



January 29, 2020

*Submitted electronically via: [www.regulations.gov](http://www.regulations.gov)*

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9115-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

**Re: CMS-9115-P – Transparency in Coverage**

Dear Sir or Madam:

Business Group on Health appreciates the opportunity to respond to the Internal Revenue Service's, Department of Labor's, and Centers for Medicare and Medicaid Services' (Departments') proposed rule regarding disclosure of cost-sharing information, in-network provider negotiated rates, and historical out-of-network allowed amounts.

The Business Group represents [441 primarily large employers](#), including 74 of the Fortune 100, who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families. Our members employ and provide health coverage under a wide variety of arrangements, often tailoring their group health offerings to the specific needs of their lines of business. This coverage generally is self-insured group health plan coverage or a combination of self-insured and insured coverage.

As our members continue to comply with the ACA, HIPAA, and other group health plan requirements, primary concerns remain:

- Providing comprehensive health benefits in an efficient, cost-effective way while ensuring access to high-quality, evidence-based care;
- Being able to provide plan participants with meaningful information on out-of-pocket costs and total cost of care, matched with provider quality and performance data;

- Engaging employees in an increasingly complex health care system as a part of an overall strategy to maintain a productive and competitive workforce; and
- Minimizing the administrative and cost burdens associated with group health plan compliance obligations.

Therefore, we support the Departments' efforts, through the Transparency in Coverage proposed rule, to:

- Provide price and benefit information to consumers;
- Reduce surprises in consumers' out-of-pocket health care costs;
- Foster competition and innovation in the health care market; and
- Lower overall health care costs.

Although our members support a more transparent health care system, we also urge the Departments, before finalizing and implementing the proposed rule, to consider the complexities specific to employer-sponsored group health plans. As large employers,<sup>1</sup> Business Group members are at the forefront of efforts to increase efficiency and quality in the health care delivery system. For example, 49% of our surveyed respondents will have at least one innovative primary care strategy in place for 2020.<sup>2</sup> 99% of our respondents will offer telehealth services for acute care by 2020.<sup>3</sup> Given employers' unique role in driving health care delivery system change, the Business Group suggests that in finalizing and implementing the proposed rule, the Departments consider the following:

- (1) The final rule should encourage employers' roles as early adopters of transparency tools and alternative payment and delivery models. The final rule should not require employers to adopt additional tools that duplicate or conflict with these innovations.
- (2) The final rule should foster a more transparent health care system—with respect to pricing and *quality* of care—for patients, providers, and *plan sponsors*.

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<sup>1</sup> For purposes of this letter, we use "employee" and "plan participant" interchangeably, although "plan participant" generally refers to all individuals (including employees' dependents) who may be enrolled in a group health plan. Likewise, we use "employer" and "plan sponsor" interchangeably.

<sup>2</sup> National Business Group on Health, *2020 Large Employers' Health Care Strategy and Plan Design Survey* 19 (2019).

<sup>3</sup> National Business Group on Health, *2020 Large Employers' Health Care Strategy and Plan Design Survey* 29 (2019).

- (3) We encourage the Departments to adopt a realistic implementation timeline that minimizes confusion for plan participants and allows group health plans time to coordinate and, if necessary, amend agreements with third-party vendors.

We provide further discussion of our recommendations below.

**I. Final rules should encourage employers' roles as early adopters of transparency tools and alternative payment and delivery models.**

- A. *Employer-sponsored group health plans already offer participants innovative tools—including transparency tools—to navigate the health care system and will continue to do so.*

For 2019 Business Group members estimate that health care costs on a per employee per year basis will be \$12,210, approximately \$2,689 of which will be borne by employees through premium contributions. These amounts do not include employees' out-of-pocket costs, which our members estimate at \$2,432. Our members expect overall health care costs to increase by approximately 5% in 2020.<sup>4</sup> As the health care system becomes more complex and costly for both employers and employees, minimizing compliance costs will be an ever greater concern.

To navigate their group health plan coverage and the health care system, employees and their dependents need information, but much—if not most—of the most critical information often is not readily available through current mandated disclosures or agreements with group health plan vendors. Plan sponsors, recognizing the need for effective health plan communications, have devoted substantial time and resources toward developing tools that participants use to navigate plan designs and a complex health care system. These tools include:

- Price transparency tools,
- Health care decision support programs,
- Advocacy tools such as claims resolution services, and
- Concierge services that help participants navigate the health care system.

