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Administrator Seema Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9915-P, Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

January 29, 2020

RE: *Transparency in Coverage Proposed Rule [CMS-9915-P]*

Dear Administrator Verma,

Thank you for the opportunity to submit comments to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, the Internal Revenue Service, Department of the Treasury, and the Employee Benefits Security Administration, Department of Labor (the “Departments”) in response to the *Transparency in Coverage (CMS-9915-P)* (the “Proposed Rule”). We appreciate the Administration’s commitment to price transparency in healthcare and its focus on empowering patients to make informed decisions about their healthcare spending as well as fostering market competition in the healthcare industry.

We believe that the Departments have compellingly explained their authority and their rationale for the policies and requirements contained in the proposed regulation, and we strongly agree with their arguments.

The existing healthcare system is deliberately opaque, inefficient, and difficult for patients to navigate.

We look forward to the day when:

- The simple, plain-English, bundled, binding, guaranteed and *affordable* prices for all healthcare services, including emergencies, are available digitally, in real time and with quality ratings associated for each provider and facility, presented by a number of competing innovative and user-friendly platforms and apps, as we have in every other industry.
- Patients are able to shop for the best quality of care at the lowest possible price, greatly reducing the costs of care and coverage, just as airline industry deregulation cut airfares in half while increasing access and improving safety.
- Patients and their insurers receive a single bill for an episode of care, no matter how many providers or facilities were involved in the episode. There is no surprise billing, because all fees and services will need to be itemized and complete within bundled or episodic care, ending the out-of-network games.

- Providers compete fiercely for the business of individuals, employers and other plan sponsors, across local and national markets, by offering the highest value care, at an affordable, transparent price and with a single, comprehensive, complete bill that matches the price and clinical experience.
- Patients have unimpeded, real-time access via open, standard APIs to all their clinical and financial records, including physician notes and easily downloadable images, and they can easily delegate their credentials to third-party apps and developers to synchronize and facilitate piecemeal or comprehensive sharing of those records originating with all providers and facilities across their full care history.
- Transparency in real pricing combined with interoperability and patient access to their information and broad access to scheduling, availability, and quality differentiation among providers will restore trust and accountability to the healthcare system, putting the patient in control with real choices.

We recognize that our current system is far from these ideals, and that the proposed regulation can't achieve all these ends at once. However, none of these ideals can be achieved without the steps toward price transparency in this proposed regulation. We have heard from thousands of patients and hundreds of businesses and are learning that the prospects for the future are bright:

- Walmart's price transparent clinics offer \$40 primary care visits, \$10 x-rays, and \$25 dental cleanings (See **Appendix A** for Walmart's price list).
- The price transparent [Surgery Center of Oklahoma](#) has actually lowered its prices four times since posting them online eleven years ago, and provides the same price to all patients at 1/6 to 1/2 the price of the opaque hospital systems.
- Employers like [Employee Solutions](#), [Stauffers](#), [HB Global](#), and the [Dallastown School System](#) are [saving 30-50% on the cost](#) of care and coverage through transparent models, and offer no copay, no deductible, and cash bonuses for shared savings.
- Since its implementation of free primary care and contracting with price transparent providers for its 6,000 employees 28 years ago, [Rosen Hotels & Resorts](#) has saved over \$400 million on healthcare costs. Due to these measures, Rosen has a healthier workforce – even those with complex diseases – resulting in one of the nation's highest employee loyalty rates.

Patient access to price information is essential to improving healthcare spending and patient outcomes. We support the regulatory efforts of the Departments to ensure patients, employers, unions, and other purchasers of healthcare have real-time access to prices and other relevant financial information regarding healthcare services in advance of care. This rule builds on the important requirements that CMS finalized to require hospitals to disclose their cash prices and

negotiated rates with insurers.<sup>1</sup> Both rules working together will launch our current system into a long-overdue transformation.

We strongly support the Administration’s proposal to end secret prices between insurance companies and healthcare providers and the goal stated in the Proposed Rule of “giving consumers the information they need to make informed decisions about their healthcare and healthcare purchases.”

We provide the following overarching comments to the Proposed Rule to ensure that patients have access to the information they need about the price and cost of their healthcare:

- Patients deserve to know the *real* price of healthcare items and services rather than unenforceable estimates or averages that may vary widely from the real price. Estimates and averages do not work. Patients should not be responsible for additional costs if a health plan’s “good faith estimate” of negotiated rates or out-of-pocket costs is inaccurate.
- The penalties for failure to comply with the Administration’s price transparency requirements need to be more meaningful than proposed, and instead should be similar to the robust penalties for “information blocking” under the 21<sup>st</sup> Century Cures Act.
- We support the proposed requirements for health plans and issuers to publicly disclose negotiated rates for in-network providers and allowed amounts for out-of-network services. These files should be updated in real-time.
- We support the requirement that all information be available on a searchable, public Internet site, free of charge to the individual and other entities that may be acting on the individual’s behalf.
- We support the requirement that patients be notified that their coverage for a given service is subject to a prerequisite, where applicable, in advance of the provisions of healthcare services.
- We support the requirement that the files with negotiated rates and allowed amounts be publicly available and accessible to any person free of charge. Individuals should not be required to register for a user account, password, or other credentials, or to submit personally identifiable information to access these files.
- We strongly urge the Departments to require health plans and issuers to provide the required disclosures via **open, standard APIs**. Technical requirements should be consistent with the proposals in the ONC and CMS Interoperability Rules.
- Self-insured employers and other plan sponsors can comply with this proposed regulation, and indeed have been crying out for a reformed market that the proposed

<sup>1</sup> *Calendar Year 2020 Hospital Outpatient Policy Payment System (OPPS) Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates: Price Transparency Requirements for Hospitals to Make Standard Charges Public (CMS-1717-F2) final rule.*

regulation would help enable. Their service providers should be permitted or required to provide the necessary disclosures for their plans.

- Information regarding provider quality must be reported to patients, employers, and other purchasers of healthcare in real-time. Measures must be publicly available in a standardized, machine-readable format.

Today, the healthcare industry is fighting the Trump Administration’s use of rules of access to patient information and pricing to maintain the status quo. The hospitals, insurers, and all the middle players are capitalizing on the health misfortune of patients, costing our country nearly twenty percent of our Gross Domestic Product – one in every five working days foregone to healthcare expenses, and growing.

Throughout our country, patients have fear and financial insecurity due to confusing, complex medical charges that are inconsistent with their clinical care experience. They have received surprise bills, balance billing, and fraudulent bills. They have faced creditors due to delays between care and insurance payment at no fault of theirs. They have been sent to medical debt collectors at high fees. They have been price gouged, sent to court, had wages garnished, and had liens put on their homes by hospitals – often tax-exempt, “charity” hospitals – where they receive care, and even in some cases, where they work. Among the top causes of bankruptcy is medical debt. The healthcare industrial complex’s opacity and runaway costs have caused a near breaking point of financial insecurity for the American worker.

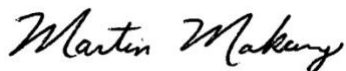
Our Federal government is charged with defending our nation’s security and has the power to stop this greed causing dis-ease and sickness to our country’s health and wealth. These transparency measures will restore to American workers trust, accountability, and *financial* security, delivering a great economic stimulus to our country. Through creating a functional, competitive marketplace in healthcare, this Administration can restore trust and accountability to our healthcare system, and put the trend of runaway healthcare costs into reverse. Patients will be empowered with choice to get the best quality of care at the best possible price that is affordable to them and their families.

The following pages outline our specific comments.

Sincerely,



Cynthia A. Fisher  
Founder, Chairman, PatientRightsAdvocate.org



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Professor of Surgery and Health Policy & Management  
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Hon. Katy Talento  
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## **I. Proposed Requirements for Disclosing Cost-Sharing Information to Participants, Beneficiaries, or Enrollees (Page 65470)**

- **We support the Departments’ proposed requirements for health plans and health insurance issuers to disclose accurate price information upon request from a participant, beneficiary, or enrollee (or his or her authorized representative).**

This information is necessary to combine with provider price information to give an accurate representation of the price borne directly by the patient and the full price assumed by self-insured employers and other purchasers of care. Cost-sharing disclosures should include the total and the net negotiated amounts paid, including itemized payments to providers, regardless of the combination of payers, and the patient’s complete out-of-pocket cost information, based on the benefit plan (including deductibles and co-payments).

- **Health plans and health insurance issuers should further be required to collect the necessary information to provide a binding price to individuals, similar to the travel, retail, and financial services industries. Patients should be able to rely on these prices, receive a single bill matching the binding price, and not be responsible for additional amounts or “balance bills.”**

This information should not be an estimate but should be binding for care that is planned to be delivered. In other words, the patient should receive full pricing information, including their cost-sharing responsibility, for all the services they are reasonably expected to receive during a service or procedure. Cost-sharing information must be accurate and include actual negotiated rates, out-of-network allowed amounts, and individual-specific accumulated amounts.

This information is not a trade secret or otherwise proprietary. It is disclosed routinely to individuals on explanation of benefit documents (EOBs) after care is received, and can easily be provided in advance of care. We agree with the position of the Departments that the proposed requirement that plans and issuers disclose this same information, to the same parties, before services are rendered does not pose any greater risk to plan or issuer proprietary information.

We recognize that not all care can be foreseen and therefore included in an upfront cost estimate. Individual care episodes can include different services based on issues that arise in the course of the episode as well as patient characteristics that were not known at the time of scheduling. We look forward to the day when all care episodes, even emergencies, are available in priced bundles. Episodic care can be bundled and priced accordingly such that emergency and urgent care can be shopped and compared, giving consumers choice which will usher in quality. However, in the interim, upfront binding prices for this subset of care (e.g. unforeseen care or care due to complications or emergencies), may not be available.

- **Patients should receive a single, comprehensive bill within 30 days of service, and providers should be prohibited from balance billing, surprise billing, and billing out-of-network rates when the individual sought care at an in-network facility.**

Providers should not be able to bill the patient when additional services are rendered due to mistakes. Binding quotes will provide incentives for higher quality care and reduction of medical mistakes. An individual should not be required to pay a bill that is contested until that bill is resolved.

The Departments' proposal to also require negotiated rates and out-of-network allowed amounts disclosures for all items and services for all providers is indispensable for patients and employers to shop for benefit coverage and healthcare services. Estimates do not work. Patients need to know real prices, and as less than ten percent of healthcare is emergent<sup>2</sup>, patients are best served to know the bundled price prior to care. Patients must be able to anticipate modifications to the estimated price of their care. In the event that their providers advise them of possible complications and risks, patients must have access to the price information for the items and services that are associated with the potential complications to determine their impact on the initial quote. This approach empowers patients, employers, and all purchasers of healthcare to challenge inappropriate billing and up-coding after the fact, and to take important steps to prevent costly complications whenever possible. It further allows population managers such as self-insured group health plans or ACOs to examine the cost implications of taking specific actions to mitigate complications at the population level.

For example, if an employer knows the exact price of emergency cesarean section deliveries in advance, and it wants to implement a program for prenatal care to prevent such deliveries, that employer is able to use the rate files to project an accurate return on investment for such a program. Such precision could help managers to persuade their company leadership to adopt the program that results not only in lower costs for the employer health plan, but also lower cost-sharing and, most importantly, much safer deliveries.

Transparency of real prices, complete and bundled, can lower the costs of care and coverage by removing the layers of middle players that substantially add to the costs. Another example is the case of plan fiduciaries who want to implement a program integrity or claims review process. Today, many plan fiduciaries have been persuaded to enter into contracts with issuers that prevent them from fully auditing all their claims. They are forced to pay for lawyers to engage in fierce negotiations and threats of litigation in order to extract their own plan's data for lawful and, indeed, obligatory plan management purposes. Then, they pay claims review and analytics firms additional sums to clean and analyze the data to determine if they have been inappropriately billed. Such analysis requires costly and proprietary data sets to serve as benchmarks, and expert reviewers. In no other industry is this sort of expense required to merely audit expenses to a firm's service providers. Removing these unnecessary middle players with transparency will eliminate these extra costs.

Instead, auditors and accountants, whether internal or externally sourced, should be able to review invoices/claims for services provided, compare them to known, real-time price lists, and determine if they are appropriate and error-free. The Institute of Medicine has estimated that a third of all healthcare spending is wasted on inappropriate care, bureaucratic bloat, price gouging and other price failures, medical errors, and more. PriceWaterhouseCoopers

<sup>2</sup> Owing the Cost of Emergency Medicine, [https://www.annemergmed.com/article/S0196-0644\(13\)00313-2/fulltext](https://www.annemergmed.com/article/S0196-0644(13)00313-2/fulltext)

has estimated this figure at a half of all healthcare spending. GAO has estimated that a tenth of all spending is outright fraud.

- **Health plan and issuer cost-sharing information should also include prescription drug price information.**

Patients, their employers, and all purchasers of healthcare should have access to information regarding the upstream arrangements that their physician, health plan or issuer enters into with pharmaceutical companies, pharmacy benefit managers (“PBMs”), or other entities that may result in conflicts of interest. Spread pricing and prescription drug rebates should be accounted for in order to advise patients that there are financial incentives on physicians or PBMs that may impact clinical decision making. Patients and employers may experience increased out-of-pocket costs and premiums for medications that are financially beneficial for clinicians, PBMs, health plans or issuers at that time or in a future plan year to maintain continuity of their medication.

