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The Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9915-P
P.O. Box 8010
Baltimore, Maryland 21244-8010

January 29, 2020

Subject: Transparency in coverage proposed regulations [CMS–9915–P; REG-118378-19]

To Whom It May Concern:

Mercer welcomes the opportunity to provide input to the US Department of Treasury; the US Department of Labor; and the US Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services ("CMS") (collectively, the "Tri-agencies") on the Transparency in Coverage Proposed Rules (the "proposed transparency rules"), in response to the request for comments on key issues as part of the rulemaking process.

Mercer is a global consulting leader helping clients around the world redefine the world of work, reshape retirement and investment outcomes, and unlock real health and well-being for their people. In the United States, Mercer provides consulting, brokerage and actuarial services to nearly 5,000 health and benefit clients, including employers of all sizes, with varying employee demographics.

Private sector employers are a significant constituent in the provision of heath care in the US: in aggregate they spent $560.7 billion just in the form of contributions for health insurance premiums in

2018[1], while approximately 175 million Americans (54 percent of covered Americans, including retirees) obtain health coverage through their employer.[2] Both Mercer and its clients are committed to improving healthcare quality, affordability and accessibility for US workers and their families. Price transparency is a critical component of that effort, as discussed in our comments below.

I. Summary of concerns and recommendations

We have worked with employers for many years on transparency initiatives and applaud the Tri-agencies for taking steps to create a more transparent healthcare marketplace. Transparency rules are necessary to address wide price variations, reduce waste in the healthcare system, and help individuals make informed choices regarding their healthcare spending. Properly structured transparency rules will benefit participants by providing a better understanding of how much they will have to pay out-of-pocket for many healthcare services.

Nevertheless, we have some issues with the proposed transparency rules. We are concerned about the practicality and effectiveness of the proposed self-service transparency tools for participants. In particular, we are apprehensive about focusing solely on price transparency as it is potentially misleading and, absent a quality component, may not allow participants to fully understand the true value of the healthcare they require. We also worry about the administrative and cost burdens on employers/plan sponsors relative to collecting and providing the requisite data to meet transparency requirements.

To address those concerns, we suggest that the Tri-agencies (1) improve the required self-service transparency tool for participants by (a) limiting it to "shoppable services," similar to the "consumer-friendly" disclosure required under CMS' Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule (the "final hospital transparency rule") (see section III.A.), and (b) including quality metrics (see section III.B.); and (2) reduce burdens to employers/plan sponsors, especially by expanding the safe harbor available to employers/plan sponsors to provide relief from steep penalties if they cannot get the required data and satisfy compliance obligations under the transparency rules (see section IV). Due to the timing constraints set by the proposed transparency rules for an accelerated comment period, we are limiting our observations and recommendations to those set forth below.

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[1] CMS National Health Expenditure Data, NHE Fact Sheet, Table 5-1 Private Business Sponsor Expenditures: Calendar Years 1987-2018

[2] U.S. Census Bureau, Current Population Survey, Annual Social and Economic (ASEC), SupplementTable H-02. Health Insurance Current Coverage Status and Type of Coverage by Selected Characteristics: 2019

II. Description of proposed transparency rules for group health plans and insurers

An executive order signed by President Trump on June 24, 2019 directed certain federal agencies to issue regulations and take other actions to improve transparency in the cost and quality of common healthcare services, including issuing the proposed transparency rules and the final hospital transparency rule. The order required the Tri-agencies to issue proposed rules seeking comments on ways to require self-insured group health plans, insurers and providers to facilitate or provide access to "expected" out-of-pocket costs for a treatment or service before the care is provided. The order also directed HHS to issue regulations requiring hospitals to publicly post standard charge information for common or "shoppable" items. The posted information must be "based on negotiated rates," provided in a user-friendly format, and updated regularly.

