



AMERICAN BENEFITS
COUNCIL

September 27, 2019

Submitted via Federal eRulemaking Portal: <http://www.regulations.gov>

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1717-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: *HHS 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*

Dear Sir or Madam,

We write on behalf of the American Benefits Council ("the Council") to provide comment in connection with the HHS Medicare Program Proposed Rule ("proposed rule" or "NPRM") published in the Federal Register on August 9, 2019, by the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) (84 Fed. Reg. 39398). Among other things, CMS issued the proposed rule to expand hospital charge display ("standard charge") requirements to include charges and information based on negotiated rates and for common "shoppable" items and services, in a manner that is consumer-friendly, and to establish a mechanism for monitoring and the application of penalties for noncompliance. The proposed rule also requests information on quality measurements relating to price transparency, and proposes to complete the two-year phase-in of a method to reduce unnecessary

utilization in outpatient services by addressing payments for clinic visits furnished in the off-campus hospital outpatient setting.

The American Benefits Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

The Council appreciates the opportunity to provide comment with respect to the proposed rule, specifically on the price transparency of hospital standard charges, quality measurements relating to price transparency and site-neutral payment reform. Employers play a critical role in the health care system, leveraging purchasing power, market efficiencies and plan design innovations to provide health coverage to over 178 million Americans. Most employers that have had success decreasing the rate of health care spending have started by taking deep dives into their data. They do this to better understand how much they are spending for various services delivered in different settings and, ultimately, to steer their enrollees to higher-value providers operating in higher-value settings. A key piece of solving the health care cost and quality puzzle remains a lack of price and quality transparency. The Council's long-term strategic plan published in 2014, *A 2020 Vision: Flexibility and the Future of Employee Benefits*,¹ included this recommendation:

Support greater quality and price transparency in the health care system. Meaningful information on price and quality is often hard to capture and adjusting for the clinical complexity of individual cases is difficult. Despite these challenges, greater transparency of quality and price information is important and urgently needed. Employees should have quality and cost calculators and other tools that provide enrollees with specific data about the quality and total out-of-pocket costs of certain services. Public policy should not impede employers' access to information needed to design and operate their plans and to help employees use these tools.

Thus, greater price and quality transparency in health care is an area of critical importance for employer plan sponsors. As a means of achieving the goals of lowering the cost and improving the value of health care in this country, we strongly view transparency as a means to achieving these goals rather than transparency being the goal itself.

As such, the Council recognizes that price is just one piece of the puzzle, and that, in terms of value, the price of the health care service does not always correlate with the quality of care and, thus, equate to better value.² While the public disclosure of

¹ <https://www.americanbenefitscouncil.org/pub/?id=E6154447-F3DA-EAEE-A09E-FBCC312A0E91>

² Colorado Value Hospital Report, Summer 2019.

negotiated rates may lead to lower costs, at least in some markets and for some services, the Council is also mindful that public transparency of negotiated rates may have the unintended and undesirable effect of increasing negotiated rates or resulting in fewer providers in a given market. Accordingly, as discussed below, the Council urges the Department to exercise due care to ensure that the increased transparency will, indeed, achieve the goals of lower cost and higher quality health care for America's working families.

BACKGROUND

Section 2718(e) of the Public Health Service Act requires each hospital operating within the United States for each year to establish (and update) and make public a list of the hospital's "standard charges" for items and services provided by the hospital, including Diagnosis Related Group (DRG) codes established under Section 1886(d)(4) of the Social Security Act. For 2015, CMS required hospitals to either make public a list of their standard charges or their policies for allowing the public to view a list of those charges in response to an inquiry, and to update the information at least annually, or more often, as appropriate, to reflect current charges. For 2019, CMS updated its guidelines to require hospitals to make available a list of their current standard charges via the internet in a machine-readable format and to update this information at least annually, or more often, as appropriate. CMS FAQ guidance provided that the publicly posted information should represent the hospital's standard charges as reflected in the hospital's chargemaster and clarified that the requirement applies to *all hospitals operating within the U.S.* and to *all items and services* provided by the hospital.

