National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

June 3, 2019

Submitted electronically via: www.regulations.gov

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program Proposed Rule
Mary E Switzer Building
Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9115-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-0955-AA01 – 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program

CMS-9116-P - Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-Facilitated Exchanges and Health Care Providers

Dear Sir or Madam:

The National Business Group on Health appreciates the opportunity to respond to the Office of the National Coordinator for Health Information Technology's and Centers for Medicare and Medicaid Services' proposed rules implementing the 21st Century Cures Act and proposing provisions that would advance interoperability and increase individuals' access to information in the health care system.

The Business Group represents 444 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 and often 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 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 ONC's and CMS's efforts to:

- Improve access to and quality of information on health care prices and outcomes while minimizing reporting burdens;
- Improve patient and provider access to electronic health information;
- Enhance competition in health care markets by lowering barriers to entry and preventing abuses of market power; and
- Increase price transparency in the health care system.

We applaud this and other efforts by ONC and CMS to promote health care data sharing, improve the quality and usefulness of data shared, resolve practical challenges to interoperability, overcome information blocking, and increase the availability of health information via mobile devices and Application Programming Interfaces while building trust in the security and confidentiality of information exchanged. While we acknowledge that ONC and CMS propose an ambitious timetable for implementing their proposals, we believe it is critical to move this important agenda ahead at an urgent but realistic pace given what is at stake: improvement of the health and health care of patients and our nation through more seamless patient and provider access to health information. The Business Group welcomes opportunities to collaborate with ONC and CMS to advance this important endeavor.

In addition to the proposed rules' potential for improving the health care system's efficiency and quality, we also believe that the proposed rules may assist in combating the opioid crisis. A report from the President's Commission on Combating Drug Addiction and the Opioid Crisis highlights prescription drug monitoring programs (PDMPs) as important tools to aid in the fight against opioid abuse. Such systems can be used for early detection and prevention of drug abuse and addiction and can also help identify patients who cross state lines to purchase drugs for purposes of misuse or diversion. The value of current PDMPs would be enhanced if states' data were harmonized and standardized.[1]

We also urge ONC and CMS, before finalizing and implementing the proposed rules, to consider the complexities specific to employer-sponsored group health plans. As large employers, Business Group members are at the forefront of efforts to improve the health care delivery system. 49% of respondents to our most recent large employer survey indicated that they are either (1) pursuing the implementation of alternative payment and delivery models such as accountable care organizations (ACOs), performance networks and centers of excellence (COEs) or (2) circumventing the delivery system to improve access, convenience, experience, and efficiency by deploying virtual and digital care point solutions, navigation, and concierge services.[2] Given employers' unique role in driving health care delivery system change, the Business Group suggests that in finalizing and implementing the proposed rules, ONC and CMS consider the following:

(1) Final rules should take into account employers' multiple roles and responsibilities within the health care system, including group health plan (i.e., HIPAA covered entity) sponsors, purchasers of health care, early adopters of health innovations, and a source of information for employees.

(2) Final rules should foster a more transparent health care system—with respect to pricing and *quality* of care—for patients, providers, and payers.

(3) We encourage HHS to undertake a subsequent rulemaking to expand access to price information—specific to the medical and pharmacy services available to plan participants through their health plans and pharmacy benefit managers—for plan participants, prospective participants, plan sponsors,[3] and health care providers.

We provide further discussion of our recommendations below.

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[1] States vary on the format and scope of data collected, type of providers that can access the data, whether PDMPs can be used only for prescribing versus diagnosis and assessment, and use of the data beyond viewing reports.

[2] National Business Group on Health, *2019 Large Employers' Health Care Strategy and Plan Design Survey* 4 (2018).

[3] 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, although in some cases (such as with collectively bargained plans), employers and plan sponsors may be separate entities.

I. Final rules should take into account employers' multiple roles and responsibilities within the health care system.

A. Employees, as group health plan participants, often already rely on employer-provided tools to navigate the health care system and likely will continue to do so.