The proposed transparency rules are intended to require most employer-based group health plans and health insurance issuers to disclose price and cost-sharing — but not quality — information to participants up front, giving them estimates of any out-of-pocket costs they must pay to meet their plan's cost-sharing requirements, while making previously unavailable price information accessible to patients and other stakeholders in a standardized way, allowing for easy comparisons.

More specifically, the proposed transparency rules would, among other things, require nongrandfathered group health plans, including self-funded plans and health insurance issuers, to:

- Provide a self-service transparency tool. This tool would disclose personalized out-of-pocket cost information for all covered health care items and services via an internet-based self-service tool (and on paper upon request). This would allow most participants to get estimates of their cost-sharing liability for healthcare for all in- and out-of-network providers, allowing them to understand how costs are determined under their plan and shop and compare costs before receiving medical care.
- Make machine-readable files publicly available. These files would contain the plan's in-network provider negotiated rates and historical payments of allowed amounts paid to out-of-network providers through standardized, regularly updated machine-readable files. The agencies said this requirement is intended to provide opportunities for price comparison and consumerism innovation in the healthcare market.

The final hospital transparency rule — which is somewhat similar but differs from the proposed transparency rules in significant ways — requires the following:

- "Consumer-friendly" disclosure. Hospitals must provide payer-specific negotiated charges, plus discounted cash prices and the de-identified minimum and maximum negotiated charges for 300 shoppable services. This information must be displayed and packaged in a "consumer-friendly" manner (which can be met by using a price estimator tool). Of the 300 shoppable services, 70 are selected by CMS and 230 are selected by the hospital.

- Make machine-readable files publicly available. Hospitals must make available to the public machine-readable files that contain gross charges and payer-specific negotiated charges, plus discounted cash prices, and the de-identified minimum and maximum negotiated charges for all items and services it provides.

III. The self-service transparency tool should be limited to shoppable services and include a quality metric

For the reasons discussed below, the proposed transparency rules should be modified to start with a more manageable tool, so that the required self-service transparency tool covers only shoppable services — and includes a quality metric. There isn't much published research or studies on the effects of transparency — this may be because of a general lack of transparency throughout the healthcare market or because transparency tools are relatively new. With additional research and utilization of transparency tools, we could better understand how employees are using the current tools available in the marketplace, the effect on cost and quality, and perhaps expand the services included or modify the quality metrics for the self-service transparency tool.

Some employers/plan sponsors already have transparency tools that they may be able to use (perhaps with only minor modifications) to satisfy more limited transparency rules. Several self-service transparency tools exist in the marketplace, and many provide information related to a broad cross-section of services. By 2016, 87% of large employers with 500 or more employees that we surveyed reported their health plan members had access to a transparency tool most often provided by the health plan (i.e., third-party administrator (TPA) or insurer) but sometimes through a separate contract with a specialty vendor (15%). However, 73% of employers with tools said they did not track/could not provide utilization rates.[3]

Published studies don't provide much additional research. A study from Harvard Medical School sought to understand the association between price transparency tool availability and outpatient spending. It compared the healthcare spending patterns of employees of two companies that offered a price transparency tool with the healthcare spending patterns of employees in companies that did not offer the tool. The study concluded that offering a price transparency tool was not associated with lower healthcare spending, but recognized that the tool was used by only a small percentage of eligible employees.[4]

Another study, published in the *American Journal of Managed Care*, found that two-thirds of responding plans shared provider performance data — a quality metric — with their members, and half of these plans included that data in their price estimator tool. Despite providing price estimator tools that include

[3] Mercer's National Survey of Employer-Sponsored Health Plans 2016.
[4] Sunita Desai, PhD ; Laura A. Hatfield, PhD ;Andrew L. Hicks, MS ; et al;
Association Between Availability of a Price Transparency Tool and Outpatient Spending, *JAMA*, May 3, 2016,

access to provider performance data, the health plans in that study still encountered challenges related to lack of member utilization.[5]

A. The self-service transparency tool should be limited to "shoppable services"

The final transparency rules should require a self-service transparency tool for participants that limits required data to that which provides real value — and includes only those services that can be shopped and compared. The standard should be similar to part of the hospital final transparency rule, which requires a hospital to make a "consumer-friendly" disclosure limited to 70 shoppable services selected by CMS and the remaining 230 shoppable services selected by the hospital. But the final transparency rules shouldn't necessarily require the exact same list of services identified under the hospital transparency rule — and it certainly should not require that all services be included. Over time, the set of services included in the self-service transparency tool could be evaluated and modified, based on participant use.

In comparing the proposed transparency rules' requirements to the recently finalized hospital transparency rule, we are struck by the discrepancy in the scope of information hospitals are required to provide as part of a "consumer-friendly" disclosure — as compared to the proposed requirements imposed on employers/plan sponsors. Hospitals have direct access to rate and certain cost information, yet are only required to make pricing information available in a consumer-friendly disclosure for a limited number of services. Employers/plan sponsors don't have access to pricing information and would have to rely on their carriers or TPAs for that information, yet the proposed transparency rules would require employers/plan sponsors to provide information about *all services* through the tool. In fact, the proposed self-service transparency tool would provide participant access to the negotiated rates for *all* in-network covered services, as well as the allowed amount (based on historical amounts) of *all* covered services for out-of-network covered services. Employers'/plan sponsors' obligations with respect to price transparency for the self-service transparency tool should be in parity with the obligations imposed on hospitals — and certainly shouldn't be more onerous than the rule for hospitals.

Based on our understanding of the participant experience with existing transparency tools, the proposed scope of required information under these rules is far too broad to be useful to the participant and could be potentially misleading or even harmful. Many healthcare services are frankly too complex, episodic, and unpredictable for a transparency tool to provide reliable or useful pricing information (e.g., an appendectomy). Even the cost of an emergency room visit can vary depending on the specific medical issue. On the other hand, certain healthcare services are routine and commoditized — or shoppable — and should be included as part of a participant transparency tool (e.g., X-rays, most blood tests, and routine primary care provider visits). These types of treatments can be performed several ways at different prices and are thus shoppable.

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[5] Aparna Higgins, MA; Nicole Brainard, PhD, MPH; and German Veselovskiy, MPP; Characterizing Health Plan Price Estimator Tools: Findings From a National Survey, *The American Journal of Managed Care,* February 16, 2016.

We are concerned about how participants might interpret data provided through the self-service transparency tools for complex services that are not shoppable. Episodes of care vary from person to person. The individual needs to understand the various components involved in a particular episode of care, many of which may be adjusted by a physician as treatment proceeds. Even something that seems simple, like a colonoscopy, can vary widely since once the colonoscopy begins, the standard procedure may vary based on the need to remove polyps, cauterize bleeding, etc. A diagnostic colonoscopy is probably subject to cost-sharing, while a preventive colonoscopy should be provided at no cost under the Affordable Care Act's preventive care rules. Those adjustments and variations can have a significant impact on pricing and cost to the participant. As a consequence, cost information participants obtain through a transparency tool may not reflect what they are actually charged. This risk of misinterpretation is greater when the services are more complicated.

It is more appropriate — and less confusing to participants — for a self-service transparency tool to include access to a plan representative or healthcare professional (e.g., a nurse help line) who could provide additional information and answer questions about more complex services that often cannot and should not be shopped. Ideally, more complex medical services should be discussed first with a healthcare professional who could review possible next steps in treatment and then with a plan representative to review any process or cost issues (such as any applicable medical management like preauthorization) with the participant. In some cases, it might make more sense for the participant to receive a preauthorization so their claim is adjudicated under current claims procedure rules prior to accessing care.