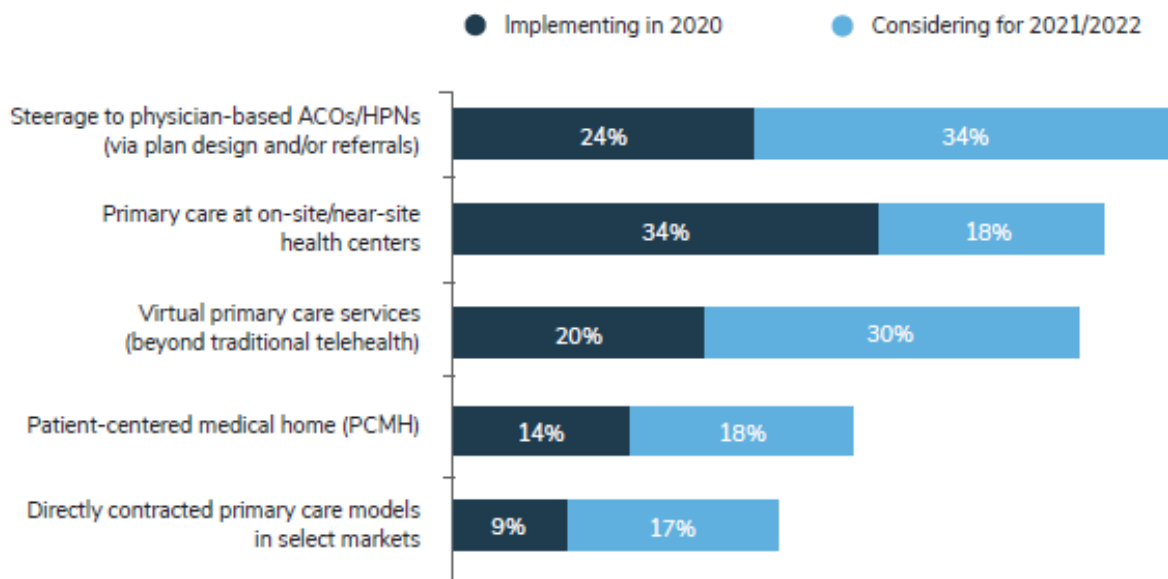
These services are increasingly available through both self-insured and insured plan options. In recent years, plan sponsors have placed increasing emphasis on tools and programs that help employees navigate medical decisions, claims, and providers *in addition to* price. These plan features aim to integrate price, quality, and the employee experience so that employees are better engaged with the group health plan, workplace, and individual health care decisions.

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<sup>4</sup> National Business Group on Health, *2020 Large Employers' Health Care Strategy and Plan Design Survey* 39-40 (2019).

Employer-sponsored group health plans also are adopting alternative payment and delivery models—such as the primary care strategies summarized below—aimed at driving plan participants toward higher value care while lowering overall health care costs.