- **Plans should be required to disclose information regarding a broader set of financial incentives, such as ACO incentives.**

If a patient is part of an Accountable Care Organization (ACO), treatment decisions can be affected by the financial incentives and relationships between providers, plans and PBMs that drive therapies recommended, referrals provided, or prescription benefit design. Transparency into the financial incentives or relationships that may impact treatment decisions can lead to more fulsome conversations with providers so that patients can make decisions about their own interests. For example in drug formulary design – brand name drugs can be cheaper than generic based on financial incentives and rebates, but may be more expensive in the new plan year when a deductible resets. Provider behaviors can provide another example of these harmful behaviors – if an integrated provider/payor or ACO and plan PBM is getting a bigger rebate on a certain medication; the doctor could experience incentives to prescribe that therapy over another. Disclosure of negotiated rates for drugs by indication must be disclosed in addition to the list charge and any other rebates. This disclosure must be available to patients free of charge without conditions.

The Departments have the authority to address such practices through regulation because they ultimately can cause harm to taxpayers and government programs due to undisclosed cost and compensations streams. Such requirements are authorized under Section 2715A of the Public Health Service Act which requires, that group health plans disclose information on cost-sharing and payments with respect to out-of-network coverage, that these plans help their members learn about cost-sharing through a web site, and that the Secretary of Health and Human Services (HHS) may determine “other appropriate information” that could and should be disclosed to plan members through a web site. Section 2718 provides that the Secretary shall establish uniform definitions of coverage activities for health insurance issuers to report out on as part of their accounting of costs. The reports must include information “(1) on reimbursement for clinical services provided to enrollees under such coverage; (2) for activities that improve healthcare quality; and (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and

licensing or regulatory fees.”<sup>3</sup> Furthermore, Section 1852(c) of the Social Security Act requires disclosure by Exchange and Medicare Advantage organizations of specific information about the plan, covered benefits, and the network of providers.<sup>4</sup> We believe that the HHS interpretation of its authorities is reasonable and well-explained in the proposed rule.

- **Separately, patients should have broad access to electronic health information as it pertains to prices outside of their insurance plan, so they can shop for care from alternative sources, for example, Walmart or physicians who can self-dispense and offer wholesale prices.**
- **Although the disclosures as proposed would contain valuable information for consumers, we note that they may not be receiving all the necessary information to understand the drivers and incentives around their costs. In particular, employers and other plan sponsors really need additional information that may be affecting the utilization patterns in their plans. We urge the Departments to encourage or incentivize (perhaps through a safe harbor or through requirements of disclosures all ERISA-regulated plans to ensure that service providers, including but not limited to brokers, drug makers, hospitals, and others disclose all fees, compensation streams, and relationships with service providers to participants.**

For example, if a PBM is accepting inappropriate kickbacks from manufacturers or self-dealing payments from pharmacies, and not disclosing these payments to a group health plan, the employer could be held liable for fiduciary breach. As such, it is essential that employers have access to all fees and compensation streams between service providers so that they can make informed choices in administering plan assets solely in the interest of plan beneficiaries, pursuant to ERISA requirements. The Department of Labor should propose regulations laying out a framework for appropriate 408(b)(2) disclosures for employee welfare plans, as the semi-annual unified regulatory agenda has included for a number of years. Such a framework should spell out the types of disclosures that employers can and should demand of their service providers in order to properly carry out their statutory obligations. Until such time, plan sponsors must demand that right for themselves, and the fact that they may be parties to any current contract with their service providers which does not provide for such disclosures should not be considered a reason to oppose the proposed regulation’s price disclosure requirements. Indeed, most contracts have clauses that provide for the nullification of any provisions that are found to be unlawful or become so due to subsequent regulation or legislation.

## **II. First Content Element: Estimated Cost-Sharing Liability (Page 65471)**

- **We urge the Departments to require health plans and issuers to provide price information including negotiated rates, a list of in-network providers, and out-of-network allowed amounts in real-time. This file should be dynamically updated as new payments to out-of-network providers are made, and in machine-readable format. In**



order to enable patients to make decisions about care they are seeking it is critical that this information be easy to access and up-to-date. Failure to require timely updates will lead to surprises for patients who rely on this information to make important healthcare decisions. Furthermore, cost-sharing information must be disclosed in “plain language” to prevent the information from misleading, misinforming, or failing to inform patients of their financial responsibility.

- **Like hospitals, health plans and issuers should also be required to publish their negotiated prices for shoppable services. Indeed, we recommend that the total number of bundled prices for shoppable services that health plans be required to report be expanded for broader listing of bundled and episodic care as well as the 70 CMS-determined services, and the majority of outpatient bundled or common shoppable services the plan covers.**

Given the amount of data health plans and issuers have on these bundled services (as compared to hospitals), they should be required to publish complete pricing information for 500 or more of these shoppable services, including a similar set required for hospitals but expanded to a number of common outpatient services. The price should be for all-inclusive bundles and thus include associated ancillary items and services, including but not limited to physical examinations or consultations with physicians, laboratory or diagnostic services, post-procedure services, and radiology. Since hospitals are already required to publish prices for 70 bundles set by CMS, and 230 others of their most shoppable services, we recommend that the Departments provide guidance to issuers and group health plans that they should list prices for services performed in a non-hospital setting but which could also be performed at a hospital. That way, the two regulations could work together to provide the maximum information to help patients shop for the same service between different care settings. For example, if hospitals report their price for a colonoscopy, the health plans in this regulation, if finalized, could report their price for a colonoscopy at an ambulatory surgery center as well. Innovative app developers can then aggregate the data and present it in a shopping app that displays it side by side for consumers.

- **We support the proposal to provide critical information related to the patient’s benefits in advance of receiving healthcare services.**

As discussed in the preamble, plans and issuers are required to disclose cost-sharing and payment information to patients after healthcare items and services have been furnished in the patient’s Explanation of Benefits (“EOB”). However, the Proposed Rule would require health plans and issuers to provide negotiated rates only if it impacts the patient’s cost-sharing amount. **We strongly disagree with this proposal and would strike estimate of the cost-sharing liability and replace it with negotiated price.** Patients are absolutely entitled to the full, negotiated price paid by all who pay for their care. Many employers are working hard to engage their enrollees about the full price of care that they may not realize – It is the full price, not the patient cost-sharing amount that is driving premiums and deductibles and coinsurance up year after year. Requiring the sellers of care to disclose the full price to ALL buyers is essential to rationalizing the market that has experienced such failure and unsustainability for a number of years – whether the patient has an obligation for a given episode of care or not.

- **Patients should always see negotiated rates, because they are the ultimate consumer and they deserve and can handle the full truth, and their care team should have to face their patients with that truth, and defend it. This market transparency will introduce several virtuous effects. One example would be that such full price disclosures could facilitate employer programs to choose patients toward lower-priced providers or care settings; whether or not the patient's out-of-pocket costs are affected.**

A patient's out-of-pocket costs include their premium payments, and as economists across the political spectrum acknowledge employer contributions for premiums come directly out of employee wages. For example, if a patient meets their maximum out-of-pocket cost, they still should know the negotiated rates because it could potentially impact future premiums. Therefore, full disclosure of negotiated rates is always important to be fully transparent.