B. The self-service transparency tool must include a quality metric

Providing *price* transparency to participants as the sole metric to assess healthcare options is not only misleading, but irresponsible. Some participants will surely associate cost with quality (the more expensive the service, the better it is), particularly for complex services. In other words, they may perceive cost as a proxy for quality, and that question should be researched further. Nevertheless, the true value of healthcare services cannot be assessed without including some type of quality metric. We recognize that many quality metrics exist today, including some that are proprietary, and none are likely to be perfect. Recognizing that, the final transparency rules should generally require an objectively created quality metric as part of the self-service transparency tool for participants, but allow for more specific guidance related to quality metrics to be provided at a later date pending additional research into effectiveness, etc.

It's our understanding that one commercial transparency vendor found (through early user testing) that providing an actual cost estimate of service — without a quality metric — often has a perverse effect on utilization. In many cases, when members learned that their cost for a specialist office visit was $150, for example, they often avoided or delayed care due to the concern over cost, especially if they participated in a high deductible health plan. In other cases, participants correlated higher cost providers with higher quality, which is not always the case.

We admit that the inclusion of an objective quality metric is not an easy task, but we contend that an imperfect or incomplete quality metric is still better than no quality metric at all. For starters, there is no universally-agreed upon standard or definition of good quality. While tools and quality measures exist in the marketplace, there is no clear or consistent description of what constitutes good quality. We suggest, as a starting point, that a quality metric try to identify or measure what constitutes poor quality. Existing metrics, such as hospital readmission rates, incidence of hospital infections, incidence of hospital slip and falls, surgery revisions, etc., developed by organizations like The Joint Commission, the National Committee for Quality Assurance, the National Quality Forum and other national accreditation organizations, can do a good job of identifying issues that tend to result in poor quality of care. Existing measures around appropriateness of care can be used to assess the prevalence of wasteful procedures at the physician and hospital level.

Another relevant system to consider would be the 5-star rating system promulgated by CMS for Medicare Advantage plans. This system scores plans across a number of categories, some of which encompass the quality of the healthcare services, while others attempt to measure the plan member's satisfaction (which is one way — albeit subjective — to measure patient outcomes when no claims system is recording any event or service). A quality rating system has also been introduced for private coverage purchased on public exchanges based on the star rating system. These systems are helpful for participants since they can pick plans with the star rating in mind, which allows for a more user-friendly shopping experience akin to making purchases from an online retailer. Once the scoring system is established, a list of top performers — and those who consistently underperform — can be published to incent providers to improve quality of care.

We acknowledge that these quality metrics, while providing some insight, do not provide the full picture. Each patient's experience is unique and some elements cannot be captured. For example, a patient may not be readmitted to a hospital after a hip replacement, but may still experience ongoing issues with mobility and pain. Those types of patient recorded outcome measures, which could support a given quality metric, are hard to get as they are not necessarily recorded in any claims data system nor consistently in providers' electronic health records. While the foregoing measures we cited are imperfect, we are adamant that employing some quality measure is better than ignoring the quality component completely.

At the very least, these quality metrics are helpful in fleshing out the quality component and, in our estimation, are reasonable enough to combine with pricing. Moreover, since these quality metrics already exist and are readily available, it does not appear to be too burdensome to require that they be included generally under the final transparency rules together with pricing for the participant transparency tool. Again, we are not asking for any specific quality measure to be included in the final transparency rules, but would be open to additional guidance related to specific quality metrics in the future.

IV. The final transparency rules should reduce burdens on employers

The proposed transparency rules apply directly to both group health plans and insurers, and would place new and additional burdens on employers/plan sponsors. While employers/plan sponsors are supportive of transparency initiatives, it is unfair and unwise to impose new fiduciary liabilities and/or administrative burdens and costs on employers/plan sponsors related to their group health plans when it isn't clear that the transparency tools will provide a return on investment. It is important to avoid unintended consequences due to the rules — for example, some employers might decide to curtail their group health plans because the complexities and costs are too burdensome. The final transparency rules should be modified to reduce those employer/plan sponsor burdens.