In the proposed rule, CMS proposes to expand the definition of "standard charges" to include payer-specific negotiated rates. Specifically, the proposed rule would require hospitals to make public their "standard charges" under the expanded definition in two ways: (1) a comprehensive machine-readable file that makes public all standard charge information for all hospital items and services, and (2) a consumer-friendly display of common "shoppable" services derived from the machine-readable file. As discussed in the proposed rule, CMS is also seeking stakeholder input on quality measurements relating to price transparency. Finally, CMS is proposing to complete the two-year phase-in of a method to reduce payment differences for Medicare between certain outpatient sites of service, specifically addressing payments for clinic visits furnished in the off-campus hospital outpatient setting.

The Council supports increased price transparency and access to pricing data for employer plan sponsors.

As discussed above and in greater detail below, transparency is not, and should not be, an end goal in its own right. Rather, transparency should be the enabler to increase competition, resulting in reduced costs, less consumer confusion, more value-driven, informed and efficient consumption of health care.

The Council strongly believes increased transparency is needed with respect to a plan and employer's access to and use of *the plan's own* pricing data, including claim and provider-specific negotiated rates. Increasing employer access to and use of pricing data will enable market forces to work more effectively and efficiently, ultimately leading to better cost and quality outcomes. Notably, of those employers that have had success in decreasing the rate of health care spending, many have done so by analyzing their plan data to better understand how much is being spent on specific health care services. This is particularly the case with health care services delivered in various clinical settings for which the plan can encourage enrollees to select higher-value providers operating in higher-value settings. Programs that are focused on value-based benefit design and value-based payment reform have the potential to transform our system by realigning incentives that keep enrollees healthier – while at the same time lowering costs. Increased price transparency and plan sponsor access to pricing data will help facilitate the development and expansion of value-based programs that encourage enrollees to select higher-value providers operating in higher-value settings. Accordingly, the Council strongly supports policies that ensure a plan and/or its employer plan sponsor have, at a minimum, access to a hospital's negotiated rate specifically applicable to the plan.

Health care price transparency alone may not alter consumer behavior. However, employer plan sponsors can use transparent price and quality information to develop innovative plan designs that steer patients towards higher-value health care providers. Employers hold the key to changing the behavior of 178 million Americans with employer-sponsored health coverage. Price and quality transparency is the necessary tool that employers need to drive this change to lower-cost, higher-quality care. Accordingly, we urge CMS to view transparency through the lens of employer plan sponsors who can effectuate broader change by encouraging consumers to make wiser decisions about where and from whom they receive their health care.

PROPOSED DEFINITIONS FOR TYPES OF “STANDARD CHARGES” AND REQUIREMENTS FOR PUBLIC DISCLOSURE

CMS is proposing to define “standard charges” as encompassing both (1) “gross charges” and (2) “payer-specific negotiated charges.” As proposed, hospitals would be required to make public these two types of standard charges. Per the NPRM:

1. A “gross charge” would be defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.
2. A “payer-specific negotiated charge” would be defined as the charge that the hospital has negotiated with a third-party payer for an item or service. Importantly, a “third-party payer” is defined as an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

The NPRM specifically seeks comment on whether and how the release of such specific charge information could result in unintended consequences. Comments are also sought on whether and how there may be different methods for making such information available to individuals who seek to understand what their out-of-pocket cost obligations may be in advance of receiving a health care service.

As noted above, the Council supports increased price transparency where it is expected to bring down costs, reduce consumer confusion, and result in more value-driven, informed and efficient consumption of health care services and items. Indeed, rather than defining transparency in terms of “charge” or “price” transparency, should we instead be looking for greater “cost” transparency? That is, a clearer and fuller picture of the actual cost of health care, rather than “charges” that bake in any margins, is a better roadmap for value-based decision-making.

So too is it important for patients to clearly understand the full cost of a hospital stay and not just the specific cost of the actual procedure. Listing the common expenses associated with the primary procedure would be helpful in preventing increases in secondary or hidden charges as a response to posting the primary procedure cost. For example, if someone has a baby, they want to know the price/cost of the entire hospital stay, including the room charge, the anesthesia, the pediatrician and the pharmacy. If negotiated rates are required to be disclosed in some form, consumers should also understand that the negotiated “prices” represent rates before a participant’s or beneficiary’s health coverage is applied to the service. The Council also recommends that the hospital services used to compose the list of 300 prices be described using uniform Medicare billing codes and a description that a layman would be able to understand. For example, this information would be helpful for when a member calls their health plan to confirm a price. To make informed decisions about health care services, consumers need to understand their complete costs prior to receiving care.