**Figure 2.5: Large Employers' Implementation of Advanced Primary Care Strategies, 2020-2022**

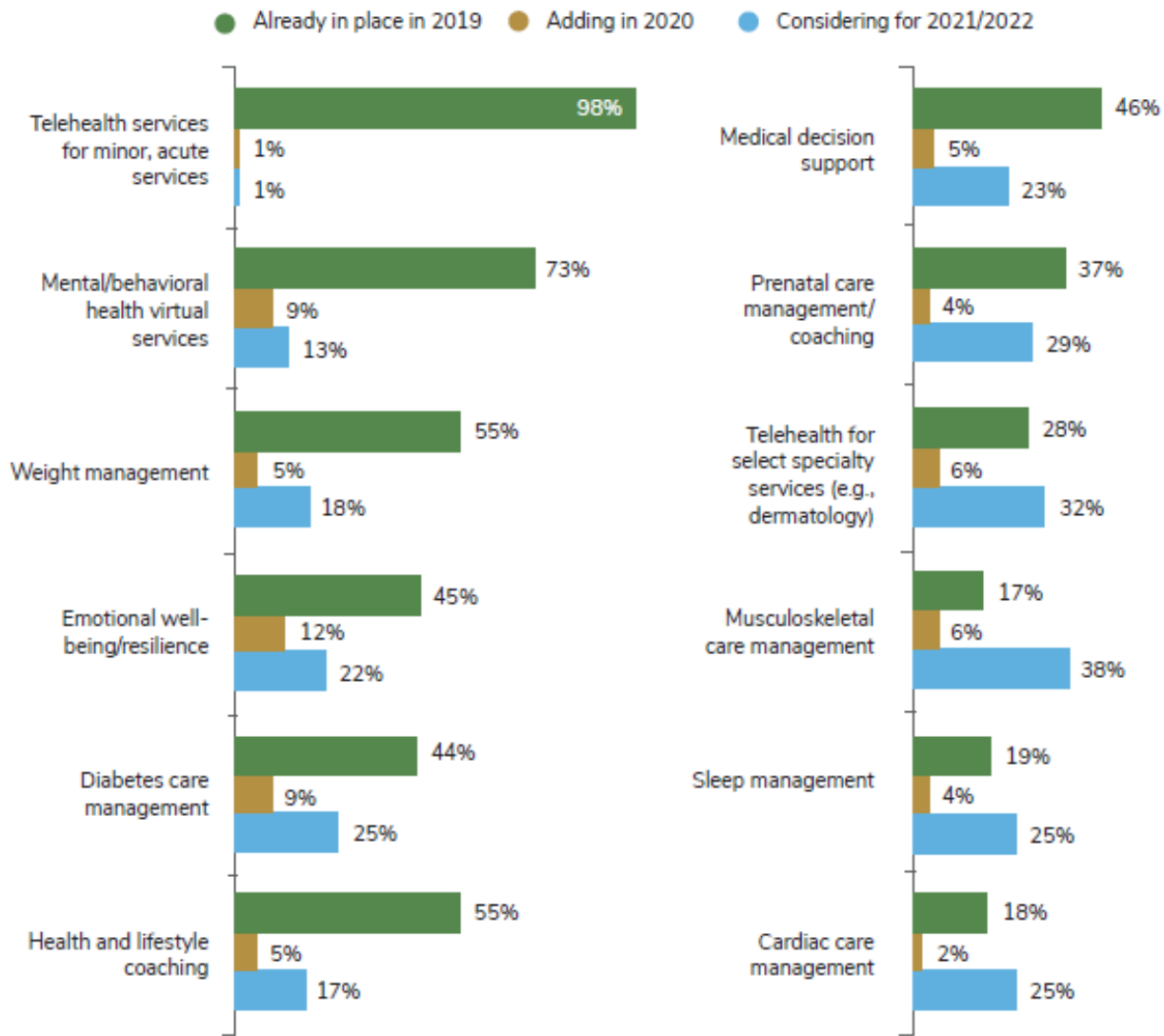


Our members view all of these tools—in conjunction with price transparency—as critical to achieving better health outcomes, a more engaged workforce, and lower health care costs.

*B. The final rule should not require employers to adopt additional tools that duplicate or conflict with these innovations.*

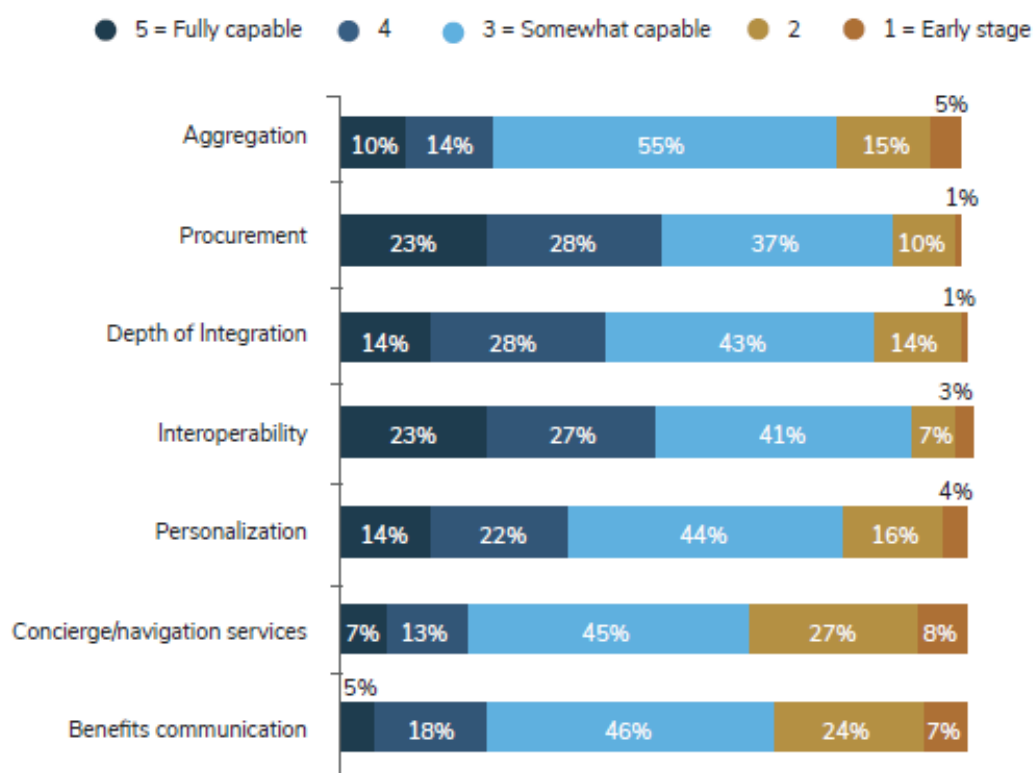
Although price transparency has a significant role to play in helping plan participants make informed health care decisions, our members are concerned that required disclosures to participants and beneficiaries, as described in the proposed rule, will require an additional internet-based tool that does not integrate with existing plan designs. Employers have been early adopters of virtual platforms that encourage plan participants to engage not only on price but also providers, specialty services, and high-cost conditions.