But beyond that use of negotiated rates for patients who may not have immediate cost-sharing obligations, there are other reasons to include the full negotiated rate in the consumer tool's display when the patient searches. The patient may have no obligation on the precise day of the search, but may have an obligation later when the deductible resets, for example. Many patients would make a different choice when timing of their care, choice of pharmaceuticals, dialysis providers, chemotherapy providers, or any other ongoing care needs, if they knew that a higher price would kick in on a certain date compared to a different choice or care plan. To adequately budget, patients need to understand what their full obligations will be throughout the year at any time, and not rely on their plan to do the math for them while hiding the full price. The proposed regulation would require health plans and issuers to disclose those same prices to the public in the form of more complicated monthly files that perhaps more sophisticated audiences would consume, so the prices will already be on hand for these plans. There is no reason a plan should oppose disclosing the full negotiated rate (real, accurate prices) except to avoid embarrassment, or protect its contracted providers and suppliers from embarrassment with patients.

Examples of the benefits of this disclosure include:

- Patient education: Patients will be empowered to budget and plan for future medical expenses as well as have conversations with their employers about the cost of insurance and their providers about the cost of care. Patients should also know total price of care, which result in future rate changes.
- Informed treatment choices and limiting surprises regarding price: Patients may shop in advance and discuss with clinicians about their treatment choices.
- Empowerment of employees with plan information: Employees can make fully informed decisions when comparing plans at open enrollment.
- Engagement of patients with their employers to participate jointly in managing costs with the choices of providers and care plans that take the full price into effect. This could help employers make the case to their employees about changes they are making to the plan to constrain costs and improve quality, such as moving to reference-based

pricing, an independent third party administrator (TPA), shared savings programs based on full negotiated rates, and other steering mechanisms.

- Exposure of patients to the fact that in some cases, their out-of-pocket expenses may be less than the cash price and not using their insurance at all.
- Mobilization of patients to seek lower-priced sites of care and to pressure their employers to waive cost-sharing or provide other incentives when they do. For example, a patient's cost-sharing obligation for a knee replacement may be \$1,500 at any location. However, if the consumer tool reveals the full negotiated rate, the patient could see that they could save their employer \$20,000 by traveling out of state to a surgery center. Armed with that information, they could ask their employer to share the savings by waiving their deductible, covering travel expenses, and even offer a cash bonus.
- Empowerment of patients to challenge their care providers. Some patients may not realize that their doctor, for instance, is one of the highest priced doctors in town. They may have a great relationship with that doctor, and be able to challenge that doctor to offer fairer prices. The power of transparency could create relationship-based accountability that would help lower-income workers on a given plan.
- Empowerment of patients to anticipate and plan for premium changes based on current decisions: Allows decisions for treatment approached that may impact costs in future plan years.
- Incentives for efficient financial decisions: Support patients paying cash in instances where it minimizes costs.
- Negotiated rates are important for calculating coinsurance amount.

### **III. Third Content Element: Negotiated Rate (page 65472)**

- **As discussed extensively in above Section A, Negotiated Rate information is critical to price transparency. While we believe that the Departments' proposal should be amended to require the disclosure of Negotiated Rates regardless of the patient's cost-sharing liability, we do support the proposed definition of Negotiated Rate. The disclosure of Negotiated Rates is essential to combat practices that purposely obfuscate payment, eligibility, and benefit information.**

The only way to achieve an efficient, competitive marketplace is through systemwide, real price transparency, including negotiated prices for contracted services. Health plans and issuers have considerable influence in payment negotiations with healthcare providers, but they have not used their position to improve the availability of information to their members, or even the plan sponsors such as employers or unions (beyond vague assertions about a percent discount off an unknown or changing list price). Health plans and issuers set the reimbursement policies, covered benefits, and negotiated rates for their network. Health plans and issuers may have access to the majority of a given region's pricing information, as prices

for items and services must be included for all in- and out-of-network claims processing. Plans retain this historical information, as it critical to setting rates, may be used in contract negotiations, is necessary for audit purposes, and/or because they are required to by law. Even with this wealth of data at their disposal, insurers' price comparison tools today remain imprecise and fail to provide patients and employers with the full range of potential charges for in-network services. Real-time price transparency will put prices and control into the hands of the consumer.

#### **IV. Sixth Content Element: Notice of Prerequisites in Coverage and Disclosure Notices (page 65473)**

- **We oppose the Departments' proposal that an individual's Notice of Prerequisites in Coverage does not explicitly describe whether the patient is required to meet those prerequisites, or has already had the service approved for coverage.**
- **We urge the Departments to require health plans and issuers to provide patients with information regarding non-covered items or services in the consumer tool. There should be a required disclaimer statement if an item or service in question is not covered by the benefit plan.**

Patients must be aware of any information that may limit coverage, including prerequisites and non-covered items services. This is critical for patients to use their health coverage for payment of items and services and to understand the cost of care that they may receive.

#### **V. Required Methods for Disclosing Information to Participants, Beneficiaries, or Enrollees (page 65474)**

##### **a. First Delivery Method: Internet-Based Self-Service Tool (page 65474)**

- **We support the Departments' proposed requirements for health plans and issuers to disclose negotiated price cost-sharing information via an Internet-based self-service tool in plain language, without a subscription or other fee, in a way that provides real-time responses.**

The tool must allow users to search by billing code, descriptive terms, name of provider, and other relevant factors. The search must also allow the participant and beneficiary to refine and reorder multiple search results based on geographic proximity and estimated cost-share liability.

- **We urge the Departments to require health plans and issuers to provide patients with full, negotiated price transparency, not merely patient cost transparency via FHIR-based open-APIs that include all proposed content elements as well as USCDI information related to financial data. We urge the Departments to require health plans and issuers to retain all historical data for seven years, as is consistent with other federal record-keeping requirements.**

The data should remain publicly available for this time period and should be real-time and searchable.

Transparency into price information across all healthcare entities is needed to establish an efficient, competitive marketplace in healthcare. The Departments should require health plans and issuers to provide accurate and real-time cost-sharing information to individuals, their authorized representatives (including third-party application developers accessing data with the individual's authorization), and the public, free of charge and easy to access electronically on their websites, in machine-readable format.

**b. Second Delivery Method: Paper Form (page 65475)**

- **We agree that plans and issuers should be required to furnish in paper format the price information that is available on the consumer tool, and that a patient requests for their care without a fee, upon request.**

**VI. Special Rule to Prevent Unnecessary Duplication (page 65476)**

- **We agree with the Departments that to the extent coverage under a plan consists of group health insurance coverage through an insurance carrier, the plan would satisfy the requirements of these proposed rules if the issuer offering the coverage is required to provide the information.**

This requirement is important so that employers that have delegated responsibility to their issuer(s) to administer benefits for their employees and are not involved in paying for healthcare services directly are able to comply with this rule by requiring the contracted party that has this information to make required disclosures under this rule.

- **We urge the Departments to extend this special rule to all employers, whether fully insured or self-insured (i.e. extend protection to employers using TPAs).**

Employers that have self-insured plans but have engaged with a TPA to administer their plan and process claims should be able to rely on their TPA to do the necessary reporting (the same way that the proposed rule allows fully-insured plans to rely on the issuers of their plans), without extra expense and without risk of a compliance violation if that TPA makes a mistake. Since TPAs that are insurance companies would already carry that responsibility for their fully-insured clients, there's no reason they can't do the same for their self-funded clients. Independent TPAs often serve smaller self-insured clients who would likely depend on them to do this reporting, which would be allowed under the proposed regulation. Those employers who have acted in good faith to contract with their TPA to comply with the reporting requirements should be held harmless with respect to compliance obligations under this regulation.

The proposed regulation should be revised, as follows (our edits in blue):

- (3) Special rule to prevent unnecessary duplication with respect to group health coverage. To the extent coverage under a group health plan consists of group health insurance coverage **or the plan sponsor uses a third-party administrator**, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage **or the third-party administrator implementing the plan**, to provide the

information pursuant to a written agreement. Accordingly, if a health insurance issuer **or third-party administrator** and a plan sponsor enter into a written agreement under which the issuer **or third-party administrator** agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer **or third-party administrator**, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

## **VII. Public Disclosure of Negotiated Rates and Historical Out-of-Network Allowed Amounts Is Necessary to Create Price Transparency For All Consumers and Payers of Health Care Items and Services, as Well as of Benefit to State and Federal Regulators (page 65477)**

- **The Departments should adopt the proposal to require group health plans and health insurance issuers to make publicly available on their websites machine-readable files with in-network provider negotiated rates and out-of-network allowed amounts for covered items and services.**

These measures will ensure that patients, employers, and purchasers of healthcare will have access to critical information when shopping for coverage that best meets their needs and will support a competitive healthcare marketplace. Public disclosure of negotiated rates and out-of-network allowed amounts will increase competition within the healthcare industry and allow patients and employers to leverage innovative service models, technology solutions, and payment arrangements to meet their needs. We agree that the Departments' requirements for public disclosure of this information will empower all patients, including the 28.5 million uninsured consumers.<sup>5</sup> Publication of price information will empower both insured and uninsured patients to better evaluate their options. We agree with the Departments that the proposed disclosures will allow consumers to "shop for services and items based on price" and result in "providers and suppliers compet[ing] to lower price and improve quality."<sup>6</sup>

## **VIII. Definitions**

- *In-network provider rates:*

**We support the proposed requirements for health plans and issuers to provide disclosures regarding the rates negotiated for in-network providers.**

This proposal will ensure that patients have access to accurate price information for each provider.

- *Out-of-network provider information:*

<sup>5</sup> Keith, K. "Two New Federal Surveys Show Stable Uninsured Rate." Health Affairs Blog. September 13, 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20180913.896261/full/>.

<sup>6</sup> Transparency in Coverage (CMS-9915-P) at 65478.

**We urge the Departments to require health plans and issuers to disclose information related to the historical data showing allowed amounts for covered items and services furnished by out-of-network providers.**

Patient and employers must know what it will cost to go out-of-network. Failure to implement this requirement could lead to providers opting to go out-of-network to avoid price transparency requirements. This proposal would create incentives for those who simplify rates for out-of-network providers, and it would provide full transparency for out-of-network providers to enable apples to apples comparison. Furthermore, this proposal provides more information to the public about the scope and defensibility of balance billing practices, which may impact future legislative efforts related to surprise bills.

Health plans and issuers should be required to report out-of-network allowed amounts for seven years in order to ensure that sufficient information is collected and made publicly available.

The Departments request comment on the appropriate threshold of minimum claims necessary to report out-of-network allowed amounts and propose two minimum claims thresholds. The Departments solicit comment on the threshold amounts and request comment on whether these protections are sufficient to mitigate privacy concerns. **We strongly disagree with the Departments' larger proposed threshold of 20 claims, as the files do not include identifiable data and therefore pose a limited privacy risk.** This higher minimum claims threshold is unnecessary and burdensome. It will compromise the integrity of the compiled information and will limit access to price information for many out-of-network services. **Instead, we support the smaller proposed threshold of 10 claims, or even less; as this restriction is sufficient to protect patient privacy.** While we acknowledge the need to protect privacy, the files should be released with the lowest number of claims possible to achieve that goal.

The Departments seek comment on whether price transparency in healthcare could enable collusion between providers and put upward pressure on prices. Economist Brian Blase, who served as a special assistant to the president at the National Economic Council focused on healthcare policy from January 2017 through June 2019, wrote a paper in September on the benefits of price transparency after reviewing the relevant economic literature.<sup>7</sup> The prevailing research indicates that price transparency will result in lower prices, and here is a relevant excerpt from the conclusion of the paper:

With more than 50 recommendations in the [Administration's 2018] Choice and Competition report, the Trump Administration is advancing a healthcare agenda centered on empowering consumers and injecting competitive forces into the financing and delivering of care. Transparent prices help advance both. Transparent prices will make it easier for consumers to search for value and for employers to establish proven programs like reference pricing models and going outside of a local market to so-called "Centers of Excellence" for expensive, elective services to help and to encourage their employees to shop for value.

<sup>7</sup> [https://galen.org/assets/Blase\\_Transparency\\_Paper\\_092719.pdf](https://galen.org/assets/Blase_Transparency_Paper_092719.pdf)

There is also evidence that consumers, particularly younger consumers, are more comfortable with shopping for care and asking for price information. Third-party administrators and innovators will continue to develop tools and applications to ease consumers' ability to shop between providers.

Transparent prices also will help employers monitor the effectiveness of insurers by comparing different rates received by providers across payers and across regions. With limited information, employers often now maintain status quo arrangements, with mid-level human resources managers relying on the advice of insurance brokers, who tend to be funded by the insurer and who often are paid a percentage-based commission. Transparent prices could lead employers, along with the assistance of entities specializing in reducing employer benefit costs, to eliminate counterproductive middlemen from the process. Ultimately, greater transparency should constrain prices by placing more competitive pressure on providers.

The notion, advanced by providers and insurers, that negotiated prices are a trade secret and that the status quo should remain in place, is noxious and works for them to maintain their market niche, but not for the rest of society. They are economically justified in fearing sunlight and competition, but that transparency is what is needed to reform healthcare. Concerns from some economists that collusion could result from price transparency are unjustified. Local markets right now are characterized by a limited number of providers, particularly hospitals, who engage in repeated interactions. They already tend to have knowledge of each other's payment rates, particularly relative to each other. Moreover, hospitals and other providers already provide consumers with pricing information in the Explanation of Benefits documents when they bill patients. Such price transparency moves the price explanation to before receiving care and enable patients to shop within and outside of their coverage.

Ultimately, seeing the negotiated prices of other plans for comparable services will inform consumers to shop, not only for better care, but also for better coverage and allow for market driven competition to greatly reduce the costs of both.

## **IX Required Method and Format for Disclosing Information to the Public (page 65481)**

- **We support the Departments' proposal that the information that is required to be publicly disclosed be available in real-time machine-readable files. We also urge the Departments to require that the files be publicly available and accessible to any person free of charge and without conditions (such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file).**

The Proposed Rule requires these files must be updated monthly and the files must indicate when they were last updated; we urge the Departments to amend this proposal and require health plans and issuers to update the files in real-time via API, as discussed further below. In addition, health plans and issuers should be required to post the date that the file was last updated to provide accountability and transparency to patients. Patients and clinicians must



be able to rely on the accuracy of this information when shopping for items and services or deciding treatment options.

#### **X. Request for Information (RFI): Disclosure of Pricing Information Through a Standards Based API (page 65483)**

- **As mentioned above, we urge the Departments to require health plans and issuers to provide patients with real, negotiated with a breakdown of patient and plan coverage (not patient cost transparency) via FHIR-based open-APIs that include all proposed content elements as well as USCDI information related to financial data.**

Price information should be automatically available to the public, and to a specific patient by his or her request. The Departments should adopt an open, standard API requirement for access to pricing information, consistent with the ONC and CMS proposed rules on interoperability and patient access.

Improved access to pricing information through open, standard APIs will enable patients and clinicians to be more accurately informed about the costs of care prior to making treatment decisions. Today, the healthcare industry is not optimizing available resources and applications that could help patients shop for care and make informed decisions. Requiring health plans and issuers to provide price information via open, standard APIs will enable patients to adopt technology solutions to shop for healthcare in ways that are consistent with other aspects of their daily lives. Innovative solutions that leverage open, standard APIs will empower patients to compare healthcare prices in ways that similar to other industries such as travel, banking, and purchasing household goods.

- Innovative technology companies have outlined that they can easily aggregate the data from providers and payers to provide meaningful comparisons to patients, employers, and the purchasers of healthcare. They are highly supportive of the proposed requirement for an open, standard API through which members or authorized third parties can access negotiated rates and other benefit information:
  - Payers will have a challenging time designing high-quality tools that will enable their members to shop effectively for different services. An API requirement would allow third party developers to build a variety of high-quality tools for patients to identify best-fit providers and predict out of pocket expense;
  - Third party developers could also supplement this data with e.g. map coordinates associated with various NPIs to enable shopping by price and location -- as one example;
  - In the longer run, this proposal could pave the way to a requirement that private insurance expose historical claims through an API, similar to the [Blue Button 2.0 API](#) for Medicare.

To enable shopping, it is essential to offer prices for groups of codes representing an actual episode of care vs. individual codes:

- The way the rule is currently written, prices and patient responsibility estimates are largely being provided for individual service codes: CPTs, HCPCS, DRG, etc. but for e.g. a knee replacement, an episode of care will consist of many of these codes. To

answer the question "how much will my knee replacement cost me", app developers will bundle together the codes we expect for a given episode and then calculate total patient responsibility.

- This episodic grouping -- mapping the relevant individual codes to a given episode of care, like a knee replacement -- can be done with historical claims data. Medicare claims from CMS could work, or any private payer databases.

See further details in **Appendix C**.

## **XI. Request for Information: Provider Quality Measurement and Reporting in the Private Health Insurance Market (page 65487)**

- Finally, while we applaud the price transparency requirements in the Departments' proposal, we want to urge them to take robust actions regarding quality transparency, pursuant to Section 4 of President Trump's June 24, 2019 Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First. Quality metrics should focus on health outcomes, prioritize clinician-anonymously reported culture of safety, and include volume thresholds, appropriateness, and patient-reported outcomes. These measures should be developed in coordination with patients, physicians with knowledge of relevant specialties, and other clinicians involved in the care being measured. Results for each provider and facility should be standardized and publicly available in real time or regular time periods in machine-readable files or using open, standard APIs. Metrics should be reported for individual physicians by name, as well as departments and facilities. Value to the patient is a subjective combination of price and quality, and patients can only evaluate the value of healthcare if they have access to both transparent price and quality information.

Significant improvement is needed in quality transparency. Current metrics are unduly burdensome on providers, are gameable, and can be counterproductive, as evidence shows occurred with the hospital re-admission reduction program.<sup>8</sup>

Despite the substantial problems with current quality measures, it is crucial to evaluate the appropriateness of healthcare utilization. In fact, waste represents an estimated 30 percent of all medical spending.<sup>9</sup>

One of us, Dr. Martin Makary, a Johns Hopkins surgeon, has spearheaded innovative work on how to best measure and thus improve patient care. In a 2017 article in the *American Journal of Medical Quality*,<sup>10</sup> Makary and his co-authors explain the approach:

Unwarranted clinical variation at the physician level is a major barrier to quality improvement, and reducing this variation remains the holy grail of healthcare. Yet quality improvement efforts have focused largely on measuring quality at the hospital level, not at the physician level. The problem with hospital-level metrics

<sup>8</sup> <https://jamanetwork.com/journals/jama/fullarticle/2719307>

<sup>9</sup> *Id.*

<sup>10</sup> Makary, Martin A., Mehta, Ambar, Xu, Tim, Improving Wisely Using Physician Metrics, *American Journal of Medical Quality*, April 29, 2017.

is that they are less relevant to physicians and, as a result, are less likely to translate into changes in physician behavior. ...

Diffusion of responsibility may explain why pay-for-performance schemes that measure hospital performance have been shown to have a limited impact on quality.<sup>11</sup>

Several industries outside of healthcare have effectively used individual feedback to improve outcomes. In 2009, the utility company Positive Energy/Opower successfully reduced overall household power consumption by decreasing variation among households.<sup>12</sup> They mailed each household a monthly or quarterly personal feedback report that compared their electricity and natural gas usage to that of similarly sized households in their area—a data feedback intervention that resulted in an overall mean reduction in household energy use. In particular, households at the extremities of the energy use bell curve modified their behavior to more closely match the mean usage of houses within their respective communities. This simple intervention also reduced the total carbon emissions of the participating houses by an equivalent of 14.3 million gallons of gas and saved more than \$20 million over the yearlong study.

Makary's research shows that informing providers of where they stand relative to their peers can reduce inappropriate antibiotic prescribing<sup>13</sup> and surgery costs.<sup>14</sup> This 'Improving Wisely' framework involves four key aspects:

- 1) The metric should be endorsed by practicing clinicians in the specialty.
- 2) The metric should target significant harm or waste among extreme outlier practice patterns.
- 3) The metric should be feasible to collect without risk of reporting bias or gaming.
- 4) The metric should facilitate actionable results for the physician.

The appropriateness measures avoid questioning the clinical judgement of a physician in any specific circumstance. As Jim Fields and Dr. Bruce Hamory of Oliver Wyman write, "Second guessing the clinical judgment of a physician in a specific situation is almost always a no-win argument, and typically creates resentment from the physician and patient, regardless of how evidence-grounded the push-back. But when a provider's clinical judgment consistently deviates from best practice standards and the practice habits of peers, it becomes a quality, cost, and safety issue. And the appropriateness of that clinical judgment should be evaluated."<sup>15</sup>

<sup>11</sup> Jha, AK. Time to get serious about pay for performance. JAMA. 2013;309:347-348.

