**Draft Model Comments on Price Transparency Provisions – OPPS Proposed Rule**

The Centers for Medicare & Medicaid Services (CMS) proposes to require that hospitals publicly post on the internet a machine-readable file containing both gross charges and “payer-specific negotiated charges” for all items and services. It also proposes to require hospitals to display, in an easy-to-understand format, negotiated charges and certain other information for 300 “shoppable” items and services.

We are deeply committed to ensuring patients have the information they need to make informed health care decisions, including timely, accurate estimates of their out-of-pocket costs. The agency’s approach would confuse – not help – patients in understanding their potential out-of-pocket cost obligations, would severely disrupt contract negotiations between providers and health plans, and exceeds the Administration's legal authority. **We urge CMS to abandon this proposal and instead convene providers, health plans, patients and other stakeholders on approaches to meet patient needs.**

In particular, we encourage CMS to take steps to facilitate the development and voluntary adoption of patient cost-estimator tools and resources by convening stakeholders to identify best practices, recommending standards for common features of cost-estimator tools, and developing solutions to common technical barriers.

**The Proposed Disclosure of Payer-Specific Negotiated Charges is Unlawful**

CMS lacks the legal authority to require hospitals to make public payer-specific negotiated charges. Section 2718(e) of the Public Health Service Act (PHSA) does not provide CMS with authority to establish these requirements. CMS’s proposal is contrary to the plain language of the statute, as negotiated charges are not “standard charges.” By definition, a “standard charge” is not privately negotiated and does not contemplate different charges for different payers. “Standard charges” has long been understood to be a technical term that means a hospital’s usual or customary chargemaster charge.

CMS’s proposed definition also violates the Administrative Procedure Act (APA) because it is unreasonable. In general usage, “standard” means “usual, common or customary.”[[1]](#footnote-1) Payer-specific negotiated charges are not usual, common or customary. They vary year by year, payer by payer and even health plan by health plan. Indeed, CMS has defined “charges” to mean “the regular rates established by the provider for services rendered to both [Medicare] beneficiaries and to other paying patients. Charges should be . . . *uniformly applied to all patients* . . . .”[[2]](#footnote-2) And the agency’s rationale for seeking to require that payer-specific negotiated charges be made public undercuts the notion that those charges are standard: CMS wants payer-specific charges to be public precisely because those charges are not standard.[[3]](#footnote-3)

CMS’s proposal would violate the First Amendment as well, by compelling the public disclosure of individual charges privately negotiated between hospitals and health plans. Government regulation of non-misleading commercial speech is unlawful unless it “directly advances” a “substantial” governmental interest, and is no “more extensive than is necessary to serve that interest.” [[4]](#footnote-4)

CMS’s stated interest in putting *consumers* “at the center of their health care” is unlikely to be served by the mandated disclosures. The agency’s own research makes clear that when it comes to price, patients are interested in their *own* out-of-pocket costs—not their health plan’s costs. CMS’ repeated admissions that the proposed disclosures are merely a “first step” or a “step towards” the rule’s stated goals make clear that the proposed rule does not “directly” and “materially” serve the stated interest.[[5]](#footnote-5)

CMS’s proposal also is much more extensive than necessary to serve the proffered interest. Because hospitals rely heavily on the confidentiality of health plan-negotiated charges to permit them to negotiate arm’s-length charges with other health plans, disclosure of prices negotiated with individual health plans would unduly burden hospitals’ ability to enter into competitive contracts; it goes well beyond the level of regulation necessary to promote the stated government interest. The charges negotiated between hospitals and health plans are confidential trade secrets.[[6]](#footnote-6) As such, requiring their public disclosure would infringe upon intellectual property rights recognized by Congress and individual states.[[7]](#footnote-7)

Mandating the public disclosure of trade secrets protected under both federal and state law would result in extreme harm to hospitals and health plans alike. The agency has failed to demonstrate that the proposed regulation is narrowly tailored or that its interests “cannot be protected adequately by more limited regulation of . . . commercial expression.”[[8]](#footnote-8)

**Disclosure of Payer-Specific Negotiated Charges Would Harm Consumers and Competition**

Apart from its legal infirmities, the proposed disclosure threatens competition and the movement toward value-based care. The Federal Trade Commission (FTC) has warned numerous times against the disclosure of competitively sensitive information, such as payer-negotiated prices. Such disclosure can “facilitate collusion, raise prices and harm…patients….”[[9]](#footnote-9) That warning extends explicitly to contract terms with health plans.[[10]](#footnote-10) The FTC has urged that transparency be limited to “predicted out-of-pocket expenses, co-pays, and quality and performance comparisons of plans or providers.”[[11]](#footnote-11)

At least one commercial health insurer warned that disclosure of payer-specific negotiated charges would “impair the movement to value-based care” and allow “[d]ominant health plans to seek and use that information to deter and punish hospitals that lower rates or enter into value-based arrangements with the dominant plan’s competitors.”[[12]](#footnote-12)

**CMS Vastly Underestimated the Proposal’s Operational Challenges**

In addition to our legal and public policy concerns, we have significant operational concerns with this proposal. This proposal, if finalized, would pose excessive burden on hospitals and health systems – far exceeding CMS’s estimate of 12 hours.

[*INCLUDE INFORMATION ON THE EXPECTED BURDEN FOR YOUR HOSPITAL/HEALTH SYSTEM. POINTS THAT YOU COULD MENTION INCLUDE:*

* *How long it took your facility to comply with the January 1, 2019 requirement. (Including information on why this proposal would be more complicated.)*
* *How many FTEs you estimate that this proposal requires to implement.*
* *The technology and vendors you would need to acquire or contract with.*
* *How your organization plan to approach developing the required spreadsheet and how large do you expect it to be.* 
  + *Number of contracts that you have.*
  + *Number of lines in your chargemaster already and how much larger you expect this file to be.*
* *What your organization would need in terms of building a consumer friendly website.*
* *What your organization is already doing to assist patients in accessing estimates of their out-of-pocket costs.*
  + *The level of effort required to implement and maintain your existing tool/resource.*
  + *How this proposal would affect your ability to maintain your tool/resource.]*

In summary, CMS’s proposed approach would not give patients the information they need to make informed health decisions, yet would introduce significant additional burden and resource requirements into the health care system. For all of this effort, we anticipate that patients will not use this information; instead they will continue to contact hospitals and health systems directly for more accurate out-of-pocket cost estimates.

1. *See, e.g.,* <https://www.dictionary.com/browse/standard>. [↑](#footnote-ref-1)
2. Provider Reimbursement Manual, No 15-1, ch. 22, § 2202.4. (Emphasis added.) [↑](#footnote-ref-2)
3. *See, e.g.,* 84 Fed. Reg. 39,175, 39,577 (Aug. 9, 2019). [↑](#footnote-ref-3)
4. *Central Hudson Gas & Electric Corp. v. Public Service Comm’n of New York*, 447 U.S. 557, 566 (1980). The agency has failed to identify a sufficient predicate to justify the application of *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985) to the facts presented here. But the regulation fails under either test. Even under *Zauderer,* a disclosure requirement cannot be “unjustified or unduly burdensome.” *Id.* at 651. [↑](#footnote-ref-4)
5. *See id*. at 39,574, 39,585, 39611. [↑](#footnote-ref-5)
6. *See* *West Penn Allegheny Health Sys., Inc. v. UPMC*, 2013 WL 121441532 (W.D. Pa. Sept. 16, 2013) (“[i]nformation regarding pricing and rates constitutes trade secret information”). [↑](#footnote-ref-6)
7. 18 U.S.C. § 1836. [↑](#footnote-ref-7)
8. *Central Hudson Gas & Electric Corp. v. Public Service Comm’n of New York*, 447 U.S. 557, 570 (1980). [↑](#footnote-ref-8)
9. FTC Letter to the Hon. Nellie Pou, April 17, 2001. [↑](#footnote-ref-9)
10. FTC Letter to Hons Joe Hoppe and Melissa Hortman, June 29, 2015. [↑](#footnote-ref-10)
11. Id. [↑](#footnote-ref-11)
12. UnitedHealth Group Comments on Re: RIN 0955-AAOI, 21st Century Cures Act, Proposed Rule, June 3, 2019. [↑](#footnote-ref-12)