American Health Policy Institute

LEVERAGING HEALTH CARE PRICE TRANSPARENCY

CHRO GUIDE

By Margaret Faso

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Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

Who is considered a fiduciary?

Four steps you can take to leverage increased health care pricing transparency

About HRPA's American Health Policy Institute

HRPA

Executive Summary

After payroll, health care is the second largest expense for most employers. Despite this, many employers passively accept annual health care cost increases of 5-20%. Why this acceptance? Often it's driven by the incredibly complex nature of the U.S. health care system, which makes it almost impossible to understand the true costs involved.

The opaque pricing nature of our health care system is largely due to the mix of private and public payers, varied coverage plans, and diverse networks of providers, significantly limiting the ability of employers to manage their costs. However, Congress and recent administrations have taken steps to remove the "black box" of health care cost information.

> ***The bottom line: CHROs and their teams should take full advantage of legislative and regulatory changes to health care price transparency.***

Taking a more active role in the development and administration of employee benefits will improve the company's bottom line and the physical, emotional, and financial well-being of its employees.

According to the Kaiser Family Foundation, health care premiums have grown 47% over the last decade. Rising costs impact Americans' ability to access needed health care services with one in four Americans delaying or going without care due to cost.

It's not just a problem for the uninsured. About half of U.S. adults state they would not be able to pay an unexpected $500 medical bill. Addressing high health care costs can provide employees with more financial stability, remove barriers to accessing care, and in turn, prevent the development or progression of costly, chronic illnesses that impact the individual's quality of life.

Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

Who is considered a fiduciary?

Four steps you can take to leverage increased health care pricing transparency

About HRPA's American Health Policy Institute

HRPA

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WHAT DO WE MEAN BY HEALTH CARE PRICE TRANSPARENCY?

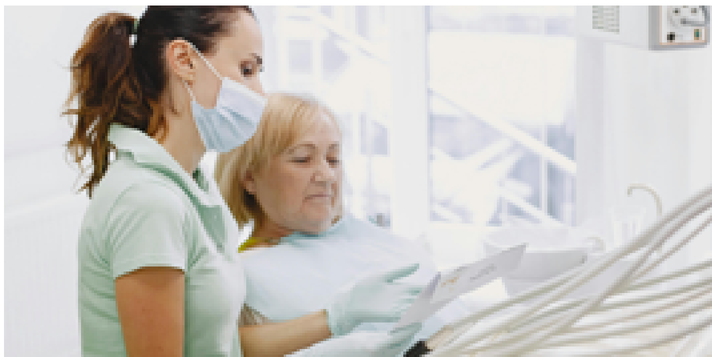
Price transparency is only achieved through publicly available data showing consumers the cost of a health care service before receiving the care.

- Opaque pricing impacts all aspects of the health care system from hospitals to carriers to pharmaceuticals.
- Unlike public payers (like Medicare and Medicaid) which have set prices for providers and hospitals, commercial payers negotiate with hospitals and providers (e.g., physicians, pharmacies) to determine the price for services.
- Historically, these negotiated rates have been considered ***proprietary***—a critical component of a provider's business strategy and market advantage. Many hospitals and insurers have used gag clauses to prevent employers from accessing negotiated prices.
- This leaves employers with ***little choice or negotiating power*** when negotiating contracts.

The challenge for employers as fiduciaries is that recent data suggests some health systems are charging well above what is considered a "fair price." However, figuring out what a "fair price" is requires all stakeholders to comply with transparency requirements and there is significant variation in the price paid for the same services across location, provider, and insurance type with little correlation to the quality of care received.

> ***Recent data suggests some health systems are charging well above what is considered a "fair price."***

- In 2020, RAND found employers paid 254% of what Medicare would have paid for hospital inpatient and outpatient services.
- Price also varies widely across states, with Arkansas paying the lowest percent of Medicare at 164% and Georgia and Florida paying the highest percent at 345%.



Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

Who is considered a fiduciary?

Four steps you can take to leverage increased health care pricing transparency

About HRPA's American Health Policy Institute

HRPA

WHERE DO PHARMACY BENEFIT MANAGERS COME IN?

- **Pharmacy Benefit Managers (PBMs) are third-party administrators (TPAs) of prescription drug programs.** PBMs are frequently used by large employers because they take on much of the administration of pharmaceutical benefits for employers. They have negotiating power with drug manufacturers, manage formularies, conduct claims processing, and often provide employee support programs through mail order pharmacies and medication adherence programs.
- **However, many employers have struggled to get data around the actual price PBMs pay for drugs.** This is in part because many PBMs operate based on negotiated discounts from the average wholesale price. Additionally, many PBMs are part of larger health care stakeholders including insurers and pharmacies.

