Preparing for Transparency in Coverage (CMS-9915-F), and the Prospects for Impact Beyond Compliance

Research and white paper by EHIR and Rx Savings Solutions

"TiC, TiC, TiC…" For health benefit managers at employers across the country, that's the sound of the clock counting down to 12:00 a.m., July 1, 2022, the first compliance deadline on deck for the Transparency in Coverage (TiC) Final Rule.

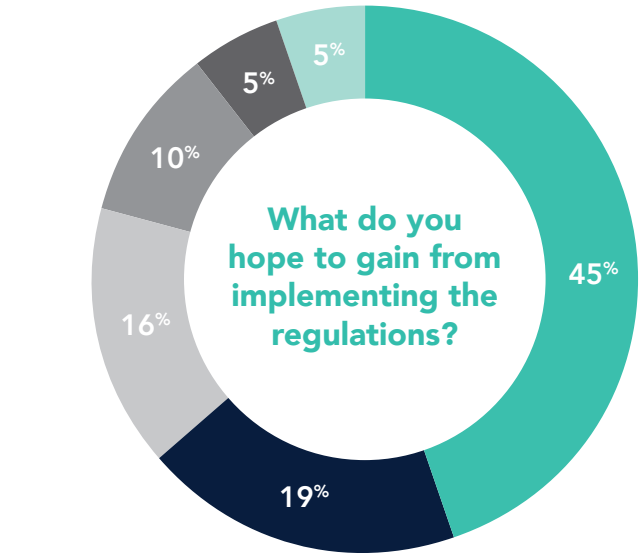
Announced in 2020, TiC regulations (CMS-9915) are intended to make healthcare pricing data public so consumers can access necessary information needed to make informed decisions.[1]

Transparency in Coverage is designed for consumers, but insurers and issuers are largely responsible for construction, starting with perhaps the most onerous piece to procure: machine-readable files for 1) in-network rates, 2) out-of-network allowed amounts and 3) billed charges. These include negotiated prices for covered prescription drugs.

EHIR members polled during meetings in fall 2021 generally favor the rule—or at least the principle behind it—but responses vary on preparation and progress toward compliance, as well as predictions for impact.

Polling results and Cohort conversations revealed several insights and sentiments on Transparency in Coverage. This report will explore these and others more deeply:

- Paths, partners and costs related to compliance
- Hope, skepticism and questions on the road to full implementation by 2024
- The difference between "check-the-box" compliance and innovation that drives meaningful change for employees and the organization

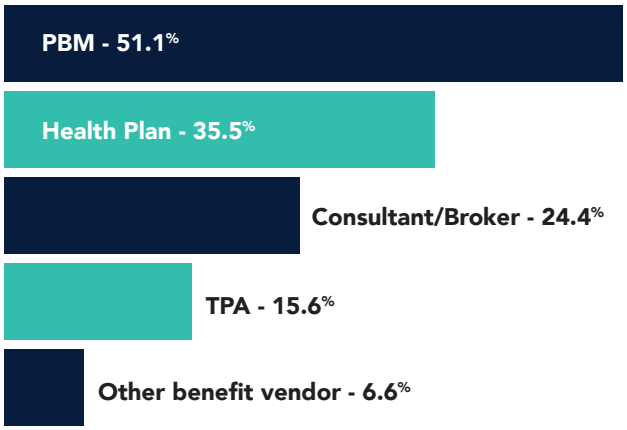


Focused on July 1, 2022

For good reason, a majority of benefits leaders who weighed in aren't looking much beyond July 1. Enforcement was originally set to begin January 1 before the Departments of Labor and Health and Human Services granted a reprieve and pledged enforcement discretion.[2]

One reason the federal government flexed on the deadline is that employers discovered how daunting the task of compiling and formatting the required data can be. While most meeting attendees (73%) reported being somewhat-to-very familiar with TiC requirements, their paths to compliance and goals beyond compliance were less clear.

Of the vendors you plan to engage to help your organization meet the requirements, which do you consider responsible for supporting your organization?

