their premium dollars.”³⁰ But, this proposal would allow issuers to spend *less* on their enrollees’ care and quality initiatives without returning the premium dollars saved to all enrollees as required by the statute. By definition, these “shared savings” are *not* spent on “reimbursement for clinical services provided to enrollees,” and cannot be included in the numerator under 42 U.S.C. § 300gg-18(a)(1). In addition, these shared savings are not designed to promote quality, and in fact may compromise quality of care by driving consumer choices based on shared savings without regard for quality. Thus, shared savings cannot constitute expenditures on “activities that improve health care quality” under 42 U.S.C. § 300gg-18(a)(2).

The Proposed Rule does not argue that the “shared savings” constitute reimbursement for clinical services or activities that improve quality. Instead, HHS urges that it has the flexibility to incorporate these “shared savings” payments in the MLR numerator in order to ensure under subsection (c) of the MLR statute that the MLR methodologies “take into account the special circumstances of smaller plans, different types of plans, and newer plans.”³¹ The MLR exception set forth in the Proposed Rule, however, would be applicable to *any* plan that shares savings with enrollees, and is thus not designed to address the “special circumstances of . . . different types of plans.”³²

As noted in the Proposed Rule, modifications have previously been made to the MLR methodology to accommodate “mini-med” plans, “expatriate” plans, student health insurance plans, qualified health plans that incurred Exchange implementation costs, “grandmothered plans,” new plans, and smaller plans.³³ In each case, however, the modifications that were made were directly tied to the plan’s size, age, or type, consistent with the statutory language. For example, mini-med plans have an “unusual expense and premium” structure, while expatriate plans face higher administrative costs associated with operating internationally.³⁴ Similarly, the regulatory demands during the initial launch of the Exchanges imposed additional administrative costs on Marketplace plans that were addressed through temporary adjustments to the MLR methodology for these plans.³⁵ Thus, the methodological adjustments addressed situations where the market served and/or regulatory structure rendered the default MLR methodology inappropriate or unreliable, and HHS properly exercised its authority to vary the MLR methodology to take into account the “special circumstances” of a particular category of plan. No such special circumstances are present here: any plan can elect to return shared savings to an

³⁰ 75 Fed. Reg. 74,864, 74,865 (Dec. 1, 2010).

³¹ 42 U.S.C. § 300gg-18(c). Notably, this provision requires the National Association of Insurance Commissioners (the “NAIC”) to establish standardized methodologies, but the Proposed Rule makes no reference to any NAIC activities. In fact, it appears that the NAIC has made no recommendation to modify the standardized MLR methodologies to account for shared-savings benefit structures.

³² *Id.*

³³ 84 Fed. Reg. at 64,589 nn.84-89 (describing modifications to the MLR methodology for mini-med plans, expatriate plans, student health plans, early Marketplace plans, “grandmothered” plans, new plans, and smaller plans).

³⁴ 75 Fed. Reg. at 74,871 – 72.

³⁵ 79 Fed. Reg. 30,240, 30,320.

enrollee through a reference-based pricing scheme or otherwise, and the option to adopt this benefits structure is available to plans of all types, regardless of size or age. Thus, no modification to the MLR methodology is permitted for shared savings reimbursements.

In the end, the proposed amendment to the MLR regulation does not “ensure policyholders receive value for their premium dollars” and would instead reward issuers for spending less on their enrollees’ care, undermining the core goals of the MLR statute.³⁶ Rather than distributing excess premium dollars to enrollees on a “pro rata basis” as required by statute,³⁷ the proposal would permit plans to share excess premium dollars with those enrollees that elect to receive care from lower-cost providers. Not only is this discriminatory in nature, and potentially in conflict with the prohibition on discriminatory premium rates under 42 U.S.C. § 300gg,³⁸ but it may also result in enrollees receiving lower-quality care based on the availability of shared savings payments.

The FAH appreciates the opportunity to comment on the Proposed Rule. We look forward to continued partnership with the CMS as we strive for a continuously improving health care system. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,



³⁶ 75 Fed. Reg. at 74865.

³⁷ 42 U.S.C. § 300gg-18(b)(1)(A).

³⁸ Observers have noted that plans using reference-based pricing schemes may discourage enrollment by sicker or high-cost enrollees if the plan design disfavors enrollees’ use of high-cost providers. David Frankford & Sara Rosenbaum, *Go Slow on Reference Pricing: Not Ready for Prime Time*, Health Affairs Blog (March 9, 2015), at <https://www.healthaffairs.org/doi/10.1377/hblog20150309.045147/full/>.