



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

January 29, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

***SUBJECT: CMS-9915-P, Transparency in Coverage; Proposed Rule, Federal Register (Vol. 84, No. 229),
November 27, 2019***

Dear Administrator Verma:

On behalf of our more than 400 member hospitals and health care systems, including post-acute care providers, the California Hospital Association (CHA) is pleased to submit comments on the recent rule proposed by the Centers for Medicare & Medicaid Services (CMS), along with the departments of Labor and Treasury, to establish a number of new price transparency requirements for health plans.

In summary, CHA supports agency efforts to provide meaningful information to consumers, but we believe this proposed rule, in many instances, misses the mark in achieving this goal. Our detailed comments are noted below.

Internet-Based Consumer Support Tool

The departments propose to require health insurers and health plans to make a self-service consumer support tool available to enrollees to enable them to estimate their cost-sharing obligations for upcoming medical care. The tool would be internet-based, but the information in the tool would also need to be made available in paper form at the request of a plan participant. Under the proposal, the tool would estimate a participant's cost-sharing liability and provide other useful pieces of information — such as any pre-requisite that must be completed before the medical care could be provided. It would also identify any items or services included in a bundled payment as appropriate.

CHA strongly supports CMS' proposal to require health insurers and health plans to make such tools available. We agree the tools should provide prospective patients with advance information on expected out-of-pocket costs for procedures. The routine availability of this information will help plan participants and enrollees understand their potential financial liability and is useful to consumers as they decide with their doctors' advice among various care settings and providers.

CHA offers the following recommendations that we believe will improve the usability of the tool and reduce confusion for plan participants and enrollees.

In addition to the participant's cost-sharing liability, the proposed rule would require disclosure of the amount the patient's insurer pays for the health care treatments, procedures, or services. More

specifically, disclosure of negotiated rates for in-network or out-of-network care. These figures would be provided in addition to the amount patients would be required to pay for the treatments, procedures, or services. We believe the proposal to require disclosure of those additional data elements through the consumer support tool will be confusing and distracting for enrollees and will raise legal concerns as described in more detail below. **CHA strongly recommends CMS focus this initiative on the information that consumers most want to know — their own out-of-pocket costs — and discourage the departments including information that is unnecessary, confusing, and would raise legal challenges.**

Without such consumer support tools, it generally falls on health care providers to make their best estimates of an enrollee's out-of-pocket costs. Many hospitals and health systems across California do their very best to provide accurate information, with limited — and sometimes flawed — data. Many have developed ways to provide potential patients information on estimated out-of-pocket costs from hospital charges associated with a procedure, but the information can only be based on general plan features and most likely does not reflect an enrollee's or plan participant's deductible. **We request that the Department consider ways to ensure that providers can access the same out-of-pocket cost information provided to patients. There are several alternative options for making this information available to providers, including: using the HIPAA-mandated standard for health eligibility and benefit inquiry and response transaction (ASC X12N 270/271); offering a secure provider website or portal; or developing an application programming interface (API) tool.** In doing so, if a patient seeks the information from their provider rather than via the internet-based tool their plan makes available to them, the provider would be able to convey the same information that the patient would be able to obtain through the tool. The information would be more accurate and would reflect the patient's personalized cost-sharing liability based on their current health plan benefits. We believe this approach would expand information access opportunities consistent with current administrative simplification requirements under HIPAA and would reduce the confusion that will likely arise when enrollees or participants receive two different estimates of their out-of-pocket costs — one from the consumer support tool and a separate one from their health care providers.

Public Use Data Files

CHA believes that the departments' proposal to require health insurers and group health plans to make publicly available data files with negotiated rates for all covered services is a significant overreach, and we encourage CMS to withdraw this proposal. Under the proposal, every insurer and group health plan would be required to provide negotiated payment rates and out-of-network amounts for every covered item, service, or procedure. Such information would need to be provided for every provider and billing code and be updated monthly. Setting aside the administrative burden of the requirement, this proposal raises significant legal concerns and still will not provide useful and usable information for consumers.

CHA agrees that providing prospective patients with a user-friendly consumer support tool that discloses expected out-of-pocket costs in advance will help plan participants better understand their potential financial liability. On the other hand, we do not support the proposal to require that public use data files be made available that include the amount the patient's insurer will pay, not the amount the patient will be required to pay.

The departments suggest the proposal would support meaningful comparisons between plan coverage options and issuer options for all consumers — a much broader objective than would be supported via

the internet-based consumer support tool for enrollees of specific plans. On the other hand, the departments acknowledge the massive data files would likely not be useful to a typical consumer; consumers are unlikely to be able to effectively use pricing information they do not understand, cannot decipher, and cannot download. The departments instead indicate that their hope is that someday web developers will find a way to make the information in the data files usable for consumers. As the proposed rule includes requirements for consumer support tools to be made available to consumers that provide meaningful information on issues that matter most (i.e., their potential out-of-pocket liability), there is no need for a proposal that cannot provide useful information to consumers. This proposal would only add confusion.

Finally, the Departments acknowledge that they are unable to predict the impact of making this information publicly available. An unintended consequence of allowing competitors to know the rates that plans and issuers have negotiated could be a dampening of incentives for competitors to lower prices, potentially resulting in higher prices. Particularly in highly concentrated markets, this information could result in anticompetitive behaviors that have the opposite impact on prices and total health care costs. **We urge CMS to withdraw this proposal until it can be assured to do more good than harm.**

Legal Concerns

CHA believes the proposed requirements on health insurers and group health plans to make publicly available data files with negotiated rates for all covered services violates free speech rights guaranteed under the First Amendment to the United States Constitution. It is a longstanding principle with respect to First Amendment free speech rights that neither Congress nor the federal government may no more compel people to speak than it can stop people from speaking. Any attempt by Congress or the federal government acting through law, regulation, or otherwise to force nongovernmental entities to disclose proprietary information or trade secrets constitutes an attempt to compel commercial speech that is otherwise protected by the First Amendment. It is also a longstanding principle that Congress or the federal government must try to accomplish any federal governmental interest without compelling private parties to disclose proprietary information or trade secrets; compelling speech among private parties must be a last resort to carry out a governmental interest. The proposal seeks to compel the public availability of negotiated rates among private insurers, plans, providers, and practitioners. **Stated differently, this proposal constitutes content-based regulation of commercial speech, and CHA believes the proposal is constitutionally suspect. We believe that, upon judicial review, the proposed requirement would be determined to be unconstitutional as well as an undue intrusion by the federal government in the private health care marketplace.**

Federal legislation or regulation that compels protected speech of private parties, as this proposal seeks to do, must meet strict constitutional legal standards. For example, the proposed requirement must directly and materially advance a **substantial** government interest. It must also be demonstrated that the substantial government interest cannot be achieved without regulating speech to the same extent. Additionally, the requirement to compel the disclosure of proprietary information or trade secrets may not be unduly burdensome.

The departments' stated rationale for the public availability of privately negotiated rates includes improving the ability of consumers to make informed decisions and to evaluate health care options, as well as reducing surprises about out-of-pocket costs. The departments also believe that the public disclosure of this pricing information may contribute to greater competition and lower prices generally.

Thus, the departments' substantial government interests are improving consumer awareness of potential out-of-pocket costs; increasing consumer ability to make health care choices; increasing competition among insurers, plans, providers, and practitioners; and lowering health care costs generally.

As noted above, CHA supports providing patients with information on anticipated out-of-pocket costs associated with a procedure. CHA member hospitals and hospital systems have been in the forefront of making this information available to the patients we serve. Thus, we support a policy to make tools readily available and easily understandable for patients and consumers to more fully understand their estimated out of pocket costs. Our experience has shown this is the information that consumers both want and need to make sound health care decisions. Thus, we fully support the proposed rule requirements for insurers and plans to make such information available to their enrollees.

However, the proposal to require insurers and group health plans to publicly disclose rates negotiated among private parties will not improve a patient's ability to make health care decisions; rather, the enormous quantity of data will only serve to confuse patients, in part due to a lack of uniformity in terms, terminology, payment methods, and services. Rather than enlightening and empowering patients, the proposal would increase confusion and make health care decisions more complicated and stressful for patients. Additionally, the availability of that vast amount of data will not impact a patient's expected out-of-pocket costs for a visit or procedure.

CHA does not believe the proposal to publicly disclose privately negotiated rates will promote health care competition or lower health care costs for consumers. We believe the public availability of rates negotiated between insurers and health care providers will result in less competition and may have the unintended consequence of increasing health care costs. This position is supported by the Federal Trade Commission (FTC), which has expressed concerns about governmental requirements to publicly disclose competitively sensitive health care price information. The FTC asserts that the public availability of competitively sensitive price information increases the likelihood of collusion among the parties in the health care marketplace. Collusion negatively impacts competition, and the result is higher prices for consumers without any improvement in care quality or patient outcomes. The FTC also believes that disclosing commercially sensitive information reduces the impact of selective contracting that insurers and group health plans use to lower health care costs and ensure high quality in the care provided to their enrollees.

Relatedly, the Department of Justice (DoJ), in conjunction with the FTC, has addressed the issue of providers who collectively provide fee-related information to buyers of health care services. DoJ warns there are potential antitrust concerns when price information is made available by competing health care providers, including use of the information to discuss or coordinate provider prices or costs. DoJ seeks to protect against collusion, price fixing, and anti-competitive behavior. The proposal to make all privately negotiated rates publicly available raises the likelihood of anticompetitive behavior among the parties, which has long concerned DoJ and the FTC.

The departments seek to compel private insurers and group health plans to publicly disclose the type of private commercial information that the federal government itself is not permitted to disclose in responding to requests from the public under the Freedom of Information Act (FOIA). Section 552(b)(4) of title 5, United States Code exempts "trade secrets and commercial or financial information obtained

from a person and privileged or confidential” from FOIA requests. Thus, if a member of the public submitted a FOIA request seeking information from the departments on the rates that qualified health plans offered on the exchanges negotiated with providers and health care practitioners, the departments would be precluded from making that information available to the requestor. Congress has long understood the importance of confidentiality not only in matters of national security but also with respect to the private matters of nongovernmental commercial parties; it has long been a priority of Congress and the agencies to protect that type of sensitive information. **The proposal is inconsistent with FOIA and with that longstanding congressional priority.**

The proposal to require the public disclosure of privately negotiated rates fails to advance any of the rationale that the departments present as substantial government interests. Because of likely anticompetitive behavior once access to all privately negotiated rates is made widely available, CHA believes the proposal will reduce competition and lead to higher prices for health care services. This will not be helpful to patients or other consumers. Because the proposal neither directly nor materially advances a substantial governmental interest, we believe it to be an unlawful violation of First Amendment free speech rights of insurers, group health plans, and the private parties with which insurers and plans negotiate on behalf of their enrollees.

Additionally, as noted earlier, the private sector has led the way in making price estimator tools available to patients. Through those tools, patients have access to the information that they want and need, and it is made available to them in a less burdensome manner than through a governmental mandate that requires more information than is wanted by, or helpful to, patients. Price estimator tools currently offered by insurers, group health plans, and certain providers do not compromise free speech rights of private parties, nor do they threaten the status of a competitive private health care marketplace that competes on both price and quality. Thus, the departments’ policy goals are currently being met, and we urge the departments not to finalize this proposal under the rule.

CHA appreciates the opportunity to provide CMS with our comments on the proposed rule. If you have any questions, please contact me at akeefe@calhospital.org or (202) 488-4688.

Sincerely,

/s/

Alyssa Keefe
Vice President, Federal Regulatory Affairs