



September 27, 2019

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

RE: CMS-1717-P

Submitted Electronically via www.regulations.gov

Dear Ms. Verma:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. NAHU appreciates the opportunity to provide comments on the proposed rule titled "Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals" published in the *Federal Register* on August 8, 2019.

The members of NAHU help individuals and employers purchase, administer and utilize health insurance coverage on a daily basis. Our membership has a keen interest in making sure that both business and individual healthcare consumers have the opportunity to purchase the highest quality services at the best possible price. As such, we appreciate the Trump Administration's desire to create more useful and consumer-friendly transparency tools to help our clients evaluate healthcare options and make responsible and informed purchasing decisions. We have focused our comments on Parts XVI and Parts XVII of the proposed rule titled "Proposed Requirements for Hospitals to Make Public a List of Their Standard Charges" and "Request for Information: Quality Measurement Relating to Price Transparency for Improving Beneficiary Access to Provider and Supplier Charge Information" respectively.

To develop this comment letter, NAHU asked a representative group of brokers who work directly with individual and business healthcare purchasers to contribute their viewpoints. They focused on how the Trump Administration's proposed approach to price transparency will impact the markets and consumers they serve. In addition to an overview about our thoughts on the scope and timing of your proposal, we have broken our



resulting comments down by topic area for your consideration according to how issues are presented in the proposed rule.

Comments About Scope and Timing of the Proposed Rule

NAHU believes the principle of transparency is critical to the future of health reform. Everyone deserves the ability to make responsible and informed decisions about their medical care, and be able to obtain the highest quality medical care at the best possible price. The purchase of healthcare drives one-sixth of our economy, yet most consumers make related decisions with minimal regard to price and quality of care. In some cases, people make decisions without considering the actual necessity of the purchase. Since most individuals have health plan coverage with a predetermined network, their care-selection process has become more about which providers and facilities are in their system rather than which people and institutions are providing high-quality services for the best price.

Our association appreciates the intent of the proposed rule—to promote consumerism, health and well-being by exposing hospital price information. Unfortunately, since the proposed rule limits its transparency requirements to merely price data, we believe it to be insufficient. Bending the cost curve is critical to ensure access to care long-term, but the cost of service should only be one factor in a consumer's informed decision about provider and hospital selection. Price information must be coupled with quality data if consumers are truly to have the ability to compare services and make educated and informed purchasing decisions. Beyond that, consumers need additional education and resources to help them determine the weight to give price, quality and other factors when making specific medical care choices.

NAHU members also have significant concerns about the timeline contemplated by CMS. The proposed rule calls for all hospitals to make charge information public by January 1, 2020. We believe that this is too short of an implementation timeline for all hospitals to release this quantity of information and develop meaningful interfaces for consumers. Ideally, NAHU would like CMS to postpone this entire project until transparency for price data can be coupled with disclosure and display requirements related to healthcare quality measures. However, we recognize that there is a strong desire to move ahead now with at least price disclosure requirements.

If CMS decides to proceed with a version of this proposed regulatory framework, we request that at least six months be added to the implementation timeline, so that the compliance date for requirements in any final rule would be July 1, 2020, or later. With health insurance coverage, plan years frequently begin on January 1, so that is a logical implementation date for new requirements related to insurers and employer-sponsored health plans. However, there is no corresponding tie to January 1 when it comes to the actual consumption of healthcare. Consumers go to the hospital for services every day of the year, so high-quality price transparency data could be revealed on any date without consequence. NAHU believes it would be much better to wait and



allow hospitals the time to develop better tools for the public, than to rush and develop ineffective tools that consumers will not use.

Beyond these general comments, NAHU members have reviewed the details of the proposed rule and we have the following comments by section:

Covered Hospitals

Section XVI, Part B of the proposed rule includes a new definition of hospitals intended to extend applicability to every hospital in the United States, with a carve out for federally owned and operated hospitals that do not treat the general public. NAHU supports the proposed definition and its resulting impact on the scope of transparency section of the proposed rule. Additionally, we wonder if the Administration would consider inclusion of ambulatory surgical centers in the scope of the rule, as services in those locations are actually more relevant to the typical elective/shopping consumer than other hospital-based services.

Covered Items and Services

The proposed definition of items and services covered by hospitals in Section XVI, Part C is very extensive by design and intended to cover every single item and service that could be provided to patients during either an inpatient stay or outpatient visit. It includes both individual items, such as specific medical tests or pharmaceuticals and items and care that may be bundled by the hospital into a package of services, as well as the services of all physicians and non-physician practitioners employed by the hospital. NAHU believes that the proposed definition is too broad. We believe that it would be extraordinarily difficult for covered hospitals to compile all of this information in the timeframe outlined in the proposed rule. Presenting it in a clear and accessible way that would provide meaning and value to consumers within the timeframe as proposed would be problematic.

NAHU also questions the usefulness of such an overwhelming amount of price data, and we are concerned about the unintended consequence this proposal could have on the consumers it is meant to serve. NAHU members assist individuals and businesses with their healthcare purchasing decisions every day. In our experience, an excess of information and data does not improve decision-making on the part of the consumer. Instead, it causes most consumers to shut down. It also leads to delayed decisions and choices made in a climate of frustration and overwhelm, rather than reason. As such, NAHU recommends that in any final rule CMS significantly limit the scope of covered services for which price data must be provided. Our members believe that simply providing data on the most common and “shoppable” items and services, as proposed in Section XVI, Part F, would be sufficient at the present time.

Proposed Definitions for Types of “Standard Charges”

Section XVI, Part D of the proposed rule outlines the proposed definitions for standard charges that will be publicly disclosed according to the requirements of the proposed rule, including both gross charges and payer-



specific negotiated rates. The proposed rule envisions requiring the public disclosure of the charges each hospital negotiates for covered items and services with every third-party payer, ranging from public payers like Medicare fee-for-service to private health insurance carriers providing fully-insured coverage to third-party payers administering claims for self-funded plans of all types.

NAHU strongly opposes the mandatory disclosure of all charges for covered items and services as negotiated by third-party payers as proposed in the rule. We join in the objections that many other entities have, and will raise, concerning the appropriateness and anti-competitive nature of a requirement to disclose all negotiated rates. NAHU believes that the disclosure requirement, as proposed, will create an unsustainable price floor, rather than a ceiling. Evidence from other transparency endeavors shows this type of transparency will make the price of medical care and health insurance premiums higher for all payers, including federal taxpayers and individual and business consumers of healthcare services. For example, in 1993, federal securities regulators began requiring publicly traded companies to adhere to transparency requirements regarding executive compensation. The hope was that the disclosure requirements would slow average executive compensation growth, which in 1993 was 131 times the rate of pay for the average worker. However, the transparency rules had the opposite effect – CEOs now compare their salaries to that of competitors and demand even more compensation. Today, the average CEO makes 369 times the rate of pay of the average American worker.

NAHU also feels that the disclosure of all third-party negotiated rates would be an extraordinarily complicated process, as that information is not immediately and readily available to each hospital covered by the scope of this rule. Typically, the hospital only readily knows what its gross charges are, as reflected by the chargemaster. As the proposed rule references, there is not always one “standard charge” for each item or service, but instead the end charges reflect the very nuanced care each individual patient receives. The final negotiated charges are a result of a detailed process that occurs on the back-end for each patient between the hospital and the issuer or a third-party claims administrator. Making all of the negotiated rate information available in a timely and user-friendly manner that makes sense for hospitals, third-party payers and consumers alike does not seem like a reasonable or productive endeavor.

Most importantly, NAHU does not see how disclosing all third-party negotiated rate information in a public file on a hospital’s website will be helpful and useful for consumers. Instead, we envision many scenarios where this level and type of disclosure will simply confuse consumers and possibly dissuade them from obtaining necessary care. A typical person would be unable to sift through the information this proposal would yield and find what is applicable to them. Even if they did, there is little evidence that they would then be able use the data to make an informed purchasing decision. It is unreasonable to expect that the disclosure of charge information will impact immediate decision-making in a hospital-based setting. CMS, hospitals and health plans must all approach transparency requirements for hospitals with the mindset that once a person enters a hospital for care, the person's ability to make provider and care choices based on transparent cost and quality data is inherently limited.



For example, envision three people who all go to the same hospital for the same ailment and to receive essentially the same care and “shoppable” services that they scheduled in advance. One of these people is covered by a Medicaid managed care plan, another by a small-group fully-insured PPO policy and the third has qualified HDHP coverage paired with an HSA offered through a large self-funded employer group plan. These three people could all easily carry health insurance cards with the same brand-name logo in their wallet. If they all met up in the hospital and discussed their insurance, they would probably all believe that they have essentially the same coverage. From their perspective, their carrier brand name is the same.

However, these three people all have coverage through three very distinct plans, with three entirely different third-party payers. Therefore, the negotiated rates for the items and services these people receive would be different too. Since all three of these individuals believe they have essentially the same coverage, provided by the same carrier, how would they be able to distinguish between the different negotiated rates associated with the brand-name of their health insurance carrier? The information on their card might not direct them to the right rates, and who’s to say that they will even reference their card when searching through the data this proposed rule would make available to them.

Even assuming everyone found the correct negotiated rates for the care and services they went to the hospital to receive, none of these people will have access to all of the cost or medical information that pertains to them specifically, either in advance of or during a hospital experience. Medical care is unpredictable, and people need treatment and service variations all of the time, particularly during hospitalization. It is highly likely that an individual will need more care during a hospitalization than was included in a “shoppable” service package that they may have referenced online. Furthermore, each covered individual has their own cost-sharing obligations, including deductibles and maximum-out-of-pocket limits and totals, all of which factor into direct personal costs. Negotiated rate information does not impact a consumer’s direct costs in the same way, and our association sees little to no benefit in a requirement to provide it to the public.

NAHU understands that the Trump Administration feels a commitment to providing consumers with price transparency data as soon as possible. To meet this need, NAHU believes that the requirement to simply disclose gross charges would be more appropriate. With regard to the more consumer accessible “shoppable services” section of the disclosures requirement, each hospital could be required to note that gross charges do not necessarily reflect the amount paid by each third-party payer, and that, for more detailed information specific to them and their plan, individuals should contact their specific health insurer or consult their explanation of benefits form.

Alternative Types of Standard Charges

The proposed rule recognizes some of the potential challenges associated with requiring the disclosure of all third-party negotiated rates and Section XVI, Part D solicits comments on various alternatives. These include



defining a standard charge to be disclosed based on the volume of patients that pay a specific charge versus a different rate (a modal rate) and requiring the disclosure of the minimum, median and maximum negotiated charge for every given item or service. Additionally, the proposed rule contemplates requiring hospitals to disclose all allowed charges, including non-negotiated charges, such as fee-for-service Medicare rates.

NAHU appreciates the recognition this section provides to the difficulty and downsides associated with the proposed requirement to disclose all third-party negotiated rates. However, we feel that both of the two alternative options to provide less data would be complicated to produce and have similar lack of utility concerns as we identified relative to posting all negotiated rates. Of the two choices, NAHU prefers a modified version of the second alternative option. NAHU suggests that “standard charges” should be both the gross charge for each service on the chargemaster, along with the average amount of their payment by service, by factoring in negotiated rates and discounts. NAHU does not support the proposed alternative to post all allowed charges. As with the negotiated rate proposal, this idea raises cost and competitive concerns. Developing it would also be extremely burdensome and have limited value for consumers.

Alternatives for Self-Payers

Section XVI, Part D of the proposed rule also inquires if, in the final regulation, CMS should require hospitals to specifically disclose price information specific to individuals who elect to self-pay for items and services, either because they are uninsured or they would prefer to pay out-of-pocket for services rather than accept third-party reimbursement. Hospitals often provide a discount from the gross charge for individuals paying directly, or provide a sliding scale discount for such consumers. The proposed rule contemplates requiring the disclosure of either a single cash-discount rate for each charge or the median rate charged to cash or cash-equivalent payers if a sliding scale is used. NAHU supports the disclosure of a single cash discount rate, since these payers are the most likely to find this type of price transparency information useful. If a hospital employs a variable or sliding scale for discounts, then we believe that this information should be clearly noted in the publicly accessible online data source. The use of a single median rate would both be complicated to produce and have limited utility for cash-paying consumers.

Disclosure Requirements

The proposed rule outlines requirements about how hospitals would be required to disclose and display standard charge data in Section XVI, Part E. Hospitals would be required to disclose a complete list of charge information in “machine readable format” and a list of at least 300 “shoppable services” on their websites. The proposed rule contemplates two potential options for the location of each hospital’s complete list of standard charge data file. The proposed document currently requires each hospital to disclose the machine-readable file information on their website in a prominently displayed single file. It mandates accessibility with a minimum number of click-through screens and without barriers to entry, such as a registration process. However, the proposed rule also solicits comments on a potential alternative, whereby hospitals would submit



their standard charge file to a single, CMS-specified source so that all files could be made available through a single section of the CMS webpage.

NAHU supports the alternative option. We believe that there are many advantages to this approach, including reducing costs and consumer confusion. Containing the data from all hospitals in a single location would also help technology-developers and researchers access the information easily. Since they are the intended consumers of the machine-readable data, a single-source location seems much more appropriate. A CMS-maintained site would also likely be easier to maintain and monitor for enforcement purposes. As CMS notes, this methodology will also allow CMS and other researchers and innovators to more easily mesh the data covered in this proposed rule with CMS hospital quality information. For all of these reasons, NAHU urges CMS to use the centralized website approach when it comes to the disclosure of standard charge information.

With regard to the required frequency of updates to charge information, NAHU supports the CMS proposal to require hospitals to update their charge lists on at least an annual basis. We also support the proposed requirement that the transparency requirements apply per individual hospital location.

Shoppable Services

NAHU generally supports the concept of adding a consumer-friendly display of shoppable services to each hospital's website. As we previously commented, our association believes that the utility of such an interface would be greatly enhanced if it was also paired with quality information about the facility and its service providers. In addition, we do not believe that such an interface should include the negotiated rates for each third-party payer, but instead list the gross charge information, discounted price for any cash or cash-equivalent payers and average amount the hospital receives for payment by service, with the average rate factoring in negotiated rates and discounts. Furthermore, the shoppable services disclosure display should prominently note that only each individual's health plan can provide entirely accurate information about the person's out-of-pocket cost obligations. Such final details can only be determined and any issues can only be resolved after treatment is complete and the claim submitted and processed by the health plan.

NAHU agrees with the decision that the consumer-friendly interface should include common procedures that may be scheduled ahead. We also support the approach to require the display of information to mirror the way people typically would receive services in the hospital, so that each common service is bundled with all related common charges. However, our membership recommends that the posted "shoppable" charge information and related service display include a prominent disclaimer that the services listed are not definitely the charges and services every individual patient will incur. The site should explicitly indicate that engaging in medical examinations and treatment can sometimes necessitate an expanded scope of care that may result in increased costs.



With regard to the 70 services identified by CMS for mandatory inclusion in each hospital's display, NAHU members feel that while these procedures are not very hospital specific, it is representative of common services that adult consumers may receive through a local hospital that serves all types of consumers. However, this list is not particularly appropriate for children's hospitals, and we imagine that many services it lists would not be routinely performed at other types of specialty hospitals. We agree that a base list of services is a sound proposal, as opposed to allowing hospitals to select any other 230 services for inclusion. However, we suggest the mandate require that a hospital include all of the 70 services on the CMS list that it does routinely, as well as the 200 most commonly performed procedures at that hospital and their related services. Additionally, we believe that any final rule should require disclosure of the pricing of established patient visits, instead of or in addition to new patient visits. Use and relevance of established patient visits compared to new patient visits is likely in excess of 20:1.

NAHU supports the CMS proposal to require hospitals to update their common services consumer-friendly interface on at least an annual basis. We also agree with the requirement that hospitals maintain a site that can be accessed with a minimum number of click-through screens and without barriers to entry, such as a registration process.

Request for Information on Quality Measurement Related to Price Transparency

As we expressed in our introductory comments, NAHU believes that to be in any way effective with its price transparency efforts, CMS needs to pair hospital-provided standard charge data with meaningful quality information. Otherwise, consumers can never make truly informed healthcare purchasing decisions. Beyond that, the public availability of quality data will help guide the development of consumer tools that consumers might use during the initial choice of facility. It will allow health plans to develop better networks, contracting terms and plan designs for consumers. With more provider quality data, health plans will also be able to design behind-the-scenes cost controls and create better consumer-engagement tools to scaffold and incent more informed patient decision-making.

NAHU appreciates that Part XVII of the proposed rule is a request for information about how CMS could use healthcare quality information to improve consumer utility of the price transparency data that will result from the public disclosure of standard hospital charge rates. In the request, CMS specifically solicits comments on sources of healthcare quality information that could be paired with hospital charge data. As a start, NAHU suggests the use of existing CMS data on hospital quality.

The RFI also asks for information about how quality information should be disseminated to consumers. NAHU believes it is essential that the hospital charge data required to be disclosed by this proposed rule be accompanied by quality data, including information about the volume of specific services performed by each hospital, success rates and complications data.



NAHU appreciates the opportunity to provide comments on the proposed rule, as well as your commitment to providing Americans with more informative, consumer-friendly healthcare cost and quality data and tools. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,

A handwritten signature in black ink, which reads "Janet Stokes Trautwein". The signature is fluid and cursive, with a large initial "J" and "S".

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters