Mercer

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February 4, 2022

The Honorable Kevin Hern
The Honorable Rick Allen
The Honorable Victoria Spartz

U.S. House of Representatives
Washington, DC 20515

RE: Healthy Future Task Force Affordability Subcommittee Request for Information

Dear Representatives Hern, Allen and Spartz:

Mercer appreciates your request for specific recommendations to help address America's rising health care costs. Mercer provides health care and group benefits consulting, brokering, and actuarial services to approximately 3,000 companies in the U.S. – of all sizes with varying employee demographics – sponsoring health care benefits for approximately 38 million American workers and family members.

Insights on Affordability from Mercer survey

The average cost of employer-sponsored health insurance jumped 6.3% in 2021 as employees and their families resumed care after avoiding it in the prior year due to the pandemic. With the highest annual increase since 2010, health benefit cost outpaced growth in inflation and workers' earnings through September, raising the question of whether employers are seeing a temporary correction to the cost trend (after last year's lower-than-average increase), or the start of a new period of higher cost growth. Employers are projecting – on average – a fairly typical cost increase of 4.4% for 2022 but that may be optimistic. A number of factors could result in ongoing cost growth acceleration. At the top of the list of concerns are higher utilization due to "catch-up" care, claims for long COVID, extremely high-cost genetic and cellular drug therapies, and possible inflation in healthcare prices.

When health benefit cost growth accelerates, employers typically ratchet up cost management efforts to keep increases at sustainable levels. However, one traditional cost management tool known as "cost shifting" – where employers shift a larger share of the cost of health services to plan members – seems to be off the table for many employers. In fact, concerns about health care affordability for lower-wage workers, along with the need to retain and attract employees in a competitive labor market, have resulted in an unexpected reversal in some health plan cost-sharing trends. Most employers not only held off on raising deductibles and other cost-sharing provisions, but some even made changes to reduce employees' out-of-pocket spending for health services. Among small employers (50-499 employees), the median deductible for individual coverage in a PPO dropped from $1,000 to $900 in 2021. Among large employers (500+ employees), the median individual deductible in an HSA-eligible plan dropped from $2,000 to $1,850 in 2021. Additionally, large employers did not increase employee premium

contributions significantly in 2021. The average monthly paycheck deduction rose by just $7 for individual coverage (from $160 to $167) and by just $12 for family coverage (from $590 to $602) in PPO plans, the most common type of medical coverage offered.

Healthy Future Task Force Affordability Subcommittee RFI: Mercer Comments

KEY: Red = Question in google document; **Black = Mercer response**.

I. Improving Healthcare for America's Workers and Small Business Owners

3. On June 20, 2019, the Trump Administration finalized the Individual Coverage Health Reimbursement Arrangement (ICHRA) rule, which allows employers to make tax advantaged, defined contributions for employees to purchase their own health insurance or pay for medical expenses. ICHRAs became available to employers January 1, 2020.

a. How can Congress build on the Trump administration's health reimbursement arrangement rule?

One big challenge for ICHRAs is end-to-end administration of the program. Most vendors that administer HRAs do not support enrolling people in health plans. Likewise, vendors that enroll people in health plans don't typically administer accounts. Enrollment services are provided only for plans or policies offered by carriers with whom they have a partnership. Currently, a safe harbor from ERISA for the underlying individual policies (but not the ICHRA) under the ICHRA regulations has a number of requirements, and appears to require members to have access to all policies offered on and off the public exchanges. This safe harbor applies to retiree only HRAs, as well as ICHRAs, and can cause complications in administration. Congress could build upon the current ERISA safe harbor by (i) clarifying that this is only a safe harbor rather than a requirement, and (ii) allowing more flexibility and reasonable limitations on the policies offered as coverage under the ICHRA. Congress should also clarify that individual Medicare Advantage polices that are reimbursed through a retiree only HRA or an ICHRA are never subject to ERISA.

b. What barriers are employers having to participating in ICHRAs

Because of the ACA affordability rules for ICHRAs, employers that use this new type of benefit for part-time populations have a large advantage over employers who may want to use it for full-time employees where ACA affordability applies. The rules force employers with ICHRAs to take into account the massive variation that exists between the policies offered on public healthcare exchanges in calculating contributions. In our experience, the affordability rule seems to discourage many employers from adopting ICHRAs.

