SIIA HEALTHCARE PRICE TRANSPARENCY FORUM PREVIEW

Written By Laura Carabello

As self-insured health plans take the lead in bringing transparency to a rapidly evolving healthcare system, they draw upon the resources of SIIA to fulfill their mission for better decision-making and optimal clinical outcomes. As they envision healthcare to include more accountability and greater transparency, it is clear that evidence of efficacy facilitates the transition to safer healthcare with value for the resources that are invested.

From the latest policy and compliance discussions to innovative ways of tackling the cost of care and prescription drugs, the upcoming SIIA 2024 Healthcare Price Transparency Forum brings together industry-leading experts and innovators who will provide expanded understanding and guidance to help navigate these complex issues. Attendees will learn the value of increasing transparency to improve care at a lower cost.

HEALTHCARE PRICE TRANSPARENCY FORUM

February 26-27, 2024

JW Marriott Charlotte, Charlotte, NC

SIIA

Ryan Work, SVP, Government Relations, Self-Insurance Institute of America, Inc. (SIIA), oversaw the design of the Forum and will be moderating several of the panels. He explains, “Price transparency has not only become an important policy and regulatory discussion before Congress and the Administration, but it is also a critical issue for the future of employer-sponsored healthcare generally and self-insured plans specifically.”

He says SIIA is hosting this event since it recognizes that members need all the tools at their disposal to ensure plans are paying the right price for the correct patient care, in addition to doing all they can collectively to effectively manage the rising cost of healthcare.

As a regulatory expert who pro-actively advocates on behalf of members, he asserts, ‘SIIA continues to actively engage with Congress and the Administration on price transparency, from the implementation of the No Surprises Act (NSA) to the ongoing debate on drug pricing and Gag Clause attestation. With ongoing litigation surrounding NSA, to congressional legislation on PBM and price transparency, our team is busy educating Federal agencies and policymakers on the Hill about what members are facing and the solutions we support.”

Encouraging attendance and participation at this year’s Forum, he advises, “The 2024 event is broader than in years past as the debate on price transparency has also widened in scope. Stemming from the implementation of NSA, the 2024 Transparency Forum will also address drug pricing, the Gag Clause prohibition, and the challenge and opportunities being faced by self-insured health plans.”

Most importantly, he says the panels of experts will address what is working, what needs to be fixed and what can be done to effectively bring transparency and lower costs to healthcare delivery.

“The Forum’s goal is to be an interactive dialogue with industry leaders, including plan sponsors, brokers, third party administrators (TPA’s) and vendors, to talk about best practices, market viewpoints and what lies ahead in an ever-changing landscape.”

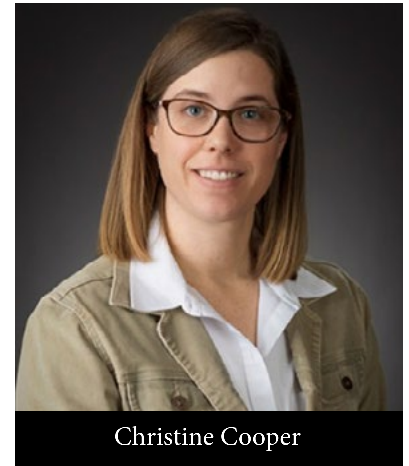
ATTEND AND LEARN

Chris Condeluci, Esq., Washington counsel, SIIA, a co-architect of the event who will also be participating and moderating many of the sessions, says, “Until we can figure out how to reduce the unit cost of healthcare, costs will continue to rise. To manage these increased costs, employers continue to look to different strategies that can empower participants to be better consumers of healthcare.”

Additionally, employers are looking at better ways to manage costs, and Condeluci advises that transparency is a means to these ends.

“For example, the public disclosure of medical prices and greater access to cost-sharing liability information will help participants consume healthcare more efficiently,” he continues. “Also, access to

pricing information and health claims data will empower employers in their contract negotiations with third-party service providers and owners of provider networks and help employers develop cost-containment programs. This Forum will discuss in detail the various types of transparency tools that are available to employers and other organizations sponsoring a self-insured health plan, and expert panelists will explain how these tools are being deployed and whether and how savings are being realized."


Christine Cooper

Condeluci points to policymakers and other healthcare experts who have heralded the Transparency in Coverage and Hospital Transparency Regulations as being transformative. But he raises this question: "3.5 years after their release, are these regulations really having a transformative impact on the healthcare industry?"

He reports that some healthcare stakeholders would say, "No," adding, "Many healthcare stakeholders would caution, "Give it time…increased access to pricing and health claims data will dramatically change the way health coverage is offered and consumed. The future and overall impact of increased transparency will be debated and explored in depth at SIIA's Healthcare Transparency Forum. If you play any type of role in the healthcare industry, you won't want to miss it."

Christine Cooper, CEO, aequum, and chair of the SIIA Transparency Committee, expects robust exploration of hospital price transparency requirements, explaining, "There is a lack of standardization in the requirements for what and how hospitals report transparency data. While the government has issued guidance relating to the requirements, the guidance is not enforceable, and we are still seeing significant non-compliance by hospitals sharing the required data."

Cooper says Machine Readable Files continue to be incomplete or missing entirely, and as of July 2023, PatientRightsAdvocate.org reported that only 36.0% of the 2000 surveyed hospitals were fully compliant: 69 providers had no usable information accessible. A new report is due out in February 2024.

SIIA FORUM PANELISTS TACKLE KEY ISSUES

Transparency: Policy & Regulatory Update
Tuesday, February 27, 2024, 8:45-9:30 AM

Attendees will benefit from the guidance of SIIA's Government Relations team, who will provide the latest insights and discussion on regulatory and legislative activities on PBMs, price transparency, and surprise medical billing, in addition to ongoing Hill debates.

Condeluci observes, "Owners of provider networks, such as entities that "rent" a provider network to a self-insured health plan, are still refusing to share pricing and claims data with self-insured health plans and their plan sponsors -- both unions and single-employers. They are filing lawsuits and asking a court of law to compel owners of provider networks to share the data with the plan and plan sponsor."

These lawsuits are currently at the District Court level, and it remains unclear when and how the Courts will rule. However, the Transparency Forum will provide ideas of how the Courts may rule, whether there are more lawsuits on the horizon, and whether these lawsuits – in and of themselves – are changing bad behavior and having a positive impact on contract negotiations between plan sponsors and owners of provider networks.

Panelists – including two lead attorneys in these data-sharing lawsuits – will take a deep dive into the ongoing struggles to access pricing and claims data and discuss what the future might hold.

Gag Clauses & Data Sharing: What Should We Do & Where Do We Go From Here?
Tuesday, February 27, 2024, 9:30-10:15 AM

While the Gag Clause Prohibition has been effective for three years, this panel of thought leaders will tackle the issues still facing plan sponsors, such as how they are getting their data and how they – and their service providers – are handling the "attestations." Presenters will also weigh in on what steps Congress and the Federal Departments or courts can take to help.

Panelist Mark Combs, CEO, Self-Insured Reporting, expects to address the impact of the attestation filing deadline and the fact that the vast majority of plan sponsors "…really couldn't tell you anything about the Consolidated Appropriations Act (CAA) or that a prohibition on gag clauses and a compliance attestation deadline even exists."

He says that there is a severe lack of understanding and information in the marketplace, which has led to silence on the matter in hopes that additional guidance, or even a delay in the requirement, will be forthcoming.

"For fully insured groups, they typically do not even know that they should indeed have access to their data now," continues Combs. "For self-insured groups, most have not given much thought to the requirement. Instead, they primarily rely upon their brokers' word that they are in the clear. The broker also rarely knows much about this, and they are relying upon the word of the TPA – which sees this as a plan sponsor requirement and is trying to avoid getting involved at all. Bottom line – it is a mess."

Combs advises that before we even talk about getting data, plan sponsors first must (1) understand what this requirement is, (2) identify and remove all gag clauses, and then (3) have access to all claims data and provider quality data.

Furthermore, for those plan sponsors who are aware of the attestation deadline, many are relying on their service providers to attest on their behalf. However, the service providers are requiring a hold harmless before they are willing to file.

"The fact of the matter is that the overwhelming majority of self-insured groups are NOT compliant," shares Combs. "Filing a false attestation to the DOL just sounds like a bad idea."

