ERIC | THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

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Attention: CMS–9915–P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244–8010

RE: Comments on Proposed Transparency In Coverage Regulations

To Whom It May Concern:

The ERISA Industry Committee ("ERIC") is pleased to submit the following comments in response to the Notice of Proposed Rulemaking ("NPRM"), setting forth proposed requirements for group health plans and health insurance issuers in the individual and group markets to disclose information about (1) specific cost-sharing information for plan- and policy-holders, (2) the health plan's and policy's negotiated in-network rates, and (3) health plan's and policy's "historical" payments to out-of-network providers.

ERIC'S INTEREST IN THE NPRM

ERIC is the only national trade association that advocates exclusively on behalf of large employers on health, retirement, and compensation public policies on the federal, state, and local levels. ERIC's member companies offer comprehensive group health benefits to their employees in compliance with the myriad federal laws including the Internal Revenue Code ("Code"), the Employee Retirement Income Security Act ("ERISA"), and the Public Health Service ("PHSA"). ERIC member companies operate in every industry sector, and regulators are likely to engage with an ERIC member company when they drive a car or fill it with gas, use a cell phone or a computer, visit a bank or hotel, fly on an airplane, watch TV, benefit from our national defense, go shopping, receive or send a package, use cosmetics, or enjoy a soft drink. ERIC supports the ability of its large employer member companies to tailor retirement, health, and compensation benefits to meet the unique needs of their workforce, providing benefits to millions of workers, retirees, and their families across the country.

ERIC member companies adhere to a simple tenet: Transparency is good both to reduce health care costs and to improve the quality of care. We continue to cope with health care costs that rise at an unsustainable rate and believe that disruption is critical in order to change this dynamic. To put things into perspective, the Kaiser Family Foundation ("KFF") recently revealed that the cost of a "family" employer-sponsored health plan is now close to $20,000

($19,616 to be exact).[1] KFF also indicated that the average deductible for an employer-sponsored plan has doubled since 2008. Premiums also went up 55 percent since 2008, even though during the past five years, premiums for employer plans have only gone up by 3 to 4 percent. For 2018, premiums for employer plans went up by 5 percent.

In short, the continued increases in health care costs cannot continue without seriously jeopardizing the viability of the employer-sponsored health insurance system. ERIC member companies know it, policymakers know it, and even the powerful stakeholders in the health care industry know it. ERIC member companies are embracing disruptive, innovative policy reforms because to do otherwise is to court the advance of a government-run system in which prices are held at bay by fiat, rather than by market forces. In our opinion, if the cost trend is not moderated, policymakers may – in time – adopt more drastic measures like "government price controls" to address this unrelenting problem.

In order to maintain a private, market-driven health care system, we need to incorporate value-based care strategies into our health care infrastructure. Key to all value-based care strategies is increasing the transparency of medical prices. For far too long, our health care system has been opaque, to the detriment of employers who are committed to keeping their employees healthy and productive, and to the detriment of employees who often times face the dilemma of paying for medical services or foregoing much-needed health care to pay for life's other necessities.

For this – and many other – reasons, we support the Administration's efforts to increase the transparency of medical prices. Specifically, we support the disclosure of (1) a participant's cost-sharing liability for a particular medical item or service, (2) the negotiated in-network rates for medical items and services covered under the plan, and (3) the "historical" payments made by the plan to out-of-network providers.

ERIC also notes that the information the Administration wishes disclosed, is information held primarily by insurance carriers. ERIC's member companies retain and rely on insurers to build their health plan networks and negotiate prices with providers. To the greatest extent possible, the Departments should endeavor to apply rules, requirements, and liability associated with price transparency to insurers and carriers, rather than develop a regime intended to penalize employers based upon the actions of insurance companies. Our comments will expand upon this.

COMMENTS

A. ERIC Believes that the Departments Have the Authority to Develop and Issue the Proposed Regulations

[1] Kaiser Family Foundation, *2018 Employer Health Benefits Survey* at https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/.

The Affordable Care Act ("ACA") added Section 2715A to the Public Health Service Act ("PHSA"), requiring fully-insured and self-insured "group health plans" to disclose, among other things, information on cost-sharing and payments with respect to any out-of-network coverage. PHSA section 2715A also requires fully-insured and self-insured "group health plans" to help their participants learn about the amount of cost-sharing the participants would be responsible for through an internet website. In addition, PHSA section 2715A gives the Department of Health and Human Services ("HHS") the authority to determine "other appropriate information" that could – and should – be disclosed to "group health plan" participants through an internet website. Note that PHSA section 2715A accomplishes all of this by cross-referencing the requirements under ACA section 1311(e)(3), which is a "certification" requirement for "individual" market plans sold through an ACA Exchange.[2]

The previous Administration never implemented these requirements. The current Administration, however, can appropriately rely on this statutory language as the basis for requiring self-insured plans, as well as fully-insured "individual" and "group health plans," to disclose to participants – through an on-line "self-service tool" – specific cost-sharing information for medical items and services covered under the plan. In addition, in accordance with HHS's authority to determine "other appropriate information" that could – and should – be disclosed to participants, the Departments determined that it would be appropriate to require self-insured plans, as well as fully-insured "individual" and "group health plans," to disclose their negotiated in-network rates, along with their "historical" payments to out-of-network providers, on public websites.

A strong argument can be made that the Departments have a clear basis for imposing these disclosure requirements on self-insured health plans, as well as fully-insured "individual" and "group health plans." In addition, it is reasonable to suggest that HHS is merely interpreting and implementing a statute (i.e., the ACA) that it has the exclusive authority to interpret and implement. We further believe that (1) HHS's interpretation of the ACA is reasonable, and (2) the Departments have rationally explained why they developed the proposed requirements.

A strong argument can also be made that the Departments are not exceeding their statutory authority when developing and issuing the proposed regulations. In many respects, the information that must be disclosed under the proposed regulation is information that must currently be included in an Explanation of Benefits ("EOB") and/or a Summary of Benefits and Coverage ("SBC"), which are already required under the law.[3] In our opinion, the Departments are merely requiring that this same information be disclosed through a different medium (i.e., an internet website) and in different formats (e.g., customized cost-sharing information based on specific inputs of information from a participant).

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[2] Also note, the requirements under Section 2715A of the Public Health Service Act ("PHSA") are incorporated by reference into the Employee Retirement Income Security ("ERISA") and the Internal Revenue Code ("Code"). *See* ERISA section 715 and Code section 9815.

[3] *See e.g.*, PHSA sections 2719 and 2715.

B. Low-Deductible Beneficiaries Must Be Equipped With Information to Help Them More Efficiently Utilize Health Care

Employees enroll in lower deductible health plans for a myriad of reasons. For example, despite the higher premium costs relative to a high-deductible health plan ("HDHP"), some employees choose lower deductible plans because they are "risk-averse" (and they would rather pay a higher premium in exchange for limits on their out-of-pocket exposure). In other cases, employees are high-medical utilizers (because, for example, the employee has a health condition, or a member of their family is in need of medical services).

Despite being protected from much of the cost of a particular medical service, employees enrolled in a low-deductible health plan need access to information to help them more efficiently utilize their health care. Specifically, while these employees may have limited out-of-pocket exposure due to the low-deductible health plan, the amount of health care they utilize in a particular year affects the premium increases they will see in the following year (because a plan's health care trend in a particular year determines whether premiums must go up – and to what extent they must go up – in the following year).

These year-over-year premium increases could be mitigated if low-deductible beneficiaries are given more information about the cost of the health care they utilize. For example, disclosing the cost of a particular in-network medical item or service is one way of revealing the true market price of their care. This could allow a beneficiary to compare the cost of a particular medical item or service that is provided by various in-network providers, and the beneficiary may choose the provider that provides the medical item or service at a lower cost. This would result in a reduction in the plan's overall health care trend even if beneficiaries are utilizing the same amount of health care in a particular year. Not all plans may (initially) include significant incentives to compel plan beneficiaries to choose the highest value (best quality and price) provider or service in every given circumstance; however one thing is abundantly clear – if patients lack clarity of medical prices, there is virtually no possibility, much less incentive, to lead them to seek higher value.

Arguments can be made that even with increased disclosure of medical prices, the behavior of low-deductible beneficiaries will not change (and thus, a plan's overall health care trend will not improve). Arguments can also be made that because low-deductible plan beneficiaries have limited out-of-pocket exposure, beneficiaries may choose a higher cost provider because they feel this provider provides better "quality" due to the higher price (in this case, health care costs will go up). ERIC member companies do not ascribe to these beliefs, and these possibilities are not sufficiently likely to justify maintaining the opaque status quo. Indeed, a stronger argument can be made that increased transparency could – in time – produce a positive result (i.e., lower health care costs), whereas, the status quo will simply foster the continued unsustainable increases in health care costs. Stated differently, doing nothing ensures no reduction in health care costs, whereas increasing the transparency of medical prices at least gives plan sponsors and beneficiaries an opportunity to better manage the cost of the health care that is utilized and make employees and their families better consumers of health care.

C. HDHP Beneficiaries Need More Information to Be Better Consumers of Health Care

Over the past two decades, employers have experimented with HDHPs. Some employers have chosen a "full-replacement strategy," where the employer offers only HDHPs to its employees. Other employers have opted for offering their employees a choice between lower deductible health plans and HDHP options.

The shift toward HDHPs was driven largely by the ever-increasing cost of health care. Specifically, as a way of managing increased costs – and as a way of keeping premium increases relatively modest for their employees – employers have been forced to shift more and more health care costs onto their employees and require employees to get engaged in cost-containment. HDHPs offer employers an avenue to do both – but their effectiveness depends upon employee engagement, and sufficient information available for employees to truly make informed decisions.

Employers continue to be faced with the dilemma of how to provide quality, affordable health care coverage to their employees. Economic data suggests that employees are unable to absorb further cost increases, especially not at the unsustainable rate of growth in the current system. As a result, employers are forced to look for alternative plan design strategies and policy proposals that could change the current dynamic without simply raising employees' premiums and deductibles and hoping for the best.[4]

ERIC member companies understand that their employees are at a breaking point (i.e., plan sponsors realize that there is a limit to the costs their employees can bear). If costs cannot be controlled, employers worry that employees will forego health coverage altogether, adding to the ranks of the uninsured and increasing the cost of coverage for those employees who stay enrolled in their employer-sponsored plan. Or beneficiaries could forego needed care, saving small sums in the short-term, but leading to much higher costs later due to hospitalizations, unmanaged chronic illness, and other complications that could have been avoided.

The rise in HDHPs was also based on the theory that if employees are required to pay a greater portion of their health care costs, these employees will become better consumers of health care. Studies have shown that HDHPs have indeed reduced health care utilization for "low-value" medical services, which is a positive result.[5] However, studies have also shown that HDHPs have resulted in employees foregoing "medically necessary" medical services, which is a concerning result.[6]

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[4] The Board of Governors for the Federal Reserve Board https://www.federalreserve.gov/publications/2018-economic-well-being-of-us-households-in-2017-dealing-with-unexpected-expenses.htm
[5] *See* RAND Corporation, Analysis of High Deductible Health Plans at https://www.rand.org/pubs/technical_reports/TR562z4/analysis-of-high-deductible-health-plans.html.
[6] *Id*.

A strong argument can be made that those employees who have foregone certain "medically necessary" services, have done so because they were not equipped with the necessary information to understand the financial commitment associated with this much-needed care. In other words, HDHPs have not failed employees who may have foregone "medically necessary" services; rather, employees lacked the appropriate amount of information needed to fully understand the out-of-pocket financial commitment that is required for their much-needed care.

Increasing the transparency of medical prices – and in particular, the cost-sharing liability associated with a particular medical item or service – will likely address this problem, and allow HDHP-beneficiaries to utilize "medically necessary" services, while also refraining from over-utilizing other "low-value" health care services. This will help bend the cost curve downward, while ensuring that employees access the health care that they need (so as to reduce the probability of a medical condition worsening and resulting in higher costs in the long run).

It cannot be overstated: there are roughly 22 million Americans currently enrolled in HDHPs.[7] For those Americans, there is no distinction between negotiated rates and out-of-pocket costs, at least not until they have spent up to their deductible. And for those Americans not enrolled in an HDHP, they will be unable to make an informed choice of health insurance plan if they cannot consider what their financial liabilities would be during that pre-deductible period should they choose an HDHP. In other words, arguments that transparency of negotiated rates are unnecessary, and all that is needed is disclosure of copay amounts, fall flat.

D. Both Low-Deductible and HDHP-Beneficiaries Need Information to Access Low-Cost, High-Value Medical Items and Services

Over the past decade, public- and private-sector employers have been experimenting with ways to incentivize their employees to (1) seek out low-cost, high-value services, and (2) shop for the best price for a particular medical item or service. The "incentive" is typically in the form of a "reward" that is given directly to an employee who seeks out a low-cost, high-value service, or the "reward" equals the amount of "savings" that the employee generates by choosing lower-costing care.

Both public- and private-sector employers have also encouraged their employees to seek out (1) low-cost, high-value services, and (2) the most cost-effective provider by reducing or eliminating the cost-sharing for a particular medical item or service. In this case, if an employee chooses a particular provider or prescription drug that the employer has identified as (1) low-cost, high-value or (2) low-cost relative to alternative options, the employer will reduce or

[7] The America's Health Insurance Plans ("AHIP") reported that as of January 2017, nearly 21.8 were enrolled in a high deductible health plan ("HDHP") at https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf. The Centers for Disease Control and Prevention reported that in 2016, 39.4 percent of individuals with private coverage were enrolled in an HDHP, increasing to 43.2 percent in 2017 at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201802.pdf?utm_source=STAT+Newsletters&utm_campaign=890c6d2626-MR&utm_medium=email&utm_term=0_8cab1d7961-890c6d2626-150494645.

eliminate any cost-sharing that an employee would otherwise be required to pay for the medical item or service covered under the plan. This plan design element exists in all employer-sponsored plans, although HDHPs are subject to some limitations before a beneficiary's deductible is met.

To maximize the efficiency and the cost-saving potential associated with both of the above described strategies, both low-deductible and HDHP-beneficiaries need access to information about the cost of a particular medical item or service. These beneficiaries also need access to information about the cost-sharing liability associated with a medical item or service provided a particular medical provider. Otherwise, employees will not be able to effectively enjoy the savings that their employers offer them under their health plan. And, employers will not be able to enjoy the potential reduction in health care costs that could otherwise be achieved under these strategies.

As such, ERIC member companies believe that limiting an employee's access to information about medical prices and cost-sharing liability will actually increase health care costs (because – as discussed more fully below – the above described strategies have been tried and proven to reduce the cost of health care for both employers and their employees). In addition, by publicly disclosing negotiated in-network rates, third parties can "mine" this information to develop on-line consumer tools that employers can use to more effectively implement the above described strategies. For example, these same third parties can work directly with employers to disclose the cost-sharing liability for the medical items and services offered under the plan. Or, these third parties can offer employers and their employees a customized, user-friendly comparison-shopping tool so employees can find the lowest cost, highest quality providers. It is a win-win: employers benefit because they can reduce health care costs, and employees will benefit from the incentives and shared-savings offered under the plan, all while obtaining quality health care.

E. With Transparency, Health Care Costs Will Likely Go Down, Not Up

Arguments have been made that increased disclosure of cost-sharing liability and negotiated in-network rates will result in health care costs going up, not down. We disagree.

On the one hand, we see merit in the argument that health care costs could go up if there are multiple providers in a geographic location. For example, currently, a particular provider in a geographic area may not know the prices which other providers in the same geographic area have negotiated with a particular insurance carrier or self-insured plan. And in this case, a provider may be under-charging for a particular medical item or service, while other providers in the area may be over-charging for the same medical item or service. If the provider that is under-charging now knows what other providers in their area are charging – because carriers and plans now have to disclose their negotiated prices – then maybe this provider would attempt to increase the amount they are charging, to be closer to what their competitors are charging. This would definitely increase health care costs.

But this same dynamic could cause costs to go down if outlier providers are over-charging for services. Upon seeing the competitive disadvantage they are in (especially with publicly available information about their prices), these providers are likely to reduce their prices to get closer to the mean. As a result, we question whether providers would err on the side of increasing prices to "match" outlier, expensive competitors. Instead, it is likely that providers would seek to compete with other providers operating in their area by lowering the amounts they charge for particular medical items and services, under the same competitive pressures that cause ERIC member companies to lower the costs of the goods and services they provide.

For example, as plan sponsors that negotiate with providers for the best rates, we understand that health providers generate revenue in one of two ways: (1) by charging higher prices for certain medical items and services, or (2) by increasing their volume. If we, as plan sponsors, know that a particular provider that we are contracting with is over-charging our plan participants for certain medical items or services, we seek to take our business elsewhere. In other words, we would likely choose to end our contract with this provider, and contract with a provider who charges more reasonable rates while delivering the same quality of care. In this case, the provider who is over-charging would lose volume, and thus lose revenue. Economics 101 tells us that this over-charging provider would opt to lower his or her rates so as to maintain (or even increase) the number of lives who are coming through their doors and utilizing their services. To do otherwise would be against the provider's best financial interests. The end result: A reduction in health care costs.

We are also skeptical of the argument that increased disclosure of medical prices will cause health care costs to increase, because we have not seen any data that indicates that costs will go up. To the contrary, in cases where an employer voluntarily provided their employees with "smart shopping" tools, data indicates that costs went down for certain medical items or services.

For example, as the preamble of the proposed regulations explains, the State of Kentucky (as an employer) offers its employees who are enrolled in the State's employer-sponsored health plan the ability to access a price transparency tool that allows these employees to shop for health care services.[8] If a State employee seeks out lower-cost care, the employee is able to share in any cost-savings that may be produced. Over a 3-year period, 42 percent of eligible employees used the program to look up information about prices and rewards, and 57 percent of these employees sought out lower-cost care, resulting in $13.2 million savings for the plan (which is funded by taxpayer dollars) and $1.9 million in cash rewards to eligible employees.

The State of New Hampshire adopted a similar program for its State employees. Here, employees were able to take advantage of an "incentive" program that provided financial rewards to employees who used a "transparency tool" to choose low-cost, high-value services.[9] Over a 3-year period, the program saved $12 million for the plan, and employees received over $1 million in rewards. New Hampshire also created a website that allows all consumers with

[8] 84 Fed. Reg. 65464, 65466 (Nov. 27, 2019).
[9] *Id.*

private health insurance to compare health care costs and quality for specified medical services. Researchers have found that this transparency tool reduced the cost of medical imaging procedures by 5 percent for patients (about $8 million in savings) and 4 percent for insurance carriers ($36 million in savings).

Although we do not have specific data points, we know that most ERIC member companies provide their plan beneficiaries access to price and cost-sharing information for covered medical items and services, which has produced savings similar to what we are seeing in the public-sector. We also know of ERIC member companies that offer their employees similar "incentive" programs through their self-insured health plan. The bottom-line is that there are concrete examples where increased transparency has reduced costs and produced savings for consumers. We have yet to see studies showing that costs have gone up, like many critics of the proposed regulations are suggesting.

F. Transparency Need Not Increase the Threat of Litigation for Plan Sponsors

Some have claimed that disclosing a participant's cost-sharing liability and/or disclosing the plan's negotiated in-network rates will expose the plan sponsor to potential lawsuits filed by plan participants. For example, concerns have been raised that if the disclosure of cost-sharing liability for a particular participant is incorrect (by mistake or otherwise), this could generate litigation against the plan sponsor. Also, the disclosure of negotiated in-network rates could equip the "plaintiff's bar" with information that could be used against plan sponsors in various class action lawsuits under other Federal laws.

While we recognize that there is always a possibility of litigation when the plan sponsor is required to communicate specific plan-related information to their participants (due to potential mistakes or for good faith compliance errors), an equally strong argument can be made that plan sponsors should be concerned about being sued for a fiduciary breach for failing to increase the transparency of prices of the medical items and services covered under the plan. Specifically, plan sponsors are under a fiduciary duty to "*defray expenses under the plan*."[10] If the use of transparency tools and the disclosure of the cost of certain medical items and services have been found to produce savings for the plan and for plan participants (as discussed above), an argument can be made that failing to increase the transparency of medical prices is a failure to defray expenses under the plan.

In addition, in accordance with the fiduciary duty requiring plan sponsors to "*act in the best interest of plan participants*,"[11] an argument can be made that plan sponsors have a fiduciary duty to inform their participants of their out-of-pocket liability for a particular medical item or service. To do otherwise, the plan sponsor is limiting the participants' capacity to make sound financial decisions and could be accused of exposing participants to surprise medical bills that could have otherwise been avoided, had the participant known of the cost-sharing liability associated with a particular medical service.

[10] Section 404(a)(1)(A)(ii) Employee Retirement Income Security Act ("ERISA").
[11] ERISA section 404(a)(1)(A)(i).

We note that these types of claims of fiduciary breaches would likely be unsuccessful. But the threat of litigation goes both ways; there may be a threat of increased litigation if plan sponsors are required to disclose more information to beneficiaries, but there could also be a threat of litigation for failing to disclose information to participants.

In recent years, the plaintiff's bar has launched a number of lawsuits against employers over their retirement benefit plans. These lawsuits have often accused employers of failing in their fiduciary duties by failing to disclose, or failing to provide sufficient diligence in controlling costs under the plan. While this litigation has not (yet) spread to employer-sponsored health benefits, that possibility does exist. And the opacity of the current system could be a weapon used against employers, accusing them of colluding with vendors (such as carriers or pharmacy benefit managers) to conceal the real costs of the plan. The Administration's proposed rule would preempt this line of argument, mooting a bevy of potential litigation before it ever gets off the ground – and doing so in a way that benefits patients, rather than trial attorneys.

Lastly, arguments have been made that plan sponsors could be disadvantaged by increased government enforcement. However, as we have seen in the past, when a particular Administration is implementing a law or regulation that achieves the Administration's policy goal, the Administration is more interested in ensuring compliance with the law, rather than imposing penalties for non-compliance with the law (provided non-compliance is not willful). In the context of health care, implementation of the Affordable Care Act is a perfect example of this approach, and we would expect and request a similar approach to implementing and enforcing the proposed regulations, should they be finalized.

Importantly, the Departments should extend the same protections afforded to employers sponsoring fully-insured plans, to those sponsoring self-insured plans, who contract out the building of networks and negotiation of prices to an insurance carrier or other third-party administrator (TPA). Employers with self-insured plans who have contracted with a TPA to administer said plan and process claims, should be able to rely on their TPA to do the necessary reporting – indeed, the NPRM already proposes to allow fully-insured plans to rely on the issuers of their plans for this. The NPRM should clarify that self-insured employers relying on TPAs to comply with this rule should not be subjected to extra expenses for the compliance assurance and should not be at risk of a compliance violation if their TPA makes a mistake. Since TPAs that are insurance companies (constituting the vast majority) would already carry that responsibility for their fully-insured clients, they would experience a minimal burden in doing the same for their self-insured clients. Those employers who have acted in good faith to contract with their TPA to comply with the reporting requirements should be held harmless with respect to compliance obligations and liability under this regulation. We suggest the following changes to the text:

> *(3) Special rule to prevent unnecessary duplication with respect to group health coverage. To the extent coverage under a group health plan consists of group health insurance coverage* ***or the plan sponsor uses a third-party administrator****, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance*

*issuer offering the coverage **or the third-party administrator implementing the plan**, to provide the information pursuant to a written agreement. Accordingly, if a health insurance issuer **or third-party administrator** and a plan sponsor enter into a written agreement under which the issuer **or third-party administrator** agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer **or third-party administrator**, but not the plan, violates the transparency disclosure requirements of this paragraph (b).*

G. The Proposed Rule Would Entail No "Price Fixing," No Required Disclosure of "Trade Secrets," and No Abrogating a Private Contract

Arguments have been made that if, for example, negotiated in-network rates are disclosed, providers will collude to charge even higher prices. Although there is always a chance for members of a particular industry to purposefully share information with each other with the intent to develop above-market prices, long-standing antitrust laws prohibit this type of behavior. We see no reason why existing antitrust laws would not prevent this type of behavior if negotiated in-network rates are required to be made public. The Federal government has a proven track record of cracking down on monopolistic behavior, regardless of which party holds the White House. In this case, we would encourage the Administration to include coordination with the Federal Trade Commission and other appropriate federal and state authorities to monitor health care provider markets for any incidences of collusion, and to prosecute violations that raise costs for patients and plan sponsors, to the fullest extent of the law.

Arguments have also been made that by requiring the disclosure of negotiated in-network rates, the Federal government is requiring the disclosure of "trade secrets." As plan sponsors that negotiate with providers and contract with carriers to develop the prices for the medical items and services covered under our self-insured health plans, we understand that there are negotiating tactics that should be protected. However, we also understand that disclosing our plans' negotiated in-network rates – as required under the proposed regulations – is akin to disclosing the "sticker price" for a particular medical item or service. In no way are we divulging our negotiating tactics when we disclose negotiated "sticker prices." As a result, we do not accept the argument that the proposed regulations are somehow requiring the disclosure of "trade secrets."

Nor do we accept the argument that the proposed regulations are somehow abrogating a contract that is negotiated between two private parties because much – if not all – of the information that must be disclosed under the proposed regulations is information that is already disclosed through an EOB or SBC, which as discussed above, is already required under the law.

It is a fallacy to characterize negotiated rates as private information that only flows between a plan or plan sponsor and provider. There are a bevy of actors that participate in the process, that process and use the data, and that rely and depend upon it. While this includes carriers acting as third-party administrators, the most important third party in this process is the patient. And all involved have ceded that the patient does indeed have a right to know what their costs will be – real or potential. It begs the question then, whether information that is already

owed to thousands or millions of people, can be considered in any way "secret." Further, often times this information is critical to individuals who are not currently beneficiaries under a given plan – when, for instance, a new hire is choosing whether or not to enroll in their new employer's health plan, or during open enrollment when an employee is choosing between plans, or even when a potential employee is choosing between employers. We believe that arguments calling for this information to be kept from individuals in these circumstances would fail, both in the courts, and in the court of public opinion.

H. Create a Safe Harbor for Plan Sponsors That Cannot Gain Access to the Necessary Information

In many cases, self-insured plan sponsors do not negotiate directly with providers to create a provider network for the plan. Instead, these self-insured plan sponsors contract with an insurance carrier that already has a provider network in place in a particular geographic area. In other words, the self-insured plan sponsor "rents" the insurance carrier's provider network. In this case, the insurance carrier typically possesses all of the information relating to the plan's negotiated in-network rates and payments to out-of-network providers (i.e., the "allowed amounts"). Carriers that possess all of the information on the plan's negotiated in-network rates and "allowed amounts" may refuse to share this information with the plan sponsor.

Because the proposed regulations require plan sponsors to disclose the plan's negotiated in-network rates and "allowed amounts," some plan sponsors fear that this information may continue to be withheld. In addition, while we hope information like the negotiated in-network rates and "allowed amounts" would be readily shared with the plan sponsor (as required under the proposed regulations), we are concerned that plan sponsors may not always be able to access this information from the carriers and/or medical providers in a timely manner.

As such, we recommend that the Departments create a "safe harbor" for self-insured plan sponsors that are trying in good faith to access and produce the necessary information that must be disclosed to participants and to the public in accordance with the proposed regulations. Specifically, in cases where a plan sponsor tries – but is unable – to gain access to the plan's negotiated in-network rates and "allowed amounts," the plan sponsor should *not* be held liable for failing to disclose the plan's negotiated in-network rates and "allowed amounts" through the on-line cost-sharing liability self-service tool and the public website that the plan must establish.

In cases where a plan sponsor can reasonably show that the contracted third-party (e.g., an insurance carrier or medical provider) withholds specific information or fails to timely transmit the information to the plan sponsor, any resulting liability for failure to comply with the proposed regulations should rest with the third-party, not the plan sponsor acting in good faith. It is critical that the Departments verify that this is the case in the rule itself, not through reference or assumption based on other rules, statutes, or legal precedents. Employers are generally wary with the proposed regulations' assignment of liability, which states that in cases where a plan sponsor contracts with a third-party, any liability that results for non-compliance with the proposed regulations rests with the plan, not the third-party. We reiterate that this liability should

be transferred, in the case of an employer sponsoring a plan that contracts with a TPA to administer claims and negotiate networks, to the carrier or TPA.

I. Insurance Carriers and Medical Providers Must Be Required to Share the Necessary Information with Designated Agents of the Plan Sponsor

The Departments suggest that plans and carriers could use "clearinghouses" to store all of the information that must be disclosed under the proposed regulations. Or alternatively, TPAs could be contracted to perform these duties, in order to reduce employers' costs and burdens of complying with the proposed regulations.

We support the use of "clearinghouses" to store all of the information that must be disclosed under the proposed regulations. We also support the outsourcing of some or all of the responsibilities for disclosing the information required under the proposed regulations to TPAs or third-party developers.

Even if the cost of contracting with "clearinghouses" and TPAs/third-party developers is reasonable, we believe that the reliance on these designated agents to comply with the proposed regulations is contingent on those entities that currently possess the data on the negotiated in-network rates and "allowed amounts" (i.e., the carriers and medical providers) to share this data – without unnecessary fees or markup – with the "clearinghouses" and TPAs/third-party developers. As discussed above, in the self-insured plan context, plan sponsors typically "rent" the provider network that a particular insurance carrier has built. Historically, insurance carriers have considered the negotiated in-network rates and "allowed amounts" associated with their provider networks to be proprietary, and carriers have at times refused to share this information with the plan sponsor, or with the employer's designated agents.

If the overall policy goal of increasing transparency of medical prices and cost-sharing liability is to be achieved, the Departments must require the insurance carriers and medical providers that possess the necessary data to share this information with the plan sponsor's designated agents. Failing to do so would make it impossible for self-insured plan sponsors to comply with these new requirements (because, for example, TPAs and third-party developers will only be able to build a cost-sharing liability tool and/or public website if the negotiated in-network rates and the "allowed amounts" are shared by an insurance carrier or medical provider that possesses this information). It may be necessary for the Departments to specify that no contract between a provider and insurer may include "gag" clauses that prevent disclosure of this data.

J. Disclosing the Negotiated In-Network Rate Is Critical Even When No Cost-Sharing Is Required

The Departments requested comments on whether a plan sponsor should be required to disclose the negotiated in-network rates in cases where the rate is irrelevant to a participant's request for cost-sharing liability information. This situation arises if the medical item or service

does not have any cost-sharing associated with it, or in cases where the participant has already met their deductible and there is no co-pay or co-insurance for the requested medical item or service.

ERIC believes that if the plan sponsor already has information on the negotiated in-network rate for a particular medical item or service, the plan should disclose the negotiated in-network rate, even if the disclosure will indicate that the plan beneficiary will not incur costs for a given item or service. We believe that disclosing the amount of the negotiated in-network rate is extremely valuable regardless of whether the disclosure of this information impacts a participant's cost-sharing liability. In our opinion, exposing participants to the negotiated in-network rate for particular medical items and services will inform them of how much these particular items and services may cost overall – informing them of the benefit they receive from their enrollment in the plan, as well as helping them to be conscious of the costs incurred by the plan overall. As discussed earlier, these costs in the long run will accrue to all plan beneficiaries by impacting premiums for the following plan year, and part of the goal of transparency is to engage all plan beneficiaries in controlling costs. If the plan has different negotiated in-network rates with different providers furnishing the same medical item or service, participants will have the opportunity to compare the different rates among the different providers.

K. Disclosing the Negotiated In-Network Rates and Cost-Sharing Liability Associated With the "Allowed Amounts" Could Reduce "Surprise Medical Bills"

As Congress attempts to solve the problem of "surprise medical bills," we encourage the Administration to use whatever means within the Administration's authority to help protect patients from these surprise bills. One way the Administration can help patients better cope with surprise bills is through the disclosure of cost-sharing liability information, as well as the disclosure of the amounts the plan has agreed to pay to out-of-network providers (i.e., the "allowed amount"). We understand that plan sponsors do not – and will not – know the overall price an out-of-network provider may charge for a particular item or service. But informing a participant of the price of the negotiated in-network rate for the same medical item or service, in addition to the "allowed amount" that the plan will pay to the out-of-network provider, will at least equip the participant with enough information to estimate a portion of what the participant may owe to the out-of-network provider. This may also motivate the participant to request – in advance – the price the out-of-network provider will be charging for the medical item or service.

In addition, in cases where a participant is undergoing a medical procedure at an in-network facility, the participant typically does not expect to be treated by an out-of-network provider. Too often, however, out-of-network providers furnish medical services at an in-network facility, which produces a bill for medical services that are not covered under the plan. If a participant at least knows the plan's negotiated in-network rate of the medical procedure, in addition to knowing any cost-sharing liability for this in-network service, the participant may confirm with the in-network provider – in advance – the amount the plan and the participant will be paying for the medical procedure. Then, if a surprise medical bill is produced because an out-of-network provider happened to furnish medical services at the in-network facility, the plan and

the participant will demonstrably not be responsible for the out-of-network charge. Instead, the in-network facility is responsible, because the participant was not informed – in advance – that an out-of-network provider would furnish the medical services.

More importantly, this disclosure will empower patients with critical information to help them to do cost-benefit analyses **before** choosing, for instance, a hospital. We envision a future in which a hospital is required to disclose the extent of their surprise billing practices, including their allowance of out-of-network providers to practice at in-network facilities, and the costs patients typically incur due to this. In a world with this kind of disclosure, patients will be less likely to go to a hospital that has high rates of (for instance) out-of-network anesthesiology billing – meaning that the hospital could lose significant market-share and volume, which might incentivize the hospital to moderate this practice.

L. Hospitals Should Be Required to Disclose Information about "Surprise Medical Bills"

The Departments requested comments on whether plans and carriers should include a disclosure advising participants of their potential exposure to a "surprise medical bill. While ERIC is committed to protecting plan beneficiaries from surprise medical bills, this cannot be achieved by heaping disclosure requirements on carriers or plan sponsors. Instead, the Departments should consider requiring that providers be transparent about surprise billing. There are a number of ways to accomplish this:

- Hospitals and facilities should be required to post on their websites which carrier networks they participate in, and whether or not their facility "fully participates" or includes a "network match".

- Hospitals should be required to **prominently** display a notice on the front page of their website, as well as at the facility itself, and when scheduling a procedure with a patient, if **any** part of the hospitals functions are largely outsourced to another operator, staffing firm, or the like. This notice should indicate whether said providers participate, or are required by the facility to participate, in the same networks as the facility itself.

- Hospitals should be required to inform patients, in advance, of the likely charges they will incur from out-of-network providers. It is not reasonable to expect a patient to find and get into contact with ancillary providers who may treat them; instead, the hospital should have to post online and disclose information relative to likely charges.

M. Clarity for Participants about Unprocessed Claims

The proposed regulations already require plans and insurance carriers to inform the participant that the cost-sharing information is merely an estimate (and that there may be other factors not considered at the time of the participant's request that may impact the participant's

cost-sharing liability). We believe the Departments should clarify that the cost-sharing estimate may not take into account health claims that have already been submitted by the participant but have not yet been processed.

Plan sponsors and carriers are likely to include notice of this, as not all claims are processed instantly, and there could be a limited amount of "lag time" in between when a patient obtains cost estimates, and when a plan reconciles other claims for said patient. This could inure to the benefit of the participant because in many cases, any out-of-pocket exposure associated with the unprocessed claim will count toward the participant's "accumulated amount," which may ultimately lower the participant's cost-sharing liability associated the participant's request. However, there may be instances where the plan has placed a limitation on the medical item or service, and the participant may have reached their limit under plan on account of the unprocessed claim, but that information will not yet be available to be conveyed upon the participant's request. As such, it is important that the Departments make clear that these estimates are an attempt to create a snapshot of a plan beneficiary's current costs and liability but are subject to modification if there are pending claims to be processed or reconciled.

N. The On-Line Cost-Sharing Liability Self-Service Tool

The Departments requested comments on whether the on-line cost-sharing liability service tool should have additional refining and reordering functionality, including whether it would be helpful or feasible to refine and reorder by provider subspecialty (e.g., providers who specialize in pediatric psychiatry), or by the quality rating of the provider, if the plan or issuer has available data on provider quality. We do not have the technical expertise to opine on whether a third-party developer may be able to build this type of refined functionality. However, we are supportive of requirements that will equip participants with the most accurate, customized cost-sharing information, but only if the proposed requirements can be implemented in a cost-effective way. We also believe that disclosing "provider quality" alongside the cost-sharing liability information is imperative, as discussed more fully below.

With respect to the cost of building and maintaining the on-line cost-sharing liability self-service tool, plan sponsors are supportive of providing more cost-sharing information to participants. However, plan sponsors are concerned that all of the data aggregation and collection required under the proposed regulations – along with the need to contract with a third-party developer to create an on-line cost-sharing liability service tool that is capable of providing customized cost-sharing information to a particular participant – may be overly costly to the plan. There may also be significant costs associated with data-storage. While we recognize that the Departments cannot control the extent to which a third-party developer may charge to build the on-line cost-sharing liability self-service tool, it is important to emphasize that there is no question that the proposed regulations will increase administrative costs for the plan, thereby adding more costs to an already bloated system. Will the increased administrative costs in the short-term be outweighed by the reduction of health care costs in the long-term? Only time will tell.

One possible way to streamline the cost of delivering the cost-sharing information to participants could be through mobile applications, instead of traditional websites. Specifically, the delivery of the cost-sharing liability information through such mobile applications could reduce administrative costs long-term (even though the short-term start-up costs could be significant). The Departments went so far as to request comments on whether the final regulations should permit the disclosure of cost-sharing information through mobile applications, or to require that the disclosures be made through multiple means, such as a website *and* a mobile application.

We believe that the delivery of the cost-sharing information should be determined by the plan sponsor, in order to best meet the unique needs of their workforce. In other words, ERIC supports an either-or approach – a plan sponsor can satisfy this disclosure requirement through a website or a plan sponsor can equally satisfy this disclosure requirement through a mobile application. We believe that some plan sponsors may choose a different means than others, but so long as this leads to beneficiaries having access to the necessary information, flexibility is preferable.

O. No Paper Delivery of the Cost-Sharing Information

ERIC understands the Departments' view that some participants may not have access to an internet website, and thus, plans and insurance carriers must furnish to participants their customized cost-sharing liability information in paper form upon a participant's request. However, we believe that the long-standing requirement that plan sponsors must disclose certain plan-related information in paper form is a woefully outdated requirement. As a result, ERIC opposes the requirement to deliver the cost-sharing information to participants in paper form.

In this day and age, most if not all participants have access to an electronic device that can access a mobile application (either through the participant's own device or through a family member's device). As a result – and consistent with our comment above – we believe that plans and carriers should be permitted to deliver the cost-sharing liability information to participants through a mobile application as opposed to just an internet website. We further believe that the ability to satisfy this disclosure requirement through a mobile application will negate the need for delivering this information in paper form (while still achieving the policy goal of ensuring that participants who may not have access to the internet still receive their customized cost-sharing information). We further believe that any plan beneficiary planning for care is able to, and indeed likely to, access either a mobile device or a computer in doing so.

It is important to emphasize that if plans and carriers are required to continue to deliver the cost-sharing information in paper form, the administrative burden associated with (1) compiling the customized cost-sharing information, (2) reducing this information to writing, and then (3) mailing the information via USPS within two business days of the participant's request would be so great that the costs would outweigh the benefit of increasing the transparency of the cost-sharing information.

On January 30, 2017, the White House issued Executive Order 13771, Reducing Regulation and Controlling Regulatory Costs. This Executive Order directs the Federal Departments to modify regulations that "impose costs that exceed benefits." We believe this aspect of the rule is a candidate for modification based on the standards set forth in the Executive Order.

In addition, on August 31, 2018, the White House issued Executive Order 13847, Strengthening Retirement Security in America, directing the Departments of Treasury and Labor to make retirement plan disclosures more understandable and useful for participants and beneficiaries while also reducing the costs and burdens these disclosure requirements impose on employers and other plan fiduciaries responsible for their production and distribution. Retirement benefits and health benefits are related, and thus, we see no reason why this same standard of reducing the burdens associated with retirement plan disclosures should not be similarly applied to health plan disclosures, and in particular, the proposed requirement to furnishing employees with a paper copy of their cost-sharing liability information.

P. Machine-Readable Files and Updating the Public Websites

We fully support the public disclosure of negotiated in-network rates and historical "allowed amount" payments to out-of-network providers. However, requiring a plan sponsor to collect all of the data that must be disclosed may prove difficult as discussed above. In addition, the cost associated with creating – and maintaining – a public website could be significant, especially in the short-term.

The Departments asked whether plan sponsors and insurance carriers could combine the negotiated in-network rate data and the historical "allowed amount" data into one file. We see no reason why this data cannot physically be combined into one file, but we believe that this one, massive file will be so large that the cost of storing the data and maintaining the website may outweigh the benefit of making this data public. In addition, the file will likely be so big that participants, researchers, and policymakers may have difficulty making use of the file, which is contrary to its intended purpose.

We also believe that the negotiated in-network rates are fundamentally different from the historical "allowed amount" payments to out-of-network providers. For example, the negotiated in-network rates are typically set prior to the start of the plan year, and these amounts often times do not change over the course of the plan year. The historical "allowed amount" payments, however, will vary over the six-month period that plans and carriers are required to display this information. And while both the negotiated in-network rates and the historical "allowed amount" payments must be updated monthly; these monthly updates are more relevant for the historical "allowed amount" file than the negotiated in-network rate file. As a result, we believe that the data should be kept separate in two different files.