For 2018, Business Group members estimate that health care costs on a per employee per year basis will be $11,730, approximately $2,572 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 $2,378. Our members expect overall health care costs to increase by approximately 5% in 2019.[4] As the health care system becomes more complex and costly for both employers and plan participants, 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 will need information, but much—if not most—of the most critical information often is not readily available. Specifically:

- When employees or their dependents need information for planning purposes (such as during open enrollment or when the need for health care arises) the most critical information—such as cost of care, the quality of services, and whether specific providers are in-network—will not be found in legally mandated disclosures.

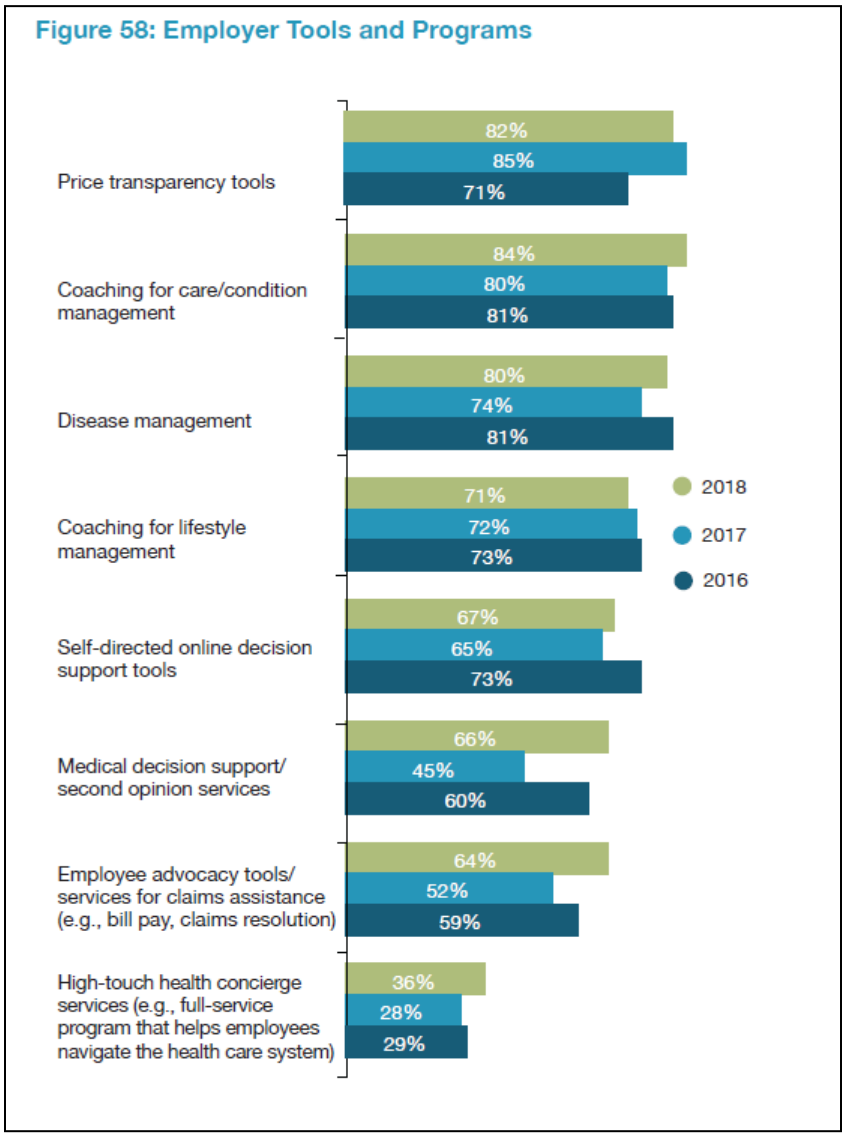
- Existing laws such as ERISA establish plan participants' rights and responsibilities in the event of a claim denial. Most often, the participant will contact the employer at the time of a claim denial to request relevant plan documents. It is not certain that a plan participant, however, will have relevant information such the price of care or out-of-pocket cost information that would be relevant *before* obtaining care or incurring health care expenses. This information is difficult to obtain for both employers and plan participants.

Plan sponsors, recognizing the need for effective health plan communications, have devoted substantial time and resources toward developing tools that participants will 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.