> ***The use of PBMs has spurred discussion on potential conflicts of interest.***

Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

Who is considered a fiduciary?

Four steps you can take to leverage increased health care pricing transparency

About HRPA's American Health Policy Institute

Working with the Health Transformation Alliance (HTA), companies have implemented several strategies including gaining control of data, additional oversight rights, switching PBMs, and revising contract structures.

THE RESULTS

COMPANY A

- Reduced overall cost for premiums in 2024 by 2.7% while keeping benefit design the same.
- Projected cost savings of 10%, or 45 million versus the average increase of 7%.
- Cost per member per month are now lower in 2024 than they were in 2019.

COMPANY B

- For Rx, in the first year experienced a -10% trend vs +8% in the market.
- For medical, in the first year experienced a -5% trend vs market +6%.

What can be done?

HR POLICY ASSOCIATION SUPPORTS THE FOLLOWING LEGISLATIVE AND REGULATORY CHANGES:

The Lower Costs, More Transparency Act passed the House with broad bipartisan support (320-71) in December 2023 and requires health care providers to publicly disclose the cost of services they provide. The Senate is now working on its legislation (Pharmacy Benefit Manager Reform Act) and is expected to act by the end of 2024.

The legislation increases reporting requirements on Pharmacy Benefit Managers (PBMs) by mandating disclosure of different forms of compensation expected to be received from pharmaceutical manufacturers.

This disclosure is important as PBMs typically receive compensation through one of three strategies:

- ***Pass-Through Pricing:*** The employer pays the PBM the same price the PBM paid the manufacturer for the drug and the PBM receives an administrative fee from the employer.
- ***Spread Pricing:*** The PBM takes the difference between the price they paid the manufacturer for the drug and the price they charge an employer for that drug as compensation.
- ***Rebates:*** When negotiating with drug manufacturers when buying products in bulk, the PBM negotiates a rebate and retains a portion or all the rebate.

Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

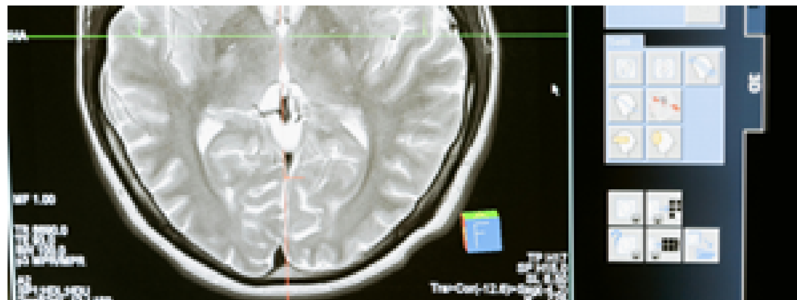
Who is considered a fiduciary?

Four steps you can take to leverage increased health care pricing transparency

About HRPA's American Health Policy Institute

HR POLICY ASSOCIATION SUPPORTS THE FOLLOWING LEGISLATIVE AND REGULATORY CHANGES *(continued)*:

The Consolidated Appropriations Act of 2021 along with the **Transparency in Coverage** rules place new requirements on employer health plans and insurance carriers requiring fee disclosures and price transparency. The CAA, effective January 2021, requires service providers, including consultants and brokers, to disclose fees related to their contracts with group health plans. The rule, with effective dates spanning 2022-2024, requires self-funded employers to publicly post cost information for health plan participants, beneficiaries, and enrollees. Hospitals also must disclose their negotiated rates for services.



RISKS ASSOCIATED WITH INCREASED TRANSPARENCY

While much of the legislative activity to increase transparency is welcomed by employers, there are some risks associated with making pricing public.

- As fiduciaries, employers must make sure they are paying fair prices for the health care services provided to employees. Making pricing information public will create an opportunity to allege a breach of fiduciary duty under ERISA related to excessive fees and expenses for beneficiaries.
- Separately, state and federal agencies are investigating the business practices of PBMs, health care vendors, and benefits consultants. If these investigations find that the parties have violated laws and negatively impacted their employer clients, employers could be at fault for not appropriately monitoring their service providers. Breaching fiduciary duty can result in removal from fiduciary status, 20% penalty as assessed by the Department of Labor, and possible criminal penalties.

WHO IS CONSIDERED A FIDUCIARY?

- Anyone who determines plan assets including CHROs, CEOs, CFOs, benefits committees, administrators, and benefits consultants.
- Plan sponsor (employer)
- Third-party claims administrators

HRPA

Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

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About HRPA's American Health Policy Institute

HRPA

Four steps you can take to leverage increased health care pricing transparency

1. Create a fiduciary committee to oversee health benefits.

The Employee Retirement Income Security Act of 1974 (ERISA) outlines several fiduciary obligations for employers administering health benefits. In recent years, class action lawsuits against employers related to health care benefits have cropped up. To mitigate the growing risks of lawsuits, employers should establish a separate formal health and welfare plans committee with well-documented processes to oversee the administration of health benefits.

See appendix 1 for sample committee charter.

2. Use transparency data to negotiate better contracts.

The increased availability of hospital price data gives employers an opportunity to compare prices across plans, services, hospitals, and Medicare. Analyzing claims data also provides years of pricing data and when combined with current pricing data can allow employers to more accurately predict future spending.

Pro tip: Use publicly available pricing tools and datasets:

***Sage Transparency*:** Developed by the Employers' Forum of Indiana, this free, public-facing tool provides hospital price, cost, and quality data as well as price data for ambulatory surgery centers and physician-administered medications. Utilize this data to compare hospital charges among peer group hospitals (similar geographic region and quality scores) as well as against other states to determine whether your geographic region is an outlier.

***National Academy for State Health Policy (NASHP) Hospital Cost Tool*:** Determine what hospitals spend on services and how these costs relate to the hospital charges (list prices) and the price paid by health plans. This tool even includes a hospital's commercial breakeven—the reimbursement rate that a hospital needs from commercial payers to cover its expenses without profit. Understanding the difference between the breakeven price and the rate commercial payers paid may provide opportunities for additional negotiation.

***RAND*:** Rand Corporation provides medical claims data and the prices paid by employers and insurers.

Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

Who is considered a fiduciary?

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About HRPA's American Health Policy Institute

3. Amend contracts with vendors to make them contractually responsible for compliance.

While self-funded employers remain legally responsible for complying with the transparency requirements, they are unable to comply without full cooperation of their health plan vendors. Employers should amend their contracts with health plan carriers, third-party administrators, and PBMs to require disclosure of necessary data. To ease the contract negotiation process, include data transparency, pricing transparency, and audit rights in related Request-for-Proposals (RFPs). In cases where employers use a consultant or intermediary to negotiate contracts, consider including a performance guarantee that aligns performance with pricing goals as a percentage of Medicare.

Sample provisions include:

- Claims Administrator agrees to support the Plan Administrator with reasonable flexibility as the Plan Administrator discharges its fiduciary duty under the law with various due diligence and good governance measures to ensure claims administration accuracy and transparency. These activities include, but are not limited to, full access to review plan data outlined in Exhibit B: Claims Data Fields, and to add, replace, augment or adjust services provided by the Claims Administrator. Plan Administrator has the sole and complete authority to determine eligibility of persons to participate in the Plan.
- All Group Confidential Information belongs to the Group and will continue to be the property of the Group. Without Group's prior written approval, the Claims Administrator and/or Claims Administrator Agents will not use Group Confidential Information for any purpose other than in connection with providing the Services or as permitted under this Agreement.
- Employer reserves to the fullest extent its rights espoused in the CAA relating to unenforceability of gag clauses and accepts the only permissible restrictions to be on public disclosure, which it defines as a disclosure in a public forum, such as a general website.
- Carrier will not add additional fees or pass to Employer any legal charges or fees related to its maintenance of its network or any disputes arising through its maintenance or provision.

See Appendix 2 for additional contract provisions used by the Health Transformation Alliance in their contract template.

Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

Who is considered a fiduciary?

▶ ***Four steps to leverage increased health care pricing transparency***

About HRPA's American Health Policy Institute

HRPA

4. Promote health literacy with employees.

Health literacy refers to the degree to which individuals have the skills necessary to obtain, process, and understand health information to make prudent health care decisions.

Employers can support health literacy in the following ways:

- Remove complex health care jargon when providing information on employee benefits.
- Routinely provide information on basic access topics like how often employees can see a provider, where to find providers, and the cost associated with primary care and specialist visits.
- Use technology to improve communication with employees on benefit offerings through mobile apps or websites.
- Utilize benefit concierge services to guide employees to high quality, lower cost providers and facilities and to reduce unnecessary ER visits.

Adults with low health literacy have four times higher health care costs and 6% more hospital stays than those with proficient health literacy.

Executive Summary

Why Prices Remain Unknown

What do we mean by health care price transparency?

Where do Pharmacy Benefit Managers (PBMs) come in?

What can be done?

Legislative and Regulatory Changes Supported by HR Policy Association

Risks associated with increased transparency

Who is considered a fiduciary?

Four steps you can take to leverage increased health care pricing transparency

▶ ***About HRPA's American Health Policy Institute***

HRPA

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National Academy for State Health Policy (NASHP) Hospital Cost Tool, https://tool.nashp.org/

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About HRPA's American Health Policy Institute

Founded in 2014, HR Policy Association's American Health Policy Institute is a health care focused think tank that examines policies that impact the ability of employers to provide quality, affordable health care to employees and their dependents.

The Institute stands as a credible voice representing the interests of large employers, who provide coverage for half of all Americans. As part of its mandate, the Institute monitors and engages with legislators, staff and administration officials to advocate for Member perspectives on key issues, providing in-depth analyses of potential impacts on employer-sponsored coverage.

Leveraging decades of experience in both the public policy and practice aspects of health care, the Institute plays an important role in helping to shape policies that preserve and strengthen employer-sponsored coverage.

Led by Margaret Faso, the Institute is guided by an Advisory Board consisting of Chief Human Resource Officers and Total Rewards Officers from America's largest employers.

EMPLOYEE BENEFITS ADMINISTRATION COMMITTEE CHARTER

Purpose

The Committee is a named fiduciary with responsibility for plan administration (but not for investment of plan assets, unless expressly provided by a plan document) and the Plan Administrator with respect to all employee benefit plans maintained by the Company which are subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Responsibilities

The powers and duties set forth herein are subject to applicable laws and the terms of the plans, and are not intended to limit the Committee's powers and duties as granted by law, the terms of the Company's plans, or any express grant of authority pursuant to the Company's governance processes. Nothing herein grants the Committee authority over or responsibility for the investment of plan assets unless such authority and responsibility are granted by the governing plan document. Subject to the foregoing, in carrying out the purpose set forth above, the Committee, with the assistance of the Company's Colleague Experience Group and such outside vendors as the Committee deems appropriate:

- Fulfills the duties imposed on plan administrators by ERISA, including the filing of annual reports (when required), responding to participant requests for information, and providing mandatory notices and disclosure documents (such as summary plan descriptions and benefit statements).
- Can establish, amend and terminate administrative rules and procedures.
- Oversees the claims and appeals process, and decides claims and appeals and makes any other administrative determinations in accordance with regulatory requirements.
- Oversees the operation of the plans in compliance with the terms of the plan documents and applicable law, and has the requisite powers and administrative discretion (including the discretionary authority to interpret the plans) to carry out such responsibility, whether granted expressly under the terms of the plans or implied by reason of being necessary or appropriate for proper administration.
- Selects, removes, evaluates and enters into contracts with one or more independent fiduciaries or other independent service providers to provide such services (including, without limitation, claims administration, insurance, accounting, legal and clerical services) and perform such functions in furtherance of the Committee's duties and responsibilities as the Committee in its discretion determines.
- Has the power to amend the trust agreement for the XX Retirement Savings Plan, the XX Retirement Plan, and the XX Trust maintained with respect to certain of the Company's non-qualified plans, and to appoint, remove and replace any trustees under such agreements as well as any custodians for such plans; provided, however, that decisions regarding the extent (if any) of discretionary investment power to be held by a trustee and the appointment of investment advisers or investment managers shall be made by the relevant plan's investment fiduciary.

May 2020

- Has full access to any relevant records of the Company and may request any employee of the Company or other person to meet with the Committee or its consultants.
- Has the authority to delegate all or a portion of its duties and authority to one or more of the Committee members, other committees or subcommittees, Company employees, or other appropriate persons, subject to applicable plan terms, laws and regulations.
- Can approve clerical amendments (and any other amendments expressly identified by the plan document as being within its authority) to the plans it administers, if so provided by the relevant plan or to the extent the amendment is within the authority of the Vice President, Global Benefits to approve.

Organization & Operations

Each Committee member shall be appointed or removed by the Vice President, Global Benefits. In the event that there is no employee holding the title Vice President, Global Benefits, references in this Charter to the Vice President, Global Benefits shall be deemed to refer to the person acting in that capacity or holding a successor title, as appropriate.

Committee members shall serve without compensation for such service but shall be entitled to be reimbursed for any amounts reasonably and necessarily expended by them in the performance of their duties hereunder.

The Committee shall elect a Chairperson, who shall be a member of the Committee. The Committee shall elect or appoint a Secretary, who may (but need not) be a member of the Committee. The Committee may authorize the Secretary or a Committee member, or when appropriate, one or more other specified individuals, to execute documents on behalf of the Committee.

Unless otherwise required by applicable law or the terms of the plans, the Committee is authorized to take action by the vote of a majority of its members at a meeting or in writing, in each case provided that a quorum is represented at the meeting or by providing consent to the written document. At any meeting, or in the case of any action taken in writing, a quorum shall consist of a majority of the Committee's members.

The Committee shall meet as often as it determines to be necessary or appropriate for the fulfillment of its responsibilities.

No Committee member may act in a matter affecting only him/herself.

The Committee shall keep such records of its activities and copies of reports provided to it as it deems necessary or appropriate for the performance of its duties and compliance with applicable law. The Committee will report to the Vice President, Global Benefits at such intervals as the Vice President, Global Benefits directs, and shall respond promptly to any inquiries from the

Vice President, Global Benefits. Nothing herein prohibits the Vice President, Global Benefits from appointing himself or herself to the Committee.

Appendix 2

(See expanded document here)

CARRIER NEGOTIATIONS

SAMPLE PROVISIONS CONTAINED IN HTA CONTRACT TEMPLATE

Financial Transparency	Claims Adjudication	Network and Data
Fee Notices Claims Administrator confirms that the fees quoted in the RFP submission are exhaustive and transparent. No additional fees or fee increases, direct or indirect, will be charged to Employer without express written approval.	**Lower of Billed/Allowed** Employer may cap maximum payment at the lower of the billed or allowed amount for any inverted claims where the allowed amount exceeds the billed amount, citing ERISA fiduciary preemption to reconcile a provider contract conflict	**Ownership of Data** Employer owns its data and may use it to manage its health plan and supplier strategy relating to hospitals and providers offering services to plan members
No Claims-Based Admin Fees Claims Administrator will not add administrative fees to claims or blend them through claims unless otherwise agreed to in writing at the direction of employer, and any such fees must be separately reported.	**Low Auto Adjudication/Manual Review >$5k** Claims administrator will perform a manual review process for claims payments above $5,000 as a final safeguard for reasonability and accuracy	**Downstream Rights/CAA Defined Sharing** Employer reserves to the fullest extent it's rights espoused in the CAA relating to un-enforceability of gag clauses and accepts the only permissible restrictions to be on public disclosure, which it defines as a disclosure in a public forum, such as a general website.
Recurring Fraud/Waste/Abuse Review Employer may perform ongoing FWA reviews with vendor(s) of its choosing. Claims Administrator confirms the ability to integrate with vendors of Employer's choosing and perform automated offset recovery of any Employer-discovered overpayments without incurring additional fees.	**Cash vs Discount** Employer reserves the right to pay posted cash prices on any claims where doing so would represent a lower cost than paying a negotiated allowed amount, citing ERISA Fiduciary preemption to resolve any provider contract conflict	**Transparent Overpayment Recovery** Fees for Claims Administrator's overpayment recovery will not exceed 20% and only apply to post payment recovery. All pre-payment claims editing should be included within the administration fee. Overpaid and recovered claims, and the associated fees, should be reported monthly as part of the payment integrity review process.
Large Claim Itemized Bill Reviews Employer reserves the right to review itemized bills, and clinical records for all claims with allowed amounts exceeding $50,000 prior to payment.	**Reasonableness Caps** Employer reserves the right to enact reasonableness caps on the upper limit of benefit reimbursement as a percentage of Medicare in the event the contracted allowed amount exceeds what a prudent fiduciary might consider reasonable.	**Direct Contracting Rights** Employer reserves the right to direct contract with any provider and have these claims separated from the standard claims flow prior to Claims Administrator repricing.
No Pass-Through Settlements Carrier will not add additional fees or pass to Employer any legal charges or fees related to its maintenance of its network or any disputes arising through its maintenance or provision.	**Clean Claims Paradigm** Employer only pays "clean claims" which do not include administrative fees or multiple parties unless requested in writing. In the event employer owes administrative fees on a claim, these must be billed on a separate invoice to maintain transparent separation.	**Provider Exclusion Rights** Employer reserves the right to exclude any low-value provider from its in-network benefit, or to establish a low-value benefit tier only minimally better than an out of network benefit.
Cash to Accrual Reconciliation Employer reserves right to reconcile raw claims data against the check register as frequently as desired with a carrier commitment to resolve any unexplained anomalies that may occur.	**Claims Intercept Ability (Cash Pay, Direct Contracts, etc.)** Employer's administration process will possess the option to receive a claim prior to it proceeding to the carrier, in the event a provider is under a direct contract, or similar to prevent duplicate billing	**Specialty Rx Carveout Rights** Employer reserves the right to carve out specialty drugs and infusion therapies to a specialty clinician group for prior authorization and procurement