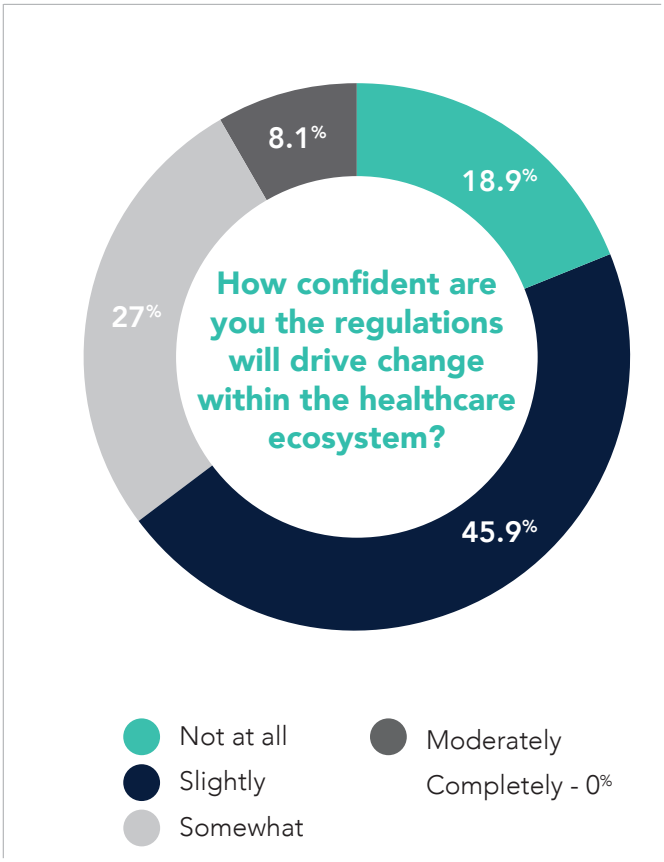


- **Who's responsible** – Employer attendees were asked which of their vendors they consider responsible for helping them meet the required medical and pharmacy components. Nearly half specified their pharmacy benefit manager (PBM), followed by health plan and consultant. ERISA councils and internal compliance departments were also mentioned.
- **Who's working on it** – Approaches and levels of benefit team involvement vary by employer size, with benefit leaders at larger employers more removed from the process. Those at smaller organizations are more involved, which creates an additional burden on teams already overwhelmed with pandemic-related and return-to-office policies. This increased demand is one reason many reported focusing solely on "checking the box."
- **What's the goal** – Many leaders see long-term value and potential for the transparency rules (see Impact on Plans and Members below). But due to the burden of meeting just the minimum requirements, most plan to do just that. One attendee said: "The challenge with looking ahead to 2024 [requirements] is that [the requirements due in] 2022 is so clunky."
- **Who's paying for it** – Some EHIR members shared that they've discussed fees for regulation-support services with responsible vendors, but most said the topic has not been broached with specific details. Those who had discussed with a PBM, TPA or consultant implied that the costs are considerable. However, some reported negotiating for dropped or reduced fees.
- **What may not need reporting** – While purely anecdotal at this point, it's worth noting that some employers, based on discussions with their PBM, indicated there may still be some question as to what they do and do not need to share, with some PBMs claiming their information is "proprietary."

Impact on Plans and Members

Discussion of the regulatory impact spurred the greatest range of opinions and speculation on outcomes. Most meeting attendees said the degree to which they can internally leverage the required data output depends on how it is presented. Many plan to take a "wait and see" approach as to whether any meaningful information can be gleaned from their own data, and from that of other organizations.

- Several stated they intend to use other plans' published data to compare against their own charges and costs. They hope to use it comparatively for plan design, but many questioned how actionable the information may be.
- Disclosing data causes some concerns relating to whether employers have the best negotiated rates. Some are skeptical that transparency will lower costs, speculating that it may instead raise rates for those with "better deals."
- Though published data will arm benefit leaders with more information, their hands may still be tied when it comes to making any sweeping changes. One benefit manager acknowledged he wouldn't remove a hospital system from the company's plan design if it were found to be charging more. Disruption for affected members wouldn't be worth it, he said.



While degrees of skepticism exist on the employer side, many are optimistic that Transparency in Coverage can spur meaningful change, particularly for consumers (employees and dependents). Machine-readable data, alone, won't move the needle much, however. It will take time and implementation of remaining components of TiC—namely the internet-based self-service tool required for 2023 plan years, as well as the inclusion of in-network rates and allowed out-of-network amounts for all covered items and services in the tool by 2024.