<sup>12</sup> Ayres, I, Raseman, S, Shih, A. Evidence from Two Large Field Experiments That Peer Comparison Feedback Can Reduce Residential Energy Usage. Cambridge, MA: National Bureau of Economic Research; 2009.

<sup>13</sup> Meeker, D, Linder, JA, Fox, CR Effect of behavioral interventions on inappropriate antibiotic prescribing among primary care practices: a randomized clinical trial. JAMA. 2016;315:562-570.

<sup>14</sup> Gunaratne, K, Cleghorn, MC, Jackson, TD. The surgeon cost report card: a novel cost-performance feedback tool. JAMA Surg. 2016;151:79-80.

<sup>15</sup> Fields, Jim, Hamory, Bruce, Next-Gen Utilization Management: Addressing Clinical Variation, Oliver Wyman Health, May, 2017. [https://health.oliverwyman.com/2017/05/next-gen\\_utilization.html](https://health.oliverwyman.com/2017/05/next-gen_utilization.html)

The main role for the government would be disseminating information—providing healthcare professionals data to evaluate their performance as compared to others on appropriateness measures that were developed in collaboration with the providers. The government could then develop a process for providing this information to the general public as well.

Dr. Makary and his team have shown that educating providers about appropriateness measures can reduce unnecessary utilization. In one example, Makary’s team sent letters to the surgeons who removed tissues during Mohs micrographic surgery at a rate which put them more than two standard deviations above the mean. Removing excessive amounts of tissue raises the risk to patients of adverse outcomes. Within a year, the mean rate of the group that received letters declined from 2.55 blocks to 2.31 blocks with 83 percent of surgeons showing a decline.

Once prices are transparent, transformative change will occur as price will usher in quality metrics by the marketplace. Requiring data on frequency of surgery, pricing, and patient reported outcomes the outcomes data, recurring surgeries. These data can be aggregated from historical claims data by provider.

A great example of the disruption that transparency brings is a simple app, [UmpScores](#), which took five months to develop with five Boston University students and a \$50,000 investment, transformed Major League Baseball (MLB) by analyzing the performance of umpires, comparing their strike calls against the robo-cameras’ results. These analytics – by umpire, by game, by training – resulted in a systemwide quality comparison and led to MLB “changing the game” and requiring umpires to be assisted with information from the robo-technology. These quality metrics will change the careers and monetary outcomes for players, teams, umpires, and the gambling industry. See **Appendix I** for screenshots of the app. Think of what access to transparency into quality metrics – by procedure, by surgeon, by hospital – will do to improve the healthcare system.

**We urge HHS and CMS to streamline burdensome quality metrics and move toward a more effective approach centered on appropriateness measures that are developed in collaboration with providers.**

As an example, innovators like SurgiPrice today allows patients and employers for surgeons based on bundled prices, de-identified patient data, and quality metrics. The ability to shop based on price and quality has proven the following benefits:

- Higher success rates
- Lower infections
- Fewer complications
- Faster recovery
- Decreased hospital stays
- Decreased revision surgeries.

## **XII. Overview of the Proposed Rule Regarding Issuer Use of Premium Revenue Under the Medical Loss Ratio Program: Reporting and Rebate Requirements – The Department of Health and Human Services (page 65489)**

Shared savings models are ways that employers and insurers can design health benefits packages in order to incentivize workers and dependents to shop for lower-priced and higher-quality providers. Policy should encourage these types of models as it is crucial that consumers and patients are more engaged in their care and specifically shopping for high value care. Shared savings models have shown that they incentivize shopping and reduce healthcare spending. The proposed rule accommodates shared savings models by making it clear that those payments will be included as a separate line item in the numerator of the calculation for the medical loss ratio (MLR). It is essential that this provision be maintained. If not, the rule would substantially discourage the use of shared savings models. Moreover, shared savings models represent another reason why prices should be disclosed to consumers and patients regardless of whether the disclosure affects the cost-sharing amount. Consumers and patients with a shared savings component stand to benefit financially from knowing the total price of procedures or services even if their copayment is the same or they have met their maximum out of pocket threshold.

It is critical that “shared savings” is not defined to include self-dealing payments by TPAs that make overpayment errors in processing claims, and then, upon subsequent review of claims by the TPA or a third-party vendor (which might be a subsidiary of the TPA), the overpayment is recovered and then the TPA pays itself out of the plan sponsor’s assets a “shared savings” percentage of the recovered funds, often without the knowledge or approval of the plan sponsor. This type of payment is not a legitimate use of plan assets, and should not be permitted in the MLR numerator (if permitted by law in the first place).

Subrogation Clause: Further, the MLR does include activities that pertain to research within payers that allow them to not use the funds for patient care. By ERISA fiduciary to the employer plan, the MLR factors need to be transparent and only used for direct patient care – or at least make the percentage and dollar amounts go to direct patient care (and not committees and research projects that are often used as accounting tricks to maximize profits and limit risk exposure).

## **XIII. Additional Comments**

### **a. Applicability (page 65489)**

- **The Departments should include ACOs and other capitated arrangements in the applicability of these rules and should require transparency and full disclosure of financial incentive arrangements that underlay capitated arrangements under a specific plan or contract, not just consumer’s anticipated liability.**

Any exemptions may actually be incentives to move toward those exemptions. **We strongly disagree with the exemption of ACOs.** If the Departments exempt ACOs, there will be an incentive to move to this opaque and potentially gamed model. Just as the Departments were concerned that limited applicability to the individual market and insured group health plans

might encourage plans and issuers to simply shift costs to these sectors of the market where these requirements would not apply, the same concerns exist with respect to ACO and other capitated arrangements. Furthermore, structures that are set up for capitated payment with either a shared savings or bonus arrangements which benefits the provider may impact the clinical decisions and impact patient care. Today there is no visibility of these shared savings arrangements by patients. These payments and incentives ultimately are paid by the employer sponsored plans and by the patient in their premiums. While the argument is that ACOs and others shared savings arrangements are designed to improve the quality of care for the patient, it may also lead to reductions in needed care to those patients. Also, if these ACOs and other shared savings programs improve healthcare outcomes and lower costs relate to the actions of the patient and the patient should share in the savings. Either way, the paying consumer (the patient and his or her employer) needs full transparency into the use and shared savings of funds and what percentage is actual patient care to fulfill the employer's fiduciary role.

ACOs may hold much promise for empowering patients and other purchasers of care to escape the broken status quo, built upon an outdated and inefficient fee-for-service billing structure that excludes access to price and quality considerations. However, we run the risk of enabling alternative care and payment models that are mere counterfeit "value," if the rules facilitating these arrangements simply allow for new and different types of secret deals benefiting the sellers of care – that is, healthcare providers and insurance companies.