However, the Council appreciates (as recognized by CMS in the preamble) that the impact resulting from the public release of provider and plan specific negotiated rates is largely unknown. The public release of such information may indeed lower costs, at least in some markets and for some services. Conversely, the public display of specific negotiated rates may have the unintended consequence of increasing health care costs of hospital services in highly concentrated markets or as a result of anticompetitive behaviors. The potential for higher prices calls for CMS to gather more data about the impact of public disclosure of negotiated rates and take steps to guard against this risk.

In light of the potential unintended and undesired adverse consequences, the Council requests that CMS strongly consider such impacts and structure any final rule to avoid such unintended consequences. For example, CMS considered including in the definition of standard charge the minimum, median and maximum negotiated charge (the lowest, median, and highest charges of the distribution of all negotiated charges across all third party payer plans and products) as opposed to the payer-specific negotiated charge, which may be more appropriate in certain markets to prevent

unintended consequences. The Council supports CMS defining standard charge as a minimum and median amount. However, in order to avoid adverse consequences, we encourage CMS to consider implementing this in a way that guards against reverse engineering of specific negotiated rates in concentrated markets. The Council is concerned about potential adverse effects with the disclosure of the maximum amount for a service as it could impact the ability to negotiate lower rates. Posting a maximum amount could have an inflationary impact as providers seek to negotiate the maximum amount for themselves. Other strategies to reduce potential for anticompetitive effects would be related to the extent of the disclosure/publicity of the negotiated rates. The Council supports making the payer-specific negotiated prices available to plan sponsors, thereby giving employers the data they need to help steer participants and beneficiaries toward higher-value care.

It is important to note that while price is important, health plans and hospitals have other negotiating differentiators that could factor into the value of care for patients. For example, hospitals could improve quality to be considered a premium system or move to value-based payment models. As evidenced by the Request for Information on quality measurements relating to price transparency, price alone does not tell the whole story.

Public disclosure of pricing information does raise concerns for plan sponsors about the potential for increased litigation under ERISA based on the release of payer-specific negotiated rates. For example, the Council is concerned that there may be an increased risk of fiduciary-based litigation similar to the spate of litigation that resulted with employer-sponsored 401(k) plans following the implementation of mandated fee disclosures. While such litigation is typically resolved in favor of the sponsoring employer/named fiduciary, the costs of this litigation on the system (e.g., in the form of forgone employer plan contributions) cannot be ignored. Accordingly, the Council requests that CMS coordinate with the U.S. Department of Labor (DOL) so that any disclosure requirement is crafted so that it does not increase liability for employer plan sponsors. For example, the DOL should consider proposing a safe harbor to protect employers from downstream risk relating to the public disclosure of negotiated rates.

The Council recommends that the applicability date for any expansion to the hospital "standard charge" requirement which, as proposed, would include charges based on negotiated rates, should be no earlier than January 1, 2021. This would give CMS time to gather additional information relating to any unintended consequence before finalizing the regulations, and time for hospitals to establish the necessary processes to comply.

REQUEST FOR INFORMATION (RFI): QUALITY MEASUREMENT RELATING TO PRICE TRANSPARENCY FOR IMPROVING BENEFICIARY ACCESS TO PROVIDER AND SUPPLIER CHARGE INFORMATION

CMS has stated two main goals in seeking comments relating to quality measurements relating to price transparency:

1. Improving availability and access to existing quality of information for third parties and health care entities to use when developing price transparency tools and when communicating charges for health care services.
2. Improving incentives and assessing the ability of health care providers and suppliers to communicate and share charge information with patients.

The Council very much supports the adoption and integration of quality measurements as part of any final rule regarding increased price transparency. Meaningful and aligned quality measures are a foundation of value-based purchasing decisions. As more large employers implement innovative payment reforms, like direct contracting or accountable care organizations, quality measures should be aligned across public programs and private plans to help lay a strong foundation to achieving more meaningful payment reforms. To that end, we note that the Council is a member of the Core Quality Measures Collaborative (CQMC), a broad-based coalition of health care leaders, including CMS, insurance providers, medical providers, consumers and purchasers promoting alignment of quality measures across public programs and the private sector. The Council recommends that CMS work within the context of the CQMC to develop a recommended process for pairing quality measure results and cost information on websites and mobile applications, including suggested formats for display.

SITE-NEUTRAL PAYMENT REFORM

The Council is a strong advocate of site-neutral payment reform and, to that end, is a member of the Alliance for Site-Neutral Payment Reform. We applaud CMS for proposing to complete the two-year phase-in of a method to reduce unnecessary utilization in outpatient services by addressing payments for clinic visits furnished in the off-campus hospital outpatient setting. The Council is aware of the recent decision by Judge Rosemary Collyer in the U.S. District Court of the District of Columbia which vacated CMS' "method" of site-neutral payments and remanded to CMS for further proceedings.

The Council and its members are very concerned about the impact that provider consolidation has had – and continues to have – on health care prices.³ In light of this,

³ <https://www.nihcm.org/topics/cost-quality/how-are-health-care-prices-related-to-physician-practice-consolidation-and-integration-with-hospitals>.

the Council encourages changes to policies that foster competition and benefit consumers and plan sponsors. The Council has urged Congress to decrease incentives that are leading to increased consolidation in Medicare by expanding implementation of site-neutral payment reform. The Council supports site-neutral payment reform, and specific policies that reduce payment differences based on the health care setting, without having the unintended consequence of pushing more cost to plan sponsors. The Council believes policies that reduce payment disparities based on health care setting will help to address over-concentration of health care services and higher costs for health care services.

The need for site-neutral payment reforms is evident. Payment policies supporting higher reimbursement in the hospital outpatient department setting have resulted in increased costs to patients, employers and taxpayers. Patients and the Medicare program pay more when the same services are delivered in the hospital outpatient department setting instead of independent physician practices for a wide variety of services such as chemotherapy: \$281 vs. \$136,⁴ cardiac imaging: \$2,078 vs. \$655 and colonoscopy: \$1,383 vs. \$625.⁵ The increased cost to both patients and Medicare is substantial. Over a three-year period, Medicare paid an additional \$2.7 billion on services and patients spent \$411 million more in out-of-pocket costs when services were delivered in a hospital-owned setting.⁶

Congress also recognized the negative consequences these payment disparities have on patients, taxpayers and businesses by directing CMS to institute site-neutral payments for newly acquired and newly built off-campus provider-based hospital outpatient departments. However, these reforms represent only a small step in the right direction. The majority of existing provider-based off-campus facilities and those that were mid-build were “grandfathered” and able to continue billing Medicare at the much higher rate for the same services. These exempted facilities still have a strong incentive to purchase physician practices and move them into existing hospital outpatient departments. Notably, the issue of site-neutral payment reforms has long had bipartisan support from policymakers, health care economists, regulators and MedPAC. In terms of savings, a recent projection from the Congressional Budget Office suggests site-neutral payments for outpatient services have the potential to save \$13.9 billion over 10 years.

The Council strongly supports regulatory changes to promote site-neutral payment reform.

⁴ Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 (CMS-1676-P).

⁵ Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services, The National Institute for Health Care Reform (NIHCR): Published online June 2014.

⁶ Avalere, PAI: Implications of Hospital Employment of Physicians on Medicare & Beneficiaries, November 2017.

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Employers are on the front lines of implementing innovative strategies to get more out of every health care dollar they spend. When commitment to their employees is coupled with their drive for innovation, employers are the key to lowering health care costs and increasing quality for working families and the health care system as whole. The Council looks forward to working with the Administration and other stakeholders to improve transparency to achieve these goals. Thank you for considering these comments. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

Ilyse Schuman

A handwritten signature in black ink that reads "Ilyse Schuman". The signature is written in a cursive, flowing style.

Senior Vice President, Health Policy
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