5 Random But Related Thoughts:

» Several EHIR members covet an "ideal" transparent system that puts information into the hands of the patients and doctors, allowing both to look up covered costs for treatments and prescriptions, "like buying sneakers on Amazon."
» Others questioned whether employees would even be aware of the published data, let alone use it in decision making, adding an additional burden on employers to help educate their members on how to access and interpret the data.
» Comparisons were made to the mandates for publishing ingredients and nutrition information on food labeling and calorie content on restaurant menus. Consumers became better informed, but there was little change in overall population health.
» However, it's important to note the contrast between food-labeling mandates and price transparency in health insurance. Unhealthy food is typically easier to afford. Given that consumers are bearing more of the cost for healthcare, there is a built-in incentive to shop for the best deals.
» One attendee speculated that it would take 5 years to see broad market change within medical transparency, and 10 years in pharmacy.

The real goal of benefit leaders is to educate and guide their employees to make the most cost-conscious choices that support their health and wellbeing.

Many expressed hope that TiC will drive change but stressed the importance of member education and support. Without those components, members will just have another layer of information and potential confusion. Transparency solutions that aggregate and distill the data into actionable insights will be paramount, as will care navigation solutions that guide members through the healthcare system.

The Perfect Entry Point and Proving Ground

A common theme that emerged among meeting attendees was that consumer access to pricing information is good, but cost is only one factor in a treatment decision. Quality of care, as well as cost, can vary greatly from one facility, doctor or hospital to another.

That's hardly the case with prescription drugs. One thing the world's most expensive pharmacy system has achieved is consistent product quality across the board. Atorvastatin is atorvastatin whether it's purchased from Walgreen's, CVS, a supermarket or shipped from a warehouse.

Pharmacy is also the most frequent and repeated health benefit with direct ties to every step in a patient's medical care journey. Yet the pharmacy benefit is arguably the most opaque and complex of them all. Which is why someone might pay $5 for Atorvastatin and her neighbor pays $350. That same neighbor likely has a suitable statin on his plan's formulary for $5, but he is simply unaware.

The fact that prescription drugs are commodities—coupled with the widespread lack of information on costs and alternatives—makes pharmacy an ideal starting point for employers' transparency initiatives. While consumers may associate higher charges for a procedure with higher quality, very few would perceive higher value in a $350 prescription than one with a $5 charge.

Price transparency on the medical side is only beginning to take shape. There are inherently more components and variables at play, more data sources to integrate, and so many involved parties across the spectrum of care. Additional solutions will no doubt emerge as we approach the self-service tool compliance dates for Transparency in Coverage in 2023 and 2024.

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However, employers have adopted pharmacy transparency solutions with increasing frequency and success for several years. In many cases, these solutions already satisfy all TiC requirements and have demonstrated cost savings for both plans and members.

The true pinnacle of transparency is viewed as the intersection of cost, quality and clinical outcomes. That future may be years from fruition, and employers may be laser-focused on the present right now, the first step in their path to compliance. The right solution can both "check the box" for compliance and serve as an innovative model for reaching the pinnacle.

Key Takeaways

- Benefit leaders face a growing burden of compliance initiatives and are looking to their key vendors to support and address the requirements.
- While many want the regulations to drive change, they believe success will depend on consumer awareness and education.
- Employers intend to leverage published data from others' plans for their own comparison and plan design.
- Many remain skeptical that the regulations will drive meaningful change in the near term, and will look to existing vendor solutions to help educate and guide members through a healthcare journey.
- Due to its "commodity" nature, frequency of consumption and data interoperability, pharmacy is an ideal place to start using price transparency to educate members on healthcare consumerism and begin nudging them in a better direction.

Citations

1. Federal Register, Nov. 11, 2020; https://www.federalregister.govdocuments/2020/11/12/2020-24591/transparency-in-coverage
2. Federal Government Announces Enforcement Discretion, Deferral for Certain Price Disclosures and Future Rulemakings; Healthcare Law Blog; Sheppard Mullin Richter & Hampton, LLP; Aug. 12, 2021, jdsupra.com

EHIR Members