[4] National Business Group on Health, *2019 Large Employers' Health Care Strategy and Plan Design Survey* 21 (2018).

These services are increasingly available through both self-insured and insured plan options.



While these tools may be helpful, as the proposed rules note, information on networks, provider quality, and price remains incomplete for employers and employees. Plan-specific price information—including out-of-pocket costs and total cost of care—matched with quality and performance data would make these tools more useful to plan participants. As the health care system undergoes rapid change, the information plan participants need—and that group health plans provide—also will change. We therefore recommend that any future regulatory guidance take into account the need for flexibility in communicating with plan participants. For patients with employer-sponsored coverage, the most critical information—related to health care quality and price—may come from navigation tools that plan sponsors, health insurance issuers, and third-party administrators develop to assist participants in making health care decisions at or near the time of service.

B. While electronic information sources are becoming more common and useful for navigating the health care system, ONC and CMS regulations should acknowledge the critical role of other communications that may be equally effective, especially when used in combination with electronic sources.

To communicate plan offerings and designs, our members rely on a mix of communications methods. For example, in 2016, we conducted a Quick Survey[5] on how employers communicate health and well-being programs and initiatives. The responses showed that while intranet, email, and print communications are the most common, employers use a wide variety of communication methods in the effort to engage their employee populations. More recently, employers have added health care concierge, navigator, and advocacy services to help employees navigate their health care options. These services augment existing communications and information so that employees have decision-making assistance in addition to information on price or coverage.

While we support rules that would establish electronic communications as a default option, rules should also allow greater flexibility and availability of information by:

- Encouraging information platforms (including websites or apps) that allow plan sponsors and participants access to all plan information in a single location at all times;

- Allowing plans sponsors the ability to integrate information from various sources (such as pricing tools and portals to lifestyle and chronic condition management programs) that may be useful to plan participants; and

- Providing easy access to coverage and pricing information for prior years. This information would be particularly helpful for group health plan participants, as group health plan designs—and prices—change from year to year and determining payments may require coverage or pricing information from a prior plan year.

II. The final rules 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 going forward.

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

[5] Ridgley, Lisa, *Quick Survey Findings: Health and Well-Being Communications – Innovative Tactics and Strategies* (2016).

have developed insights into how transparency can shape and improve the health care system, including the following:

- It is critical that information be understandable and actionable for all parties in the health care system. With respect to group health plan participants, this information should be specific to the plans in which participants are enrolled. Patient data transparency efforts, such as making patient health records easily accessible across the entire continuum of care, should not create additional complexity with doctors' workflow. We also note that increased data availability can result in increased risk of privacy breaches and may not necessarily result in improved patient care or outcomes.

- Price transparency efforts should focus on informing *future* 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 would not necessarily assist individuals in making informed health care decisions.

- ACOs and other provider groups are taking on greater accountability for the health outcomes and cost of patients. Partnerships with these provider groups give plan sponsors a platform to push for deployment and utilization of price transparency information.

- 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. The push for patient data transparency will help ACOs better manage care and reduce waste, as they become less reliant on external data feeds that have a time lag and can lead to avoidance of duplicate services.

- 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.

- 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.

B. The Business Group supports including price information within the scope of electronic health information for purposes of information blocking.

As our comments above suggest, we agree with the Preamble's premises regarding price information:

- The fragmented and complex nature of pricing within the health care system has decreased the efficiency of the health care system.

- Pricing information continues to grow in importance with the increase of high deductible health plans and surprise billing, which have resulted in an increase in out-of-pocket health care spending.

- Increased consumer demand, aligned incentives, more accessible and digestible information, and the evolution of price transparency tools are critical components to moving to a health care system that pays for value.

In addition, there is evidence to support the premise that having access to electronic health information may improve adherence to physician recommendations for treatment and preventive screenings.[6] More efficient electronic health information systems—tailored to the specific needs of patients, providers and payors—also could reduce unnecessary testing and services and reduce negative drug interactions.

