



CONSUMERS F1RST

The Alliance to Make the Health Care
System Work for Everyone

January 29, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS- 9915 –P (Transparency in Coverage)

Submitted via regulations.gov

Dear Administrator Verma:

Consumers First: The Alliance to Make the Health System Work for Everyone, brings together powerful interests representing consumers, children, employers, labor unions, and primary care providers working to change the fundamental economic incentives and design of the health care system. Our work is to realign the incentives and design of health care so that the system truly delivers the health and high-quality care that all families across our nation deserve.

Consumers First appreciates the opportunity to provide comment on the Transparency in Coverage proposed rule. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety. These comments represent the consensus views of the Consumers First steering committee, listed at the conclusion of this letter. Some individual members of the steering committee are also submitting their own comments on the rule.

We believe price and quality transparency are critical to achieving higher value for health care consumers. Thus, last fall, *Consumers First* provided supportive comments on the hospital price transparency rule (CMS-1717-F2). In our comments on the hospital price transparency rule, we urged serious consideration of the possibility that public disclosure of negotiated rates could result in higher prices and provided a number of comments intended to mitigate that risk. Despite these concerns, when fully implemented, that rule will allow policymakers, researchers, and consumers to understand the price of health care services negotiated between providers and health insurers. This information is critical to ensuring that the health care system will finally be held accountable for providing high value care that is good for patients and reasonably priced.

Consumers First similarly supports significantly strengthened public transparency on the part of health plans. While we agree on the importance of providing more transparency in coverage, the Administration's efforts to affect consumer behavior

through greater transparency are based on faulty assumptions regarding the primary audience for price transparency, which could undermine the ability of the rule to provide meaningful value to consumers seeking to reduce their health care costs and improve health care outcomes. Below, we recommend changes to the underlying assumptions asserted in the rule and recommend several policy changes to maximize consumer benefit of the proposed rule and the Administration’s overall efforts to improve health care value and transparency.

This comment letter focuses on the three key areas of the rule, and makes recommendations for further Administration action, not included in the rule.

- Comments on Section II (A) of the rule: “Proposed Requirements for Disclosing Cost-Sharing Information to Participants, Beneficiaries, or Enrollees”
- Comments on Section II (B) of the rule: “Proposed Requirements for Public Disclosure of Negotiated Rates and Historical Allowed Amount Data for Covered Items and Services from Out-of-Network Providers”
- Comments on Section V of the rule: “Issuer Use of Premium Revenue under the Medical Loss Ratio Program: Reporting and Rebate Requirements”
- Recommendations for further Administration action to support health care value efforts at the federal and state levels

Comments on Section II (A): Do Not Expect Consumers to Bargain for Their Own Care

Section II (A) of the proposed rule establishes a framework to provide enhanced transparency for consumers regarding cost-sharing requirements. In the rule’s “Benefits of Transparency...” Section (P. 6), the rule asserts: “The overarching goal of these proposed rules is to support a market-driven health care system by giving consumers the information they need to make informed decisions about their health care and health care purchases.” While we support consumer-facing price and quality transparency, we believe that the underlying assumption implicit in this assertion is false. Our health care markets are ripe with classic market distortions of asymmetry of information, monopolistic pricing, and externalities. Thus, it is unrealistic to expect health care consumers to effectively bargain for their own health care. Rather than assuming health care consumers, on their own, can be the primary drivers of higher-quality, lower-cost health care, we urge the Administration to view transparency in a holistic way that includes employers and other payers, plans, providers and patients as vital consumers of transparent pricing and quality information.

More than 50 years ago, Nobel Laureate Kenneth Arrow identified that the demand for medical services are unlike other services which operate in a more effective market.¹ Demand for health care is inelastic and unpredictable, and thus consumers’ ability to effectively drive down prices is highly limited, even when out-of-pocket costs are better understood. More recent evidence suggests that health care price transparency alone has little-to-no impact on consumer behavior.² There are a number of reasons this may

be the case, including lack of quality data against which to compare price, consumer deference to providers recommending high cost services, and a lack of agency for people near the end of their lives, when health care costs are often highest. Further, recent empirical evidence finds that greater consumer exposure to higher out of pocket costs leads to reduced utilization of both high value and low value care in roughly equal proportion.³ For example, although the use of high deductible health plans has been moderately successful at reducing health care costs for some consumers, in some cases consumers have reduced both inappropriate and appropriate care, including high value preventive care, to minimize their own costs.⁴

Given that our system currently relies significantly on patient cost-sharing through deductibles and co-insurance, we believe it would be helpful to evaluate whether it is possible to provide useful tools for patients to use at the point of service so that consumers can act on the information in real time. Although we generally support the cost-sharing estimate tool in the proposed regulations, the proposed rule does not provide a basis for evaluation of the usefulness of the tool because it would be imposed nationally with little experience in testing how feasible it will be for plans to provide actually useful tools. We recommend testing it first with health plans that have some experience with producing the data being requested and which seek to participate. And because a meaningful test of the approach properly requires an array of comparative prices across most of the hospitals and health plans in an area, we suggest that testing take place in a few states and perhaps sub-state, logical market areas such as hospital referral regions (HRRs).

Moreover, under the proposed regulations regarding the cost-sharing estimate tool, it is participants and beneficiaries who have the burden of correctly identifying the proper billing code or descriptive term to enter for purposes of the cost-sharing estimate. Given the complexities of the items and services that are provided and the plethora of codes (i.e., there are over 10,000 CPT codes), this will undercut the potential accuracy of the cost-sharing estimate and place the burden on the consumer when it should be on the provider. Thus, we urge the Administration to address the critical role and responsibility of providers as part of the efforts to increase consumer-facing transparency.