The ICHRA affordability rule requires an employer to compare leftover exchange premium - after employer subsidy - to a certain percentage of an employee's household income. In order to ensure ACA compliance, the employer must contribute enough so that the leftover premium is less than the calculated income amount. For example:

If the Silver plan premium on the exchange is $600, the employer HRA amount is $300, and the employee salary is $40,000:

- The leftover amount after the HRA is applied to the premium is ($600 - $300) = $300
- The household income formula safe harbor is 9.78% * ($40,000 / 12) = $326
- The leftover amount is smaller than the safe harbor, so this HRA amount is considered affordable for this employee

But the formula above is required to be performed on a person by person basis, and many employers have populations that span numerous different ACA marketplaces across states. Any one "outlier" employee – someone who lives in a public exchange marketplace with high premiums, or who is older than the average employee working for the employer – can cause the entire subsidy to be higher for the group. Mercer has conducted a few feasibility studies for clients interested in offering an ICHRA. One in particular showed that for an employer with fewer than 2,000 employees the final expected subsidy required to maintain ACA compliance would actually increase their costs by almost 60%. Needless to say, the employer immediately turned down the ICHRA proposal.

In order to expand the rule and make ICHRAs more of an option, the affordability formula should be re-imagined for groups that may have access to multiple public exchange marketplaces. One suggestion would be to change the calculation to allow the use of an average premium amount, rather than requiring it to be done seriatim.

II Promoting programs to lower costs and improve care

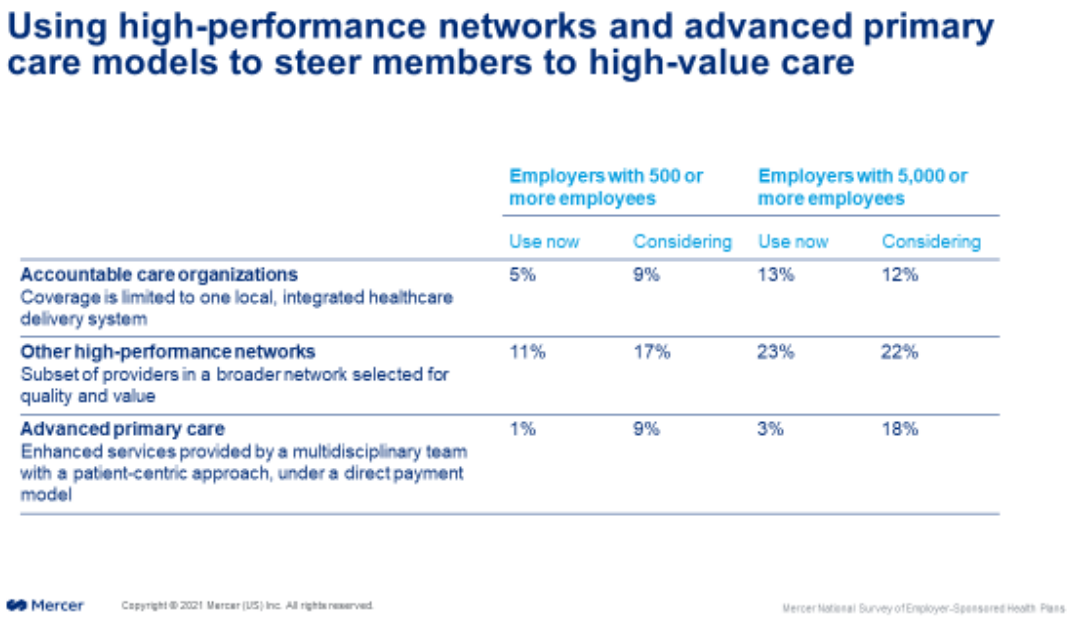
Q1. Many large employers are participating in innovative initiatives to lower costs and improve care such as direct contracting, high performance networks, and centers for excellence; however, midsize and smaller employers often face barriers such as establishing "critical mass" to utilizing these programs. The goal of the following questions is to 1) identify barriers that exist for employers which prevent them from entering these programs, and 2) work towards achieving policy solutions to help employers of all sizes and in all geographic regions provide health care at a lower cost and higher value to their employees.

a. In what ways can the federal government help midsize and smaller employers enter the programs listed above?

High Performance Network (HPN) products (also known as narrow network plans) are offered by insurance companies to fully-insured and self-insured plan sponsors. Given your focus on small and mid-

size employers, you might be interested to know these programs are currently utilized by 11% of employers with 500 or more employees and 23% of employers with 5,000 or more employees according to Mercer's Survey of Employer Sponsored Health Plans, 2021 – see graphic below. There are several reasons why more employers have not implemented these plans

- Plan sponsor concern for too much disruption upon review of data on existing medical provider relationships
- Population is already using the HPN providers, so limited opportunity for additional savings
- Savings not significant enough to justify the change from their current network of providers.
- Additional administrative effort required if HPN is not available in all locations. So rather than replacing a plan, it becomes an additional plan to administer and manage.



Using high-performance networks and advanced primary care models to steer members to high-value care

	Employers with 500 or more employees		Employers with 5,000 or more employees	
	Use now	Considering	Use now	Considering
Accountable care organizations Coverage is limited to one local, integrated healthcare delivery system	5%	9%	13%	12%
Other high-performance networks Subset of providers in a broader network selected for quality and value	11%	17%	23%	22%
Advanced primary care Enhanced services provided by a multidisciplinary team with a patient-centric approach, under a direct payment model	1%	9%	3%	18%

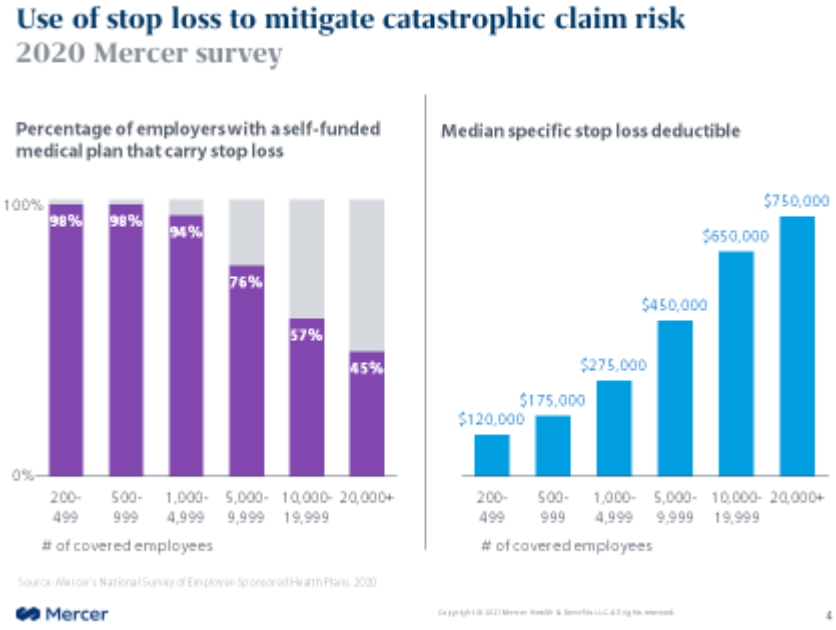
Centers of Excellence. About one third of large employers (500 or more employees) offer Centers of Excellence (COE) programs. The major insurance companies have COE programs and offer them to plan sponsors. In addition, companies like Optum offer COE programs on a stand-alone basis to Third Party Administrators.

There are several reasons why these programs are not widely used:

- For many of these conditions, there will be very few, if any, cases. Employers want and expect their health plan to manage the claims, but if the COE is an additional program, may not be able to justify paying for another program that may or may not be used.
- Unfortunately, many COE programs have not done a good job demonstrating their value and the outcomes are a "black box."
- The more narrow COE networks are challenging for national employers – e,g, if someone lives in New York City and is being referred to a COE in San Francisco (or vice versa), they will question the necessity of travel cross country when there are so many high quality hospitals where they live.
- While this is not the biggest driving factor, it is worth noting that in many cities, hospitals are among the biggest employers in town and influential in the community making it hard for employers to implement programs that take business away from their communities.

The best way to get plan members to use a COE is to provide a plan design incentive and yet very few employers do that as demonstrated in the survey data below. Two issues with the plan incentive – there is a cost associated with enriching the benefit to use the COE which dilutes the savings and also a reluctance to “penalize” someone for using a local network hospital because of reasons stated above.

Another opportunity to manage costs. According to Mercer survey data, the top health benefit management priorities for employers are managing high cost claimants and managing the cost for specialty drugs. These two goals are interrelated – as the high cost claimants likely include specialty drugs. The issue all employers are trying to manage for is **risk**. Since the passage of the ACA, removal of lifetime maximum benefits, and more and more new high cost therapies hitting the market, we have seen a surge in plan sponsors buying stop loss insurance – and not just small employers. According to the Sun Life Book of Business Report, from 2015-2020 the total number of claimants with $1M in paid claims has grown by 67%.



Specialty Rx is changing catastrophic claim risk – Novel high-cost therapies create unprecedented challenges

- One plan member can potentially have a catastrophic financial impact on plan cost.
- Cellular and gene replacement therapies among the highest priced.
- Largest currently approved gene therapy drugs are Zolgensma and Luxturna at costs of $2.1M and $850K respectively.
- Roctavian is a gene therapy being developed for treatment of hemophilia A with potential approval in mid to late 2022. Cost could exceed $3M!

Unique considerations complicate coverage decisions.

- Legal and ethical implications of excluding coverage.
- Potential for long-term savings with curative treatments but with significant short-term impact.

We would be pleased to discuss ideas for how to address this risk issue for all employers – especially for small and mid-size groups who are adversely impacted by multi-million dollar claims.

e. What innovative tools, like medical decision support tools, can employers offer to help employees navigate the healthcare system and improve convenience?

- Transparency along with quality information is needed to help address affordability. See our response to Question III.1.c.
- Rx transparency -- The proposed pharmacy reporting tools under CAA will help address the need for patient information. Employers have been working with various other providers well prior to the introduction of CAA reporting. Additionally many members have used third party apps such as GoodRx as a de facto pricing tool. Some employers have hired third parties such as Rx Savings Solutions, Scripta Insights or various PBM programs to assist members in getting the best value from their Pharmacy benefits. The fact that members use third party apps separate from their plan illustrates the strong need for patient data regarding pharmacy options.
- In-home care. Low-acuity care that is delivered in a home setting, where clinical services are provided digitally/virtually and aided by technology. One promising new care model borne of the pandemic is the acute hospital at home program. The CMS model has been shown effective in reducing mortality and reducing costs by as much as 19%. Advancements in digital health and remote patient monitoring will complement the hospital at home, care anywhere service model(s), ushering in the Internet of Medical Things (IoMT) era, one where payer, patient and provider are more connected than ever before.
- Virtual first care (V1C) is medical care for individuals or a community accessed through digital interactions where possible, guided by a clinician, and integrated into a person's everyday life." (IMPACT, 2020) Today, V1C programs play around the margins of the healthcare system – but that is changing. Employers already use services that are considered V1C, even if they haven't realized their full potential – condition management solutions, telehealth, and virtual behavioral healthcare. Virtual Primary Care offerings are coming to market from telemedicine, onsite/near-site clinic, and care delivery vendors. Carriers and health plans are rolling out V1C plans.

d – What data barriers exist that prevent employers from entering these types of programs?

The data barriers are many, for the arrangements/strategies mentioned as well as others (Reference-Based pricing, for example). Price transparency will only help with part of this. In addition, other data are not publicly or readily available, including:

- Standardized quality metrics that are applied to the commercial insurance populations
- Reliable, user-friendly reporting on the relationship between price and quality, so employers and consumers can make trade-offs
- Detailed information on pharmacy prices and quality, in addition to medical

Congress could improve access to this information by building on the transparency regulations in order to ensure that more information floods the market. This information being easy to access will be critical in how quickly the market can respond with employer-facing tools for entering into these types of value-based arrangements.

One first step in ensuring more data becomes available is for Congress to put the burden of data sharing on the insurance companies and other organizations that employers currently partner with when offering their benefit programs. Even though gag clauses are now banned under the CAA, employers who self-fund their benefits are still having issues getting access to detailed data for their population from carrier systems, even though most of that data would not exist there had the employer not partnered with them in the first place. Data ownership is becoming a strong prerogative for employers when implementing new contracts with carrier partners. Congress should step in to clear up who really owns this data – for example, by clarifying that health plan data is an ERISA plan asset.

II, Q2. Entities who participate or are planning to participate in programs such as direct contracting, high performance networks, and centers for excellence must determine how to measure value and health care outcomes. For those who participate in these types of private value-based programs please answer the following questions:

a. How is "value" defined?

As explained in our response to **Question II. Q1. a.,** there are a number of reasons why more employers do not use High Performance Networks and Centers of Excellence programs.

Broadly speaking, employers want a balance of cost and quality in order to achieve value. They might be willing to pay more in some instances if they can be assured of a positive outcome for the member, but they also don't have the budget to increase their healthcare spending on everyone – so driving towards more efficient providers is also a goal. In this sense, value can be improved by lowering cost, increasing quality, or doing both at the same time.

When we talk with our clients, information on healthcare quality is the newer part of this conversation. Employers have been seeing – and experiencing – cost reporting from hospitals and physicians through

their health plan networks for decades. But meaningful, robust reporting on the quality of that network is something that has only recently come to the market.

It's also important to understand the potential for trade-offs. Some employers may start their value journey wanting to prioritize cost and quality 50/50, or maybe 75/25. The result of this analysis might be a detailed listing of in-network providers, as ranked by the employer's definition of value. But if the first few providers in that list are 25 or more miles away, some employers may go back to the drawing board. They often don't want to suggest that their employees need to drive far to access high-quality, high-value healthcare. So some will also incorporate a feature of geographic access into the final results. It's important to note that access should not play an issue in the scoring of healthcare quality itself, but can be something imposed upon the value definition near the end, according to the employer's stated goals for their employee population.

III. Increasing Transparency and Marketplace Innovation

1. Hospitals in the United States typically have more than 20,000 items in their chargemaster files, making it very difficult for patients to compare the price of individual services across hospitals. On November 27, 2019, the Department of Health and Human Services finalized price transparency requirements that make hospitals publish a list of user-friendly, standard charges for certain items and services online.

c. What quality measurements should hospitals incorporate on their consumer price transparency tools?

We believe quality measures are critical to the long-term goal of transparency in healthcare; without them, consumers may mistakenly correlate higher cost with high quality or a better clinical result. We know from our own research that this isn't always true.

Whatever quality metrics we ask for from hospitals, a system should also be put in place to audit these in such a way to ensure that reporting is accurate and derived from data and not qualitative surveying.

Reporting quality information in the hospitals' consumer price tool may be of limited use to consumers, and simply represent a reporting burden on health systems. Depending on the number of metrics included, having quality metrics reported in a separate system/structure that health insurers and employer plans sponsors can easily access and import into their health plan member decision support/transparency tools would be preferable as we suspect insurers/employers will begin directing health plan members to the plan's consumer price tools – not the hospitals' tools – beginning in 2023.

III. Q2. In the following series of questions we compare, contrast and inquire about the strengths and weaknesses of price transparency tools run by states, health plans and consumer groups.

b. On average, 9.9 percent of enrollees access price transparency tools their health insurance plan offers. What factors contribute to low utilization of price transparency tools run by health plans?

Given the lack of education about healthcare benefits and the healthcare system, many patients could often be led to simply take the advice of their physician in who to seek care from next. Data from 2018 suggest that 42% of patients trust their physician without question. But the provider "data point" should only be used as a reference against what consumer tools would suggest, but too often people will make the next appointment without conferring with any available tool. So we not only need tools that consumers can use, but we need tools that physicians are comfortable using at the time of referral – tools that they can share transparently with the patient as a way to corroborate their suggestion and reinforce their understanding of the healthcare system.

From there, if patients do decide to use a tool, they will often turn to "tools" like yelp.com, whose 5-star rating system and user commentary in prose form makes finding a doctor easy. In fact, a 2017 study in the Journal of American Medical – Surgery found that yelp.com was the number one source for choosing a surgeon, and was used three times more often than the Physician Compare tool from Medicare. These sites are based solely on patient experience, and while that isn't something to be completely disregarded, the conclusions can often vary widely from those derived from data-driven quality and cost information.

c. On November 12, 2020, the Trump Administration finalized the transparency in coverage rule to require group health plans and health insurance issuers to disclose cost sharing information upon request to patients. What policies should Congress consider to build on this rule? Where can Congress improve the requirements set forth in the rule?

Mercer and its clients are committed to improving healthcare quality, affordability and accessibility for US workers and their families. Price transparency is a critical component of that effort. We have worked with employers for many years on transparency initiatives and applaud Congress and the agencies for taking steps to create a more transparent healthcare marketplace. Transparency rules are necessary to address wide price variations, reduce waste in the healthcare system, and help individuals make informed choices regarding their healthcare spending.

Nevertheless, we have some issues with the final Transparency in Coverage (TiC) rules. We are particularly worried about the administrative and cost burdens on employer plan sponsors relative to collecting and providing the requisite data to meet transparency requirements. Following is a summary of our key concerns and recommendations. *[Please note: Full response is below. Abbreviated response submitted in Google Form due to size restrictions.]*

1. ***Update the rules so that third party administrators (TPAs) and pharmacy benefit managers (PBMs) for self-funded plans are directly responsible for compliance with the machine readable file (MRF) and transparency tool requirements under the TiC rule.***

a. Alternatively, provide employers sponsoring self-funded plans with broad relief from penalties, including a lengthy non-enforcement period and good faith compliance relief if an employer reasonably relies on TPAs/PBMs, if they are unable to obtain the data necessary for these compliance obligations.

2. ***Update the TiC rules so that insurance carriers are <u>always</u> responsible for TiC compliance for an insured plan***. The current rule gives an option for carriers to agree to such compliance with a written agreement. This language is confusing and contractual language that carriers are relying on for this purpose is unclear in many cases. Insured plan sponsors are typically smaller employers and don't have the resources or expertise to be able to comply with the TiC requirements or ensure that the written agreement adequately protects their interests.

    a. Alternatively, provide additional guidance on appropriate contractual language for carriers to agree to take on TiC compliance for an insured plan sponsor.

3. ***Update TiC regulations requiring a self-service transparency tool to incorporate Consolidated Appropriations Act (CAA) requirements for a price comparison tool.***

4. ***Permanently eliminate the requirement for a prescription drug MRF***. The prescription drug MRF would be unnecessary and redundant of the new prescription drug reporting requirement under the CAA.

5. ***Confirm that the transparency price comparison tool must include prescription drug data.*** In order to provide the maximum transparency to consumers, the tool should include prescription drug data, even if that data is not required to be reported on a MRF.

6. ***Clarify what a public website of the plan means under the TiC rules so that hyperlinks to MRFs that are posted on a vendor or TPA's website are always considered to be posted on the public website of the plan.***

    a. Hyperlinks to MRFs should always be permitted <u>as an option</u> for self-funded plan sponsors for both the negotiated rate file and the out of network allowed amount file. It is too difficult and costly for plan sponsors to download, post, and archive the MRFs themselves.
    b. Confirm that <u>insured</u> plan sponsors do not need to hyperlink or otherwise direct researchers to their insurance carrier's website to view their MRFs.

c. This guidance on public websites could also be applied to the NSA requirement to post the Surprise Billing Notice.

7. ***Provide simplified recordkeeping requirements for MRFs.***

a. TPAs, insurance carrier and PBMs (if applicable) should always be responsible for recordkeeping with respect to the TiC rule, rather than plan sponsors.
b. Due to the massive amount of data contained in the MRFs and the cost associated with storage of that data, recordkeeping should only be required for 3 years.

8. ***Conform the TiC rules with technical guidance that has been released via GitHub***.

a. In particular, the rules should be updated to provide guidance on how to aggregate plans (including self-funded plans) for purposes of the MRFs.
b. Provide schedule for updates to the MRF schemas published on GitHub. For example, the final schema is published by Sept. 1 of each year for MRFs to be posted the following Jan. 1.

IV. Increasing Competition and Identifying Anti- Competitive Consolidation

The 340B program was developed in 1992 with the expressed intent of assisting hospitals with a high percentage of indigent care. While the program still assists with that goal, policy changes over the years changed its impact.

The biggest issue is an administrative infrastructure that makes it difficult to track program benefits. This infrastructure issue is supplemented by the explosion of contract pharmacies due to a policy decision in 2010 allowing an unlimited number of contract pharmacies by covered entity.

IV, Q3. Since its establishment in 1992, the 340B program's mission has been to help stretch scare federal resources. But as the number of providers increased substantially to roughly 2,500 active hospitals and over 26,000 contract pharmacy sites in 2020, allowing for increased profiting from the program while prices of drugs for patients actually purchasing these drugs increase, we must consider areas that merit reform and modernization in order to deliver on targeted drug and services affordability. The 2019 Government Accountability Office (GAO) report and a 2018 House Energy & Commerce Committee report found issues within the program, including high rates of fraud and abuse in the program like duplicate discounts and diversion, and raised the need for reforms. As Congress considers next steps for the program, please provide responses to the following areas of interest:

a. Program Eligibility:

i. Are there other recommended measures for program eligibility, other than Disproportionate Share Hospital?

The DSH program eligibility definition does not appear to be the key driver of the fraud and abuse noted in the question. The key drivers are an unprecedented growth of contract pharmacies from 1,300 in 2010 to over 28,000 in 2021 and the lack of an administrative infrastructure to support the program's original intent. Today 340B is the second largest Federal Pharmacy benefit program after Medicare Part D with over $38B in spend in 2020—a 27% increase over 2019.

In 1996 covered entities were allowed to have one outside "contract pharmacy" to assist with 340B program administration for the benefit of indigent patients if they did not have an in-house pharmacy. In 2010 covered entities were allowed to contract with an unlimited number of contract pharmacies even if they had an in-house pharmacy. This change led to the explosion in the number of for-profit 340B contract pharmacies from 2010 until now. The lack of an administrative infrastructure led to fraud with inappropriate duplicate submissions.

Pharma companies noticed these duplicate discounts and as recently as last year major players said they would discontinue 340B pricing. The Health and Human Services Department reversed this decision but duplicate submissions continue. Commercial plan sponsors have had issues as well as many PBMs will not pay rebates on any drug dispensed from a 340B pharmacy. However, in many cases the drug was NOT dispensed as a 340B drug so would still be eligible for a commercial rebate. Commercial plan sponsors are financially disadvantaged when their members unknowingly happen to get a prescription filled at a 340B pharmacy.

Addressing contract pharmacies/covered entity ratios and the current administrative infrastructure are key steps to improve program efficacy. For instance, one approach might be to specify parameters for use of contract pharmacies and/or a maximum number of contract pharmacies per any covered entity.

The administrative infrastructure is a more complicated issue. However, covered entities (either using a contract pharmacy or not) should be required to do the following:

- Identify which claims were provided a 340B discount and the level of that discount
- Report how the 340B discount was divided among the covered entity, the contract pharmacy (if used) and the patient
- Illustrate compliance with other program requirements

ii. Should there be separate eligibility standards for child sites?

It does not appear that separate eligibility standards for child sites are required if the site meets the reporting and contract pharmacy guidelines suggested above.

iii. How should eligibility for child sites be considered, if the child site becomes a child site after being acquired by a covered entity?

No other eligibility rules required assuming compliance with program guidelines.

b. Transparency:

i. In order to shed light on utilization and true cost savings, while also balancing over burdensome reporting, what are appropriate types of information that should be submitted by covered entities to give both patients and taxpayers a better understanding and confidence that the program's mission is being met?

Appropriate data elements are mentioned above in our response to question <insert question number>. Today one of the major points of confusion is how 340B discounts are divided among various stakeholders – covered entity, contract pharmacy and patient. Since the program was designed to help disproportionate share hospitals stretch scarce dollars, the reporting elements should answer those questions.

Reporting that illustrates cash flows to each stakeholder would address the question of quantifying the program's mission.

c. Program Integrity:

i. If an independent audit was required for some covered entities, what should the audit assess and evaluate, aside from the Health Resources and Service Administration's authorities?

The following standard items should continue to be audited:

- Eligibility of the member in the 340B program
- Accuracy of the covered entity's Information in the Office of Pharmacy Affairs information
- Diversion (diverting members who should not get 340B) to another program
- Duplicate discount management (a 340B discount and a Medicaid rebate should not be paid on the same claim)
- Accurate reporting on a new format that outlines the size and distribution of 340B discounts to stakeholders

ii. What data and measures should be included in a contract pharmacy audits?

In general, the contract pharmacy audit should contain the same data elements (except perhaps the information to the Office of Pharmacy Affairs as they may not be listed on the OPA website. However, contract pharmacies should also be audited on adherence to their contract with covered entities.

iii. Are there other audit and reform policies that could be taken to reduce rates of duplicate discounts and reforms among eligible entities?

d. Are there any unique issues that have developed since the start of the COVID-19 pandemic that would merit additional considerations?

The impact of COVID has resulted in a massive increase in telehealth visits. It is unclear if this phenomena has resulted in any challenges/opportunities in maintaining the patient/doctor relationship required under 340B guidelines. In many cases the use of telehealth may make developing or maintaining these relationships more accessible. However it assumes that low income patients have access to the required technology. This barrier, and accompanying issues with public transportation and other access issues may complicate care. Depending on the situation, if the patient has known technology and transportation issues then maintaining the doctor/patient relationship may become challenging.

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We appreciate this opportunity to submit Mercer's comments to the RFI and would be pleased to meet with you to discuss any of these topics.

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