**Figure 6.2: Large Employers' Current and Projected Virtual Solutions Offerings, 2019-2022**



Although our members are optimistic about these new platforms' ability to improve the employee experience—and ultimately lower costs—within the health care system, we caution that implementation is, for most employers, still at an early stage. Employers and the health care industry will need to refine these platforms over time to achieve the desired improvements in engagement, health outcomes, and cost savings.

Figure 6.5: Large Employers' Views on the Maturity of Engagement Platforms, 2019



Our members are concerned that the proposed 29 C.F.R. § 2590.715-2715A(b) will:

- Require an additional internet-based tool that involves substantial additional costs but is poorly integrated with group health plans' existing transparency, navigation, and care management platforms;
- Require disclosure of price information that plan sponsors, to date, have not been able to access, which limits plan sponsors' ability to evaluate and confirm the accuracy of that information;
- Result in a tool that provides cost information that conflicts with information from existing price transparency tools that are tailored to a specific employer population and its needs—thereby causing confusion for employees;
- Divert employees' attention to a tool focused on the fee-for-service billing code system when an employer has adopted alternative payment models that do not easily adapt to the proposed billing code format; and

- Divert substantial staff time toward communicating about the new tool and providing information on paper upon request when more effective, better-integrated tools are already available.

Therefore, we recommend that the final rule encourage employers to continue their innovations with alternative payment models and virtual platforms by:

- Including a deemed compliance standard for employers that already offer transparency tools designed to assist participants with cost estimates and obtaining up-to-date cost-sharing information; and
- Allowing employer-sponsored group health plans to build upon existing transparency tools by adapting their current tools over a reasonable period of time to incorporate the information described in the proposed rule.

**II. The final rule should foster a more transparent health care system—with respect to pricing *and quality of care*—for patients, providers, and payers.**

*A. Insights from employers’ use of innovative payment models should inform the regulatory approach to transparency.*

In recent years, the Business Group has convened large employers and their health care industry partners to explore and implement health care delivery innovations such as [accountable care organizations](#) and [centers of excellence](#). Through these efforts, our members have developed insights into the benefits and limitations of price transparency, including the following:

- Currently, a large portion of health care price and quality information is not available to plan sponsors, especially in markets where certain providers or health systems dominate those markets. In fact, many provider and vendor agreements explicitly prohibit full disclosure of price and quality information. The transparency in coverage rule therefore should extend not only to group health plans but also to providers and other plan vendors. Implementation of the proposed transparency in coverage rule likely will require substantial changes to the contractual relationships between group health plans and their vendors.
- It is critical that information be understandable and actionable for all parties in the health care system, including plan sponsors. Price transparency, as described in the proposed rule, may not provide useful information to plan participants, as participants generally are not familiar with the numerous billing codes and descriptive terms that may apply to any given health care service, medication, or device.