Finally, he states that it is clear that Congress is seeking to use market influence as a tool to clean up the marketplace, adding, "In a perfect world, Congress would simply make gag clauses illegal at the TPA/PBM/Carrier level so that the plan sponsor would not have to deal with it directly – although that may not be realistic. At the end of the day, there is no getting around the marketplace having to learn what in the world this whole thing is about. Brokers need to up their game and guide their clients, as opposed to taking the TPAs' word for it that things are all good."

Decided in Court: Lawsuits to Access Pricing and Claims Data
Tuesday, February 27, 2024, 10:45-11:30 AM

Self-insured plan sponsors have filed numerous lawsuits to get access to the plans' claims data, while other lawsuits have challenged and changed the course of the No Surprises Act.

While some cases have settled and others are still making their way through the courts, this discussion will provide attendees with current information, what these lawsuits mean for increased price and claims data transparency, and how to plan for the future.

Panelist Herman Hofman, partner, Varnum Law Firm, expects to bring clarity to the issues of ownership of the claims data and whether plan sponsors or TPAs own the claims data; the role of TPAs as fiduciaries and how to determine if a plan's TPA is a fiduciary to the plan – including the implications of fiduciary status to a plan sponsor's ability to access and use their claims data.

Hofman points to the barriers to accessing claims data, questioning, "What effect do contractual audit provisions and gag clauses have on a plan sponsor's ability to access claims data, and how can you overcome barriers?"

He states that barriers to using and interpreting claims data also raise questions, "Assuming a plan sponsor obtains some or all of their claims data, what other barriers often exist to using and interpreting the claims data? Furthermore, what should plan sponsors be on the lookout for in reviewing the claims data, and how can they overcome those barriers?"

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Expect some lively discussions as presenter Julie Selesnick, Esq., senior counsel, Berger Montague, declares, "We need MORE lawsuits filed against payers/insurance carriers that contract with employer-sponsored health plans to give them access to provider networks if transparency in pricing and full, unmasked claims data is ever going to become the norm. And it needs to become the norm if we are ever going to gain control of healthcare costs."

She says the current environment is completely opaque, and the masking of cost and quality information, in concert with other actions taken by the large payers/insurance carriers, has left us "...in an environment devoid of competition, where even the largest companies are forced to sign contracts of adhesion if they want access to one of the "BUCA" networks (Blue Cross, United, Cigna or Aetna)."

While Selesnick acknowledges that there have been many advances over the past several years in the law (e.g., the gag clause prohibition in the Consolidated Appropriations Act of 2021, No Surprises Act), by executive order (Transparency in Coverage and Hospital Price Transparency), and in rulemaking and guidance by the DOL and other regulatory bodies, "There is still a major lack of cooperation from the payers/insurance carriers hired by self-funded plans or their independent TPAs to provide the plan participants with access to their established networks at their negotiated rates."

She cites that one of the major reasons for this lack of cooperation by insurance carriers is that it is critical for them to keep the terms of their agreements with providers and facilities a secret if the current business model is to continue.

"Once those terms become public, there will likely be a huge backlash against some of the provisions in these contracts that most self-funded plans currently have no idea they are subject to," she advises. "It appears that the only way we are going to make substantial progress towards this goal, however, is by self-funded plans, through the plan fiduciaries, suing these payers to establish their right to unfettered access to the data, as the law doesn't seem to be enough to change some long-engrained anticompetitive behavior."

She cautions that, unfortunately, the majority of cases filed against the payers/carriers, to date, have settled prior to any court opinions being rendered on the topic and prior to the completion of discovery -- which might make public the types of information that would motivate other plans to act.

Hugh O'Toole, CEO, Innovu, views this discussion as an opportunity for employers to harness their data, yield significant financial benefits, and enhance healthcare outcomes for employers and their plan participants.

"This is the first time in American history that Plan Sponsors in health insurance have the disclosure and data necessary to work in the best interest of their participants," imparts O'Toole. "In response to this, the laggers will say that they're waiting to see if the government is serious and what the consequences are. Just like what we saw with retirement, civil lawsuits are becoming more common."

He points to a plan participant's lawsuit against Major League Baseball/Aetna over mental health and a lack of parity.

"Not only are plan participants taking legal action but also is the government," he continues. "We are seeing the DOL directly getting involved, such as suing UMR for not following the Plan document in adjudicating emergency claims on behalf of the plan."

He says the evidence is clear: "The government has intentionally put the Plan Sponsor in harm's way. They know from experience that a Plan Sponsor in harm's way will discipline the industry that puts them at risk."

O'Toole looks forward to expanding on several key concerns:

- Why governmental involvement mirrors that of the 401k Industry
- The economic value to the employer and employee of functioning as a fiduciary -- appreciating the role and importance of data, deciphering the stories within the data, and differentiating between intriguing insights and straightforward findings.
- Utilizing new data sets and revealing how the new data sets can help the advisor/employer differentiate their offerings in the market, as well as achieving hospital and payer transparency wherein quality data is integrated with the paid claims.

Hospital & Provider Price Transparency: Is It Making A Difference?
Tuesday, February 27, 2024, 11:30 AM– 12:15 PM

Compliance with the Hospital Transparency Rule is still woefully low despite the threat of increased penalties. However, there is an increase in the percentage of hospitals and providers that are making efforts to post pricing information on a public website. Attendees can expect to learn a great deal about the usability of pricing information among self-insured plan sponsors and participants – and what more can be done.

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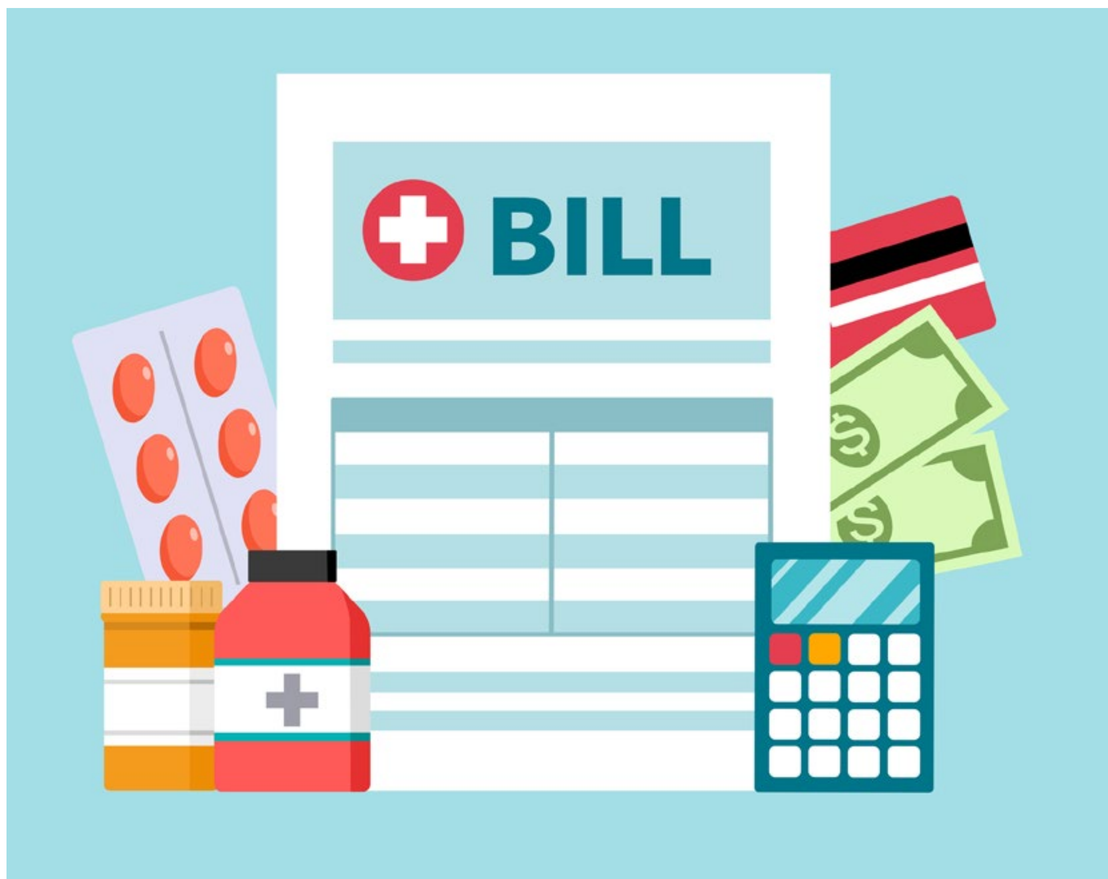
Here's a preview from panelist Cheryl Matochik, Managing Director, Third Horizon Strategies, "The charge on price transparency continues. It is not the destination but rather an essential step on the journey of upending historic black box pricing dynamics in healthcare to create a more transparent and accountable healthcare system."

She points out that lawmakers will continue to look to a variety of policy levers to provide relief to their constituents, as evidenced by these initiatives, which will be discussed more fully during the presentation:

- Unusual broad-backed House passage of the Lower Costs, More Transparency Act which requires hospitals and insurers to spell out more clearly their costs to consumers and reduces Medicare payments to hospitals for some services that are provided in outpatient facilities and doctor's offices.
- Updates to the Hospital Transparency Rule: by 7/1/2024, hospitals and health systems must publish machine-readable files (MRFs) according to a standard format that includes more detailed data elements. CMS has coupled the required MRF format with additional measures designed to strengthen and automate enforcement efforts.

"Our organization is encouraged and interested to see how this update plays out in a few key areas," says Matochik. "Each payer-negotiated rate must now be accompanied by a description of the contract provision used to calculate the rate (i.e., case rate, per diem, etc.). This needed context on contract payment methodology has been missing, making it difficult to create apples-to-apples comparisons. Additionally, the final rules also require providers to elaborate on how each rate was calculated throughout the process of creating the MRFs."

She suggests that these changes should bolster price transparency data quality by removing a lot of current guesswork required to add meaning to dollar values that exist without a defined methodology.



"It will be really interesting to see if in 2024 CMS requires these updates to the payer MRFs as well -- we expect they will," she advises.

Finally, Matochik cites State actions to control commercial healthcare costs, including:

- States are enacting legislation to enforce federal price transparency rules for hospitals and insurance plans, as well as establish additional state-level requirements
- States are floating proposals on capping hospital rates based on Medicare payments (ex. Indiana)
- States are looking to address health facility fees

Panelist Patrick Haig, CEO and co-founder, GoodBill, offers this perspective: "Current pricing information is a good start, though it's still not actionable for the average patient and average plan. But it's useful if you're armed with the right way to access the information and use it."

He maintains that software and data are the tools needed to ingest the data from the price transparency files and use it – but in no way is it easy for patients to use.

"The files come in all formats and sizes that are hard to access, and not everyone's computer is capable of opening or parsing a JSON file," he asserts. "Then there's the question of what the average patient can do once they have that data. The spirit of price transparency is well and good, but it's only useful to patients if they can tie a line item on a bill to its published price and if they can get their hands on that information in a timely manner."

To do that, he argues that you need to get the underlying procedure codes to match line items one for one.

"Those codes are on the claim or itemized bill, but I can't tell you how many facilities still refuse to provide patients with a copy of their claim (such as a UB-04), even though it's part of the designated record set that patients are entitled to under HIPAA Right of Access."

He contends that there is not enough awareness and that the average American doesn't know if their hospital's prices are published. A lot of times, he insists that even the workers in hospital billing departments don't even know about the data.

Haig calls for the inclusion of transparency around contracting terms, giving patients programmatic access to their claims and EOBs in one place and enabling third parties to connect the dots with medical record data.

The call for hospital price transparency will get additional substantiation from panelist Ahmed Marmoush, CEO, Handl Health, who says, "Schemas are becoming standardized, and the growth in compliance and quality of data we've seen over the last 2.5 years is significant from the standpoint of data access, scalability and manipulation. The manpower involved in creating a national database, interrogating that data, and making apples-to-apples comparisons is substantial. Standardization will start to make a big difference for people and companies looking to meaningfully use this data."

He believes there have been lessons learned on the value of standardized schemas to support scalable analytics and interrogation of data to drive decision-making.

"The unique component of the hospital price transparency data is that discounted cash rates are published," he explains. "In a world where direct contracting and specialty carveouts are becoming more common, having data points around the relative differences between contract negotiated rates and cash

payments is material, and it also begs the question of why there are such differences in cost and inflation of the true cost of healthcare."

Marmoush cites the value of provider price transparency as it relates to real-time payments and cash payments, noting, "If there was a world whereby, in the same way we got hospital cash price transparency, we got provider cash discount prices, we would not only know that it costs, say, $467 for an MRI, but we could then start to understand the cash payment to see a physical therapist or your family medicine doctor or even to have a mole removed. This creates an entirely new world of direct contracting and carveouts for health plans that we see a little bit through direct primary care models."

Finally, he views one of the most exciting things about price transparency is the No Surprises Act and the Good Faith Estimate, predicting, "That's where we see the future of healthcare going. A world whereby a consumer can understand exactly how much an appointment costs and even how much an elected surgical procedure costs. This could be approved by all the parties involved, such as the provider, the employer, the TPA, or the carrier, and can be transacted at the point of care delivery — or at least within a few hours after. The Good Faith Estimate provision and the Advanced Explanation of Benefits lays the groundwork for this world."

Surprise Billing Arbitration: The Future of Uncertainty
Tuesday, February 27, 2024, 1:15-2:15 PM

The last year has proven to be challenging for self-insured plans and their service providers, defending against disputes initiated by providers over out-of-network care. With fits and starts and changes to the Federal IDR process and the development of the QPA, this panel will explore what industry participants should know and where this is headed.

Christine Cooper provides this update, with deeper discussion on the topic during the panel presentation:

Batching of Claims: will not be implemented until the later of August 15, 2024 or 90 days after effective date of the final rules.

- Providers can submit multiple claims for a single adjudication so long as the services were rendered by the same provider, within the same 30 business days, were paid for by the same payer, and were related to the treatment of a similar condition. This is limited to 25 line items per dispute.
- Open Negotiation (not implemented until the later of August 15, 2024 or 90 days after effective date of the final rules).

Parties will be required to conduct activities through the online portal, which is currently only used for the arbitration process. The initiating party will be required to include additional information with its negotiation notices, including more details about the disputed items or services; the non-initiating party will be required to file a response within 15 business days of receiving the initiating party's open negotiation notice.

IDR Process: will not be implemented until the later of August 15, 2024 or 90 days after effective date of the final rules. Notice of IDR would have to include additional information identical to the ONN.

- The non-initiating party will be required to furnish a written response regarding claim eligibility within three business days of receiving the Notice of IDR Initiation.
- A preliminary three-business day selection window in which the parties could negotiate regarding IDRE selection, followed by a final selection window in which the IDRE would undergo conflicts screening

IDR Government Fee

- As of 2024, increases to $150; payment due within 2 business days following selection; fee submitted to CMS directly

IDR Registry: payers would register with the Departments and provide general information on the applicability of the Federal IDR process to items or services covered by the plan or coverage; payers would receive a registration number

How Did We Get There: PBMs, Gene Therapy and Drug Pricing Tools
Tuesday, February 27, 2024, 2:15-3:15 PM

Policymakers and regulators are taking a serious look at PBM practices and drug pricing transparency. With ever-increasing drug costs and more and more states including self-insured plans in legislative activities, what does the future hold for PBM transparency and the cost of prescription drugs? What best practices are in place for self-insured plans?

It's likely going to be a robust discussion, given the recent announcement by CVS, an initiative that is part of a broader effort to stabilize its retail pharmacy business and address criticisms regarding the complexity and lack of transparency in drug pricing.

Kristi Bohn, VP, Lead Actuary, RGA, looks forward to explaining the role of PBMs with an overview of the disruptor Mark Cuban effort and an update on plans and employer uptake of that effort.

"In terms of gene therapy and how we get there, I will touch on several sub-topics such as the role of stop-loss/reinsurance, access, equity, network considerations including discounts, warranties, and other aspects," says Bohn. "For the discussion of drug pricing tools, we will review particular tools being referenced or practices that entities each employ, as well as data mining practices and benchmark resources not related to a particular tool."

She points to facilities' J-code upcharges as a major concern, as this is more commonly problematic than retail drugs.

Will Price Transparency Lead to Lower Costs?
Tuesday, February 27, 2024, 3:45-4:30 PM

While great strides have been taken by the government and the private sector to increase price transparency, this panel confronts the remaining questions: does all of the new information and data that is now available really matter, and do the prospects for it actually lead to lower costs for self-insured plans and healthcare consumers?

Panelist Francois de Brantes, senior partner, HVC Incentives Advisory Group, leads the discussion, reframing the title: Will Price Transparency Lead to Lower Costs Prices?

"In the year 2000, the average annual cost for an employer to cover a family was about $6,400, and the annual per beneficiary costs for Medicare were $5,800," he begins. "By 2023, the costs to cover a family had risen to $24,000 and per Medicare beneficiary costs had risen to $15,700. Therefore, while per Medicare beneficiary costs had multiplied by 2.7, family coverage had been multiplied by 3.7, reflecting a significantly higher rate of inflation."

He says we all know that Medicare beneficiaries are older and sicker than under 65 employed individuals, and what accounts for the more than doubling of costs comes from the expansion of Medicare to cover pharmacy, new treatments, and the yearly price increases that the government applies to Medicare rates.

"However, by all accounts, families in the year 2023 aren't sicker or older than in 2000," he comments. "So, what accounts for the close to fourfold increase in total yearly costs? Certainly, new treatments, but mostly much, much higher prices. We knew this as early as 2003 when a group of academic researchers famously titled their study: 'It's the Prices, Stupid!' And that has been confirmed many times since, including in 2019 with another study aptly entitled: 'It's Still the Prices, Stupid!' "

Since July 1, 2022, when the first payer rate files were released, the evidence of the differences in prices paid by Medicare and the private sector has poured out and unambiguously confirmed what the researchers found.

"There should be no doubt left for anyone that the single biggest contributor to price increases has been the lack of transparency," he asserts. "Behind a carefully guarded veil of secrecy, carriers have allowed prices on employed populations to increase because they have directly benefited from those increases. With the passage of the Affordable Care Act, carriers have seen their total profit margin for insured plans capped at a fixed percent of total premiums. But if premiums increase, so do total profits. Further, with the increase in popularity of and enrollment in Medicare Advantage, carriers have bargained hard to get lower than Medicare rates from hospitals, mostly in exchange for ever-increasing prices on employers."

De Brantes says we now know one thing for sure, which is that the lack of transparency has led to higher prices.

"But will transparency help lower prices?" he asks. "By itself, the release of the information is unlikely to lead to lower prices. However, there are several other factors that will inevitably lead to lower prices and greater competition amongst providers."

He cites these points:

1. First, employers have to give their plan members estimates of cost-sharing for upcoming care, and

they have to show those estimates by provider. There is ample evidence of plan member price-sensitivity, dating all the way back to the famous RAND study in the 1980s, which was reaffirmed in the early 2000s.

2. Second, employers have new fiduciary responsibilities related to their health benefits plan that compels them to attest to the prudent use of funds. And certainly, it's not very prudent for an employer to spend two to three times more for a given service with a given provider than they otherwise would. That's why benefits consultants are hard at work developing new tools that leverage all of the published rate files to construct much smarter ways to assess and build networks.

3. Third, the regulators have already corrected the deficiencies in the hospital rate files, which will lead to even greater specificity, completeness, and accuracy of that information, and the same will happen with the payer rate files.

"The democratization of all the information contained in the price transparency files is happening and will likely accelerate as the demand from employers and their plan members for better ways to compare rates and control costs goes up," he concludes. "And it will, because once you realize you've been fleeced for years, you rarely stand still waiting to be fleeced again."■

Laura Carabello holds a degree in Journalism from the Newhouse School of Communications at Syracuse University, is a recognized expert in medical travel, and is a widely published writer on healthcare issues. She is a Principal at CPR Strategic Marketing Communications. www.cpronline.com

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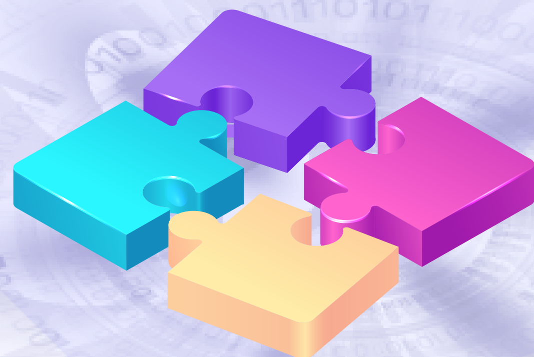

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