It is important to remember that insurance companies, despite the common use of the term in industry circles, are never actually the "payer." The true payers for healthcare are patients, employers and other plan sponsors, and taxpayers. The same is true for fully-insured health plans where payers buy care through premiums that are driven by underlying prices, or self-insured plans where payers pay claims themselves, usually facilitated through a third party. Value-based care, if it is to live up to its name, must allow for the assessment of value by the buyers of care, not just the sellers. The only way they can do this without the help of high-priced consultants and analytics firms available only to the richest companies, is if price-for-outcomes information is made publicly available by providers with competing offerings across the market. With this information, patients, employers and other purchasers can compare options and select the best match on price, quality, and convenience for their needs. Without a requirement for this type of market competition among offerors of value-based arrangements, this well-intentioned Proposed Rule could risk missing the mark and cause harm to allow for secret dealing and passage of employee-earned benefits and taxpayer dollars.

While some argue that ACOs and other shared savings arrangements are designed to improve the quality of care for the patient, very few ACOs are actually down-side-risk-bearing yet, which means that they are not yet mature as a model. ACOs should be allowed to be formed, evaluated and matured into full dual-risk bearing status, with clear outcomes and savings estimates that accrue not just to providers or insurers, but to patients and plan sponsors. This process is ongoing and will take time. In the meantime, ACOs should not get a pass on full price and quality transparency, indeed it is all the more important that they are fully transparent. We urge the Departments to facilitate this authentic value-based transformation

by ensuring full transparency with respect to price, including cash price, the financial incentives/relationships and quality outcomes for all entities subject to the Proposed Rule.

**b. Frequency of updates to machine readable files (page 65498)**

- **The Departments should require group health plans and health insurance issuers to update machine readable files regarding the negotiated rates and out-of-network allowed amounts as soon as the prices change.**

We agree with the Departments that more frequent updates would provide a number of benefits for the patient, providers and the public. We do not believe this requirement imposes an undue burden. Plans and issuers can set it up for automatic updates. They must maintain up-to-date systems in order to pay claims appropriately and should make the updates to the public files concurrently so that patients have accurate information. This requirement is critical so that patients can rely on the price information that is available to them.

Costco, Walmart, and Amazon have tens of thousands of items priced every day in clear view in their stores and online. As in retail, grocery, and travel, healthcare can only be trusted and accountable through real-time pricing which will enable competition and allow innovators to drive down the costs of care and coverage.

**c. Central Location (page 65498)**

- **The Departments should not create a central location for negotiated rate information and historical data.**

The private sector, and not the government, is in the best position to provide the information to consumers in usable, easy to understand, tools. Creating a single, central repository would squelch innovation and competition. Opening up these data through open, standard API's will best allow technology innovators to aggregate and harmonize the data, and enable competition to thrive.

**d. Transparency-Enabling Technology**

To facilitate this transition to complete quality and price transparency, we also urge the Departments to make after-the-fact billing more rational by linking billing codes (currently using proprietary CPT codes owned and sold by a physician group) to real-time clinical USCDI, that is, the clinical information behind what is being billed. Today, clinical information is more real-time than claims and billing information. We encourage the Secretary of HHS to consider the following:

- **Direct CMS to develop an alternate set of standards for financial codes that are non-proprietary, free and open to the public and use by innovators in developing systems and applications for providers, payers and the public to use in claims processing.**

This action would also facilitate the development of new codes for items and services without having to lobby a physician group to assign a code in order for innovators to be reimbursed for their new product or technology. The Secretary could request that the National Committee on Vital and Health Statistics make recommendations, and include participation of innovative technology companies.

- **Extend the HIPAA Transaction Rule such that payment transactions include both financial and clinical data.**

This measure would facilitate the sending of clinical information (USCDI) by a provider to a payer, along with financial information, and using a FHIR standard for patient access to such information, which would enable a vast improvement in patients and other consumers to understand bills, overall costs for quality and could accelerate the value transformation in healthcare.

- **Direct CMS and other agencies to use their authorities to promote the adoption of a single, itemized bill for a healthcare episode, where each charge is linked to clinical USCDI information, no matter how many providers are included in the episode.**

## **IX. Conclusion**

We applaud the Departments for their efforts to make price information available for patients in free, machine-readable formats. These proposals will ensure that patients, providers, and employers have the information they need to make decisions about coverage, treatment, and out-of-pocket costs.

We recognize that many of those who benefit from the broken status quo will oppose these policies and raise a number of objections. We attempt to answer those objections in the attached Myth-Fact document contained in **Appendix J**. Patient access to price and payment information is critical to improving healthcare clinical outcomes and cost reductions. Public disclosure of price information will increase competition within the healthcare market and will allow patients to shop for services and items based on price and quality. We urge the Departments to finalize proposals that will encourage innovation and allow patients to make informed decisions about the costs of their care.

May you all have the fortitude to implement these bold measures and free our citizens and business from the overwhelming financial burden of healthcare. You can create the trusted, competitive marketplace through full transparency into real pricing followed by value and outcomes. You can empower consumers to ultimately manage their own health and wealth for generations to come.



**Attachments:**

- Appendix A: Walmart Price List
- Appendix B: Ability for HHS to Achieve Timely Implementation of Negotiated Rate Disclosure Using Existing Examples
- Appendix C: How Third Party Technology Developers will Aggregate Pricing Data
- Appendix D: Implementation Suggestions for Sections 3(a) and 3(b) of the Executive Order on Improving Price and Quality Transparency
- Appendix E: How Full Contracted Rate Transparency Effects Healthcare Decisions (Not Just Out of Pocket Costs)
- Appendix F: Benefits of Issuers Full Contracted Rate Transparency (Not Just Out of Pocket Costs) in Addition to Provider Price Transparency
- Appendix G: ERISA Can Be Used to Promote Meaningful Healthcare Price Transparency
- Appendix H: Federal Health Care Price Transparency Rules Are Lawful And Pro-Competitive
- Appendix I: UmpScores App Screenshots
- Appendix J: Price Transparency in Health Care: MYTHS v. FACTS

## APPENDIX A Walmart Price List



### Summarized Pricing List for Dallas, GA Store #3403

Primary Care Basic Services	Price
Office Visit	\$40.00
Annual Checkup - Adult	\$30.00
Annual Checkup - Youth	\$20.00

Primary Care Add-ons	Price
Lipid Test	\$10.00
A1C Test	\$10.00
Pregnancy Test	\$10.00
Flu Test	\$20.00
Strep Test	\$20.00
Mono Test	\$20.00
Stitches & Other	\$115.64*

Counseling Services	Price
Individual Counseling, Existing Patient (45 minutes)	\$45.00
New Patient Therapy Intake	\$60.00

Dental Services	Price
Patient Exam (Including X-Rays)	\$25.00
Teeth Cleaning - Adult	(Starting at) \$25.00
Teeth Cleaning - Youth	(Starting at) \$15.00
Porcelain Crown	\$675.00*
Teeth Whitening