We also stress the potential benefits of providing timely, accurate pricing and quality information to providers. With this information, providers would be able to benchmark their quality and prices with competing providers, steer patients to high quality, efficient providers, and better understand costs of treatment options for their patients. Payors would also benefit from being able to adjust plan designs to include higher-quality and more efficient providers.

We therefore support including price information within the scope of EHI for purposes of information blocking. Specifically, we support including the following in EHI:

- The amount to be charged to and paid for by the patient's health plan and the amount to be charged to and collected from the patient, including for drugs or medical devices;

- All out-of-pocket costs such as deductibles, copayments, and coinsurance;

- A reference price as a comparison tool such as the Medicare rate; and

- A requirement that price information be reasonably available in advance and at the point of sale.

However, we caution that entities providing such information (electronically or otherwise) should do so in a manner that provides appropriate context and encourages evidence-based care. For example:

[6] Coughlin, S. et al. Patient web portals, disease management, and primary prevention. Risk Management and Healthcare Policy. 2017; 10: 33–40. April 2017.

- An individual enrolled in an employer-sponsored group health plan should receive price information tailored to the plan design, out-of-pocket cost structure, and vendor agreements that govern the specific plan at issue. The Medicare rate may not be helpful in this context.

- If price information is to be made available on public websites so that plan participants (or payors) can shop for care without having to contact individual providers, such information should be with reference to the specific health plans in those individuals are (or were) enrolled. There also should be a requirement that individuals or payors be able to rely on that information.

C. Future rulemaking

For the reasons above, the Business Group supports HHS undertaking future rulemaking to require health IT developers to include in their platforms a mechanism for patients to see price information, and for health care providers to have access to price information, tailored to an individual patient, integrated into the practice or clinical workflow through APIs. We also support, regarding efforts to reduce or prevent surprise medical billing:

- The provision of a single bill that includes all health care providers involved in a health care service, including network status;

- Ensuring that all health care providers in an in-network facility charge the in-network rate;

- Requiring that all providers at in-network facilities contract with the same health insurance issuers and third-party administrators that the facilities do; and

- Notification of billing policies such as timely invoice dates for all providers and facilities, including network status, due date for invoice payments by the prospective patient's payers and out-of-pocket obligations, date when unpaid balances are referred for collections, and appeals rights and procedures for patients wishing to contest an invoice.

While not all of these measures would necessarily be used at the same time by a single provider, it would be helpful for payors and providers to have these options.

Price information, within the scope of electronic health information for purposes of information blocking, would also help to reduce or prevent surprise billing. For plan participants, plan sponsors, and providers, having the following information publicly available in advance would further the above-noted goals of encouraging cost-effective, evidence-based care and increasing plan participant engagement. Ideally, hospitals and other health care facilities would provide this information with respect to each health insurance issuer with which they contract.

Such information would provide plan participants with more details about providers' "in-network" designation, allow patients to choose among facilities in non-emergency situations, and could encourage plan sponsors and health insurance issuers to assess the network status of facilities and negotiate for more complete in-network coverage:

- Whether or not a hospital or other facility requires physicians to have contractual agreements with the same health insurance issuers the hospital/facility does, and if not, which carriers

- The percentage of time in a calendar quarter that each core service performed by facility-based or facility-contracted physicians (e.g., emergency room physicians, radiologists, anesthesiologists, and pathologists[7])—which patients generally do not choose—is performed by out-of-network physicians

- Whether or not plan participants will receive a single bill for a health care service, and if not, the services for which participants may receive a separate bill

- If receiving a separate bill for any of these types of services, the average, median, and range of prices plan participants can expect for each of these services

- The average in-network rate across all health insurance issuers for each of these services, if used for purposes of provider reimbursement

We believe that the above recommendations, if implemented, will reduce fiscal and regulatory burdens for employers, improve affordability, increase transparency, 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 ONC and CMS in the rulemaking process. Please contact me or Debbie Harrison at the Business Group's policy team at (202) 202-558-3004 if you would like to discuss.

Sincerely,

Brian Marcotte
President

[7] These are among the most common services for which patients receive surprise bills, but there are other physicians who are contracted by facilities whom patients do not choose.