More specifically, the transparency rules should be changed so that employers sponsoring self-funded plans — in addition to those with fully-insured plans — have relief from steep penalties if they cannot get the required data to satisfy their costly and burdensome compliance obligations. Employers/plans sponsors will have to make expensive technology investments — or pay a vendor — to build and maintain files that include both negotiated rates for all in-network services and historical allowable amounts for out-of-network services offered through a plan. It is unfair to also assess penalties against such an employer/plan sponsor in the event that their insurer or TPA fails to comply, especially when insurers and TPAs rarely provide this type of transparency data to employers/plan sponsors currently.

Group health plans would face steep penalties under the ACA if they fail to meet the requirements of the new transparency rules ($100 per day per participant), but many of the requirements simply can't be met by a group health plan on its own. Recognizing this, the proposed transparency rules includes a special rule (or safe harbor) that alleviates the burden for employers to provide the required disclosures to participants, but only to the extent that group health coverage is provided through insurance. Under this proposed special rule, an employer with a fully-insured group health plan satisfies the transparency rules if it requires the insurer to provide transparency information pursuant to a written agreement. If the insurer subsequently fails to provide the required information, the insurer and not the group health plan is considered to have violated the transparency disclosure requirements. This protective language should be expanded in the final transparency rules to also protect employers/plan sponsors with self-funded group health plans that rely on TPAs (that often are also insurers) to provide the required information.

The collection of data is an expensive proposition for employers/plan sponsors. In most if not all instances, employers/plan sponsors do not negotiate the rates for services offered through their sponsored plans; they pay insurance carriers or TPAs for access to the rates those entities negotiate with providers. Employers will need to rely on insurers and TPAs to provide those rates to comply with the transparency rules. It is even more challenging for employers/plan sponsors to obtain the required historical out-of-network out-of-pocket cost data. Employers/plan sponsors do not have ready access to that data and most don't have the resources to undertake the collection of that data. We expect that a cottage industry will develop around this data collection component. Employers/plan sponsors that are not well-positioned to perform this task will likely outsource this function to a third party, thereby incurring additional costs. Once the data is collected, it needs to be maintained and updated, which

creates another layer of cost and liability. Undoubtedly, employers/plan sponsors will pass these costs along to their employees.

Limiting the information required to be provided by the self-service transparency tool to shoppable services, as discussed above, would also help to reduce the burden and cost of compliance placed on employers/plan sponsors and bring the employer/plan sponsor investment in these tools more in line with an unsure return on that investment. The Tri-agencies should also be aware that imposing any additional technological requirements on group health plans through the final transparency rules, like the CMS Interoperability and Patient Access proposed rule, would only increase the implementation burden on employers/plan sponsors.

The Tri-agencies should take all of these potential burdens and costs into account when finalizing the regulation, and at a minimum should expand the special rule that provides relief from liability to cover not only insured plans but also self-funded plans, and give plans and plan sponsors adequate time to implement the transparency rules. Employers/plan sponsors should not have to comply with the final transparency rules until the first day of the first plan year that is two years after the date on which the rules are published. So, if the transparency rules are finalized in 2020, employers/plan sponsors with a calendar year plan would not be required to comply until January 1, 2023. Additionally, the specified set of services that must be disclosed under the final transparency rules should be reevaluated after three years to ensure that the transparency is working as intended.

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Mercer would like to thank the Tri-agencies for establishing a platform for an important conversation around our healthcare system: increasing cost transparency available to participants. In the ever-evolving discussions we have with our thousands of clients, we often hear that employers desperately want to bring transparency to their employees and their employees' families to avoid unexpected bills. The proposed regulations are certainly a step in the right direction, but the final transparency rules must (1) improve the self-service transparency tool for participants by limiting it to shoppable services and including quality metrics, and (2) reduce burdens on employers and plan sponsors, especially by expanding the safe harbor to cover self-funded plans in addition to insured plans.

We would be more than happy to participate directly in any further conversations on this topic, or answer any questions that you may have.

Sincerely,

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