As stated, updating the negotiated in-network rate file monthly will typically not show any differences in the disclosed rates from month-to-month. Because this data may not change as often, the negotiated in-network rate file may need to be updated less often, such as on a quarterly or semi-annual basis.

With respect to updating the historical "allowed amount" file, we do believe that the file should be updated monthly. While an argument can be made that this file should be updated more frequently than monthly (due to the dynamic nature of the varying out-of-network health claims that a plan or carrier pays during the course of a particular month), we believe that requiring plans and carriers to update this file more frequently than monthly would be overly burdensome.

Q. Public API and APIs That Can Be Used by Patients and Providers

ERIC supports the use of a publicly accessible standards-based application program interface ("API") developed and maintained by HHS. An HHS-developed and maintained API will also allow third-party developers to create mobile applications that would connect directly with the API and would allow participants and providers to access data specific to the plan or carrier that is providing health coverage to the participant (e.g., the plan's or carrier's negotiated in-network rates and "allowed amounts"). This type of public API would significantly reduce the administrative burdens and costs associated with data-storage, and the costs of each plan and carrier building its own internet website.

In addition, the development of a publicly accessible API through HHS will resolve the concern that plan sponsors have regarding the potential for insurance carriers and medical providers to refuse to share data like the negotiated in-network rates and the "allowed amounts" with plan sponsors and their designated agents. In this case, the insurance carrier and medical providers will be required to share the necessary information directly with HHS. And, if the insurance carrier or medical provider refuses to share the information – or they fail to provide the information in a timely manner – the conflict is between the insurance carrier or medical provider and HHS, not the insurance carrier or medical provider and the plan sponsor.

If HHS chooses not to develop and maintain a publicly accessible API, we are supportive of allowing individual plan sponsors and insurance carriers to create an API that third-party developers can then access to create a mobile application that would provide participants with their cost-sharing liability information upon their request, as well as a mobile application for the negotiated in-network and "allowed amount" files that can be accessed by participants, researchers, and policymakers. Again, we believe that the development of an API will streamline the administrative burdens and costs associated with building a plan- or carrier-specific cost-sharing liability tool and an internet website for the negotiated in-network and "allowed amount" files.

R. Delay the Effective Date of the Regulations and Implement a Gradual Transition

As discussed throughout this comment letter, ERIC is supportive of increased transparency of medical prices and cost-sharing information. However, due to the difficulties plan sponsors may experience when attempting to access the information required under the proposed regulations from third-parties, and due to the technical difficulties plan sponsors may experience in creating (1) an on-line cost-sharing liability self-service tool, and (2) a public website to disclose the plan's negotiated in-network rates and "allowable amounts" – not to mention the difficulties and cost associated with data-storage – the Departments should consider delaying the final effective date of the regulations by at least one year.

In addition, the Departments have signaled that plan sponsors should be able to comply with the proposed regulations by outsourcing the data aggregation and collection to third-parties, and also hiring third-parties to develop an on-line cost-sharing liability self-service tool (with all of its inputs and customization) and public websites. However, if every self-insured plan sponsor is expected to hire these third-party developers and/or data aggregators and collectors, there may not immediately be enough capacity within third-party service providers to satisfy the demand for complying with the regulations. A plan sponsor should not be found liable for failing to comply with the proposed regulations in cases where they try – but are unable – to find a third-party developer and/or data aggregator and collector to meet their needs within the required period of time. Transition relief should be afforded to plan sponsors that find themselves in this situation. The Departments could consider implementing this through a "safe harbor" for plan sponsors, or the Departments could delay the effective date of the regulations for another year.

We are also concerned that carriers may need more time to implement the requirements on plan sponsors' behalf. As such, we recommend that the proposed rule could be implemented in a more gradual fashion. For instance, in the first year, carriers and plan sponsors could be required to provide a price transparency tool that covers a more narrow data set (for instance, focus in on the most common shoppable services first). Over time, this scope could be broadened to eventually be fully inclusive, but an initial narrow focus could increase the chance that patients have critical, actionable information as soon as possible.

S. Explore "Quality" Measures and Benchmarks That Can Accompany the Disclosure of Medical Prices and Cost-Sharing Liability Information

As discussed, we believe that increasing the disclosure of medical prices and cost-sharing information will likely lower health care costs and empower patients to be better consumers of health care. But, the overall impact on health care spending will be limited without increased transparency of the "quality" of the care that providers are furnishing to patients. For this reason, we encourage the Departments explore how quality measures and benchmarks can be integrated with the proposed regulation. This will help patients base their health care decisions not only on price, but on quality.

ERIC member companies are focused on improving the quality of care – and believe that doing so can reduce utilization of low-value care, eliminate medical errors and unnecessary care, improve adherence and high-value care, and incentivize providers to focus on value. While we understand that the Departments are focused on cost as the first step in moving toward transparency, we believe that quality transparency is an equally important piece of the puzzle, and that the Departments must work toward a system in which patients are empowered with both cost and quality data.

For example, a patient may gravitate toward a higher-costing provider under the assumption that this provider provides better quality of care relative to lower-cost providers. However, there are countless instances where a lower-cost provider actually provides better quality than the higher-cost provider. We recognize how difficult developing uniform quality measures and benchmarks can be but believe much work has already been accomplished through multi-stakeholder groups and by the Departments – this work merely needs to be leveraged as part of this effort. We encourage the Department to explore how quality measures and benchmarks can accompany the disclosure of medical prices and cost-sharing information. We believe that the disclosure of medical prices and cost-sharing information, coupled with quality transparency, will transform our health care system into a private-based, value-driven health care system that is sustainable for decades to come.

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Thank you in advance for considering these comments. Please do not hesitate to contact me with any questions, or if ERIC can serve as a resource on these very important issues.

Sincerely,

James P. Gelfand
Senior Vice President, Health Policy