- There is a risk that fostering price-based competition may come at the expense of clinical quality. Plan participants often construe high health care prices as markers of high quality, even though evidence shows health care quality often is not correlated with price.
- Consumer shopping for health care services may be influenced by many factors other than price, including, but not limited to, network coverage, provider recommendations, reference prices, and other financial incentives.
- Increased data availability as described in the proposed 29 C.F.R. § 2590.715-2715A(c) may increase the risk of privacy breaches—beyond the control of any plan sponsor—and may not improve patient care or outcomes.
- Price transparency efforts should focus on informing health care decisions and serve as decision support and therefore should encourage providing price and quality information at the time that individuals and providers are making treatment decisions. Price transparency also should be tied to quality transparency. Pricing information alone will not necessarily assist individuals in making informed health care decisions.
- In our members' experience, simply providing pricing information through price transparency tools may not change consumer behavior in a manner that results in higher-value care. Studies that have evaluated existing websites or price searching applications have offered mixed conclusions about price transparency. While some found that these search tools led to lower prices, a majority found that transparency tools were not used at high rates, did not meaningfully decrease spending, and needed to be accompanied with greater quality transparency.
- Accountability in value-based purchasing models encourages providers to use transparency tools, for both medical and pharmacy services. These tools should also encourage providers to take responsibility for the total cost of care. Price transparency tools, in isolation, will likely be less effective than transparency tools that are integrated with value-based purchasing models.
- Bundled payments for an episode of care, often utilized in accountable care models, make price transparency simpler and more meaningful for consumers. Bundled payments, tied to an episode of care, are more easily understood than several discrete services billed for in the fee-for-service model, which is the model most frequently reflected in current Explanations of Benefit.
- Price transparency is not a panacea. For more complex diagnoses and treatments, a number of clinical factors should inform health care decisions, in addition to price and provider quality.

While our members appreciate the role of price transparency in lowering health care costs, they remain concerned that price transparency measures alone (1) may detract from existing efforts to integrate price and quality data and (2) place undue emphasis on the fee-for-service system at the expense of alternative payment models. Therefore, we recommend that the Departments—in consultation with relevant stakeholders—include in the final rule provisions to incorporate available quality, health outcomes, and comparative effectiveness data into the proposed rule’s requirements. We also recommend that the final rule include provisions to require disclosure of price and quality information *to plan sponsors* in a timely fashion.

### **III. The final rule should include a realistic implementation timeline.**

*A. The implementation date should allow sufficient time for plan sponsors to adopt well-integrated, useful tools.*

As discussed above, our members remain concerned that the stand-alone transparency measures described in the proposed rule are insufficient to drive the innovation and payment and delivery reforms needed to improve health outcomes and lower overall health care costs. The required disclaimers in the proposed 29 C.F.R. § 2590.715-2715A(b)(1)(vii), for example, highlight the limitations of the required disclosures, which:

- Will not include any balance billing for which plan participants may be responsible;
- May not reflect actual charges for any covered item or service; and
- Will not guarantee provision of plan benefits.

Given these limitations, disclosing the information required in the proposed rule could easily result in greater confusion for plan participants and higher costs for plan sponsors. We therefore are concerned that the proposed effective date will not allow sufficient time to develop a usable tool that enables the desired consumer behavior and cost savings.

*B. The implementation date should allow sufficient time to coordinate and, if necessary, amend agreements with third-party vendors.*

Finally, we urge the Departments to consider the following:

- The proposed rule requires a large volume of price information that plan sponsors currently do not have. As noted above, current vendor agreements often preclude disclosure of price and quality information to plan sponsors.
- Plan sponsors will need to coordinate with multiple third parties—including medical, pharmacy, wellness, on-site clinic, ACO, EAP, and other vendors—to obtain the price information required in the proposed rule.

- Complying with the proposed rule likely will require amending agreements with the above third parties.
- Generally, adoption of a new plan participant-facing platform requires a minimum of 6-9 months *after* the platform has been finalized and selected by the plan sponsor.

Given the above time constraints, we recommend that the implementation date be at least 2 years after adoption of a final rule.

We believe that the above recommendations, if implemented, will reduce regulatory burdens for employers, improve affordability, and promote value-based health benefit design.

Thank you for considering our comments and recommendations. We would be happy to provide additional details and work with the Departments in the rulemaking process. Please feel free to contact me ([marcotte@businessgrouphealth.org](mailto:marcotte@businessgrouphealth.org)) or Debbie Harrison ([harrison@businessgrouphealth.org](mailto:harrison@businessgrouphealth.org)), the Business Group's Director, Regulatory and Compliance, to discuss.

Sincerely,

A handwritten signature in black ink that reads "Brian Marcotte". The signature is written in a cursive, flowing style.

Brian Marcotte  
President