Comments on Section II (B): Transparency Should Focus on Modifying Provider, Plan and Policymaker Behavior

Section II (B) of the rule establishes a framework to provide broad public disclosure rates for covered health care services between providers and private health plans, among other provisions. Despite our divergence on the primary immediate audience for enhanced price transparency, we believe that price transparency can and should inform other parties with the ability to act on the information. To that end, we recommend that the Administration refocus the target of their price transparency efforts from changing consumer behavior to changing the behavior of providers and payers, and to informing policymakers and regulators. Individual providers (physicians and other clinicians who direct most health care spending in the United States) can effectively use price and

quality information to encourage patients to access lower-cost, higher-value referred providers. The same holds for employers and other payers, who can use transparent price information to drive care toward higher value providers. For employers and other purchasers, transparent price and quality information can be used to develop innovative plan designs that guide patients towards higher-value health care providers.

Providing public information on actual health care prices – including those negotiated between health plans and providers – can provide employers and health plans with comparative pricing information so that they can take requisite action to demand more reasonable rates and guide patients to more high-value providers.

For example, in 2006, the State of New Hampshire began posting health care procedure prices for all commercial insurers and all providers on a publicly available website.⁵ This state-level experiment in price transparency resulted in an 11 percent reduction in out-of-pocket costs for consumers. While the goal of the public website was to inform consumers regarding relative prices, a 2018 study found that the policy resulted in significant supply-side effects. As the study states, “Overall, this is evidence of a significant reduction in negotiated prices, especially in the long run.”⁶

While *Consumers First* is broadly supportive of disclosure of negotiated prices, some research suggests that broad public transparency of negotiated prices may drive up costs in certain markets. The possibility of higher prices also warrants serious consideration. We recommend that the Departments take precautions to mitigate the risk of higher prices. To mitigate the risk of higher prices and gain more meaningful data regarding the effect of price transparency on health care costs, we recommend CMS take the following precautions:

- Pilot full public price transparency in several health care markets and conduct longitudinal studies on the impact of the policy on negotiated prices.
- Make provider- and plan-specific negotiated prices available to plan sponsors and researchers in the large group market.
- Provide negotiated prices to individuals, plan sponsors, and researchers in the small group and individual markets.
- Provide limited information to the public on negotiated prices. This could include providing statistical information including the range and distribution of privately negotiated rates between providers and health plans for each of the services identified by CMS.

Comments on Section V: The Rule Should Define “Higher-Value Provider” for Purpose of Proposed MLR Shared Savings

To provide an incentive for consumers to choose higher value providers, the proposed rule would allow issuers that offer shared savings payments "made to an enrollee as a result of the enrollee choosing to obtain health care from a lower-cost, higher-value provider," to include such costs in the numerator of the calculation of their Medical Loss Ratio (MLR) Proposed 42 C.F.R. § 158.221(b)(9). The rule does not define, however,

what would qualify a provider as “higher-value.” Current rules on calculation of MLR allow certain quality-improvement activities to be include the MLR numerator. These rules could be used as a starting point for definition of “higher-value provider.”

While we support the concept of offering shared savings to consumers, we are concerned that absent additional regulatory language defining what it means to be a “higher-value provider,” issuers will simply create incentives to choose lower-cost providers that may not be improving the health or health outcomes of their patients and may be, therefore, increasing costs over the long-term. We strongly urge the Administration to clearly define “higher-value provider” in the rule, and ensure shared savings payments be based on consumers choosing providers that are both “lower-cost” and higher-value.”

Further Recommendations: The Administration Should Support Congressional and States Efforts to Pursue Complementary Efforts, including All-Payer Claims Databases

While we support administrative efforts to substantially improve health care price transparency, Congress and the states have at their disposal even more effective tools to unveil prices. We support ongoing efforts in many states to develop all payer claims databases (APCD) with respect to the individual and insured markets. We believe access to paid claims and related data will assist all stakeholders in making more informed utilization and plan design decisions. Making paid claims public is most easily done as part of an APCD. We thus strongly approve of legislation approved by the Senate Committee on Health, Education, Labor and Pensions (HELP) that designates a single entity to collect claims data from self-insured plans and that provides support for the development of state APCDs.

In addition, Congress can meaningfully reduce market distortions by prohibiting anti-competitive contract provisions including banning gag clauses and clauses requiring plans to contract with all facilities and physician practices within a health system. These vital statutory changes are likewise included in Sections 301 and 302 of the *Lower Health Care Costs Act (LHCC)*, bicameral, bipartisan legislation initially developed by the Senate HELP Committee.

While these changes are under the purview of Congress and state lawmakers, the Administration can meaningfully support these efforts. Specifically, the Administration should accelerate these efforts by providing guidance to states setting up their own APCDs, and requiring more aggressive data exchange in Medicare Conditions of Participation requirements. Further, as the Administration engages with Congress and state policymakers in 2020, we strongly urge it to vocally support these vital efforts on Capitol Hill and across the country, including by adding these proposals in the president’s 2020 budget request to Congress and pushing for Sections 301-302 of the LHCC to be included in upcoming legislation.

Thank you for considering the above recommendations. Please contact Shawn Gremminger, Senior Director of Federal Relations at Families USA (sgremminger@familiesusa.org) for further information.

Sincerely,

American Academy of Family Physicians
American Benefits Council
American Federation of State, County, and Municipal Employees
Families USA
First Focus on Children
Pacific Business Group on Health

¹ https://web.stanford.edu/~jay/health_class/Readings/Lecture01/arrow.pdf

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797351/>

³ https://www.rand.org/pubs/research_briefs/RB9174.html

⁴ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0610>

⁵ <https://www.beckershospitalreview.com/finance/new-hampshire-s-price-transparency-website-helped-patients-save-money.html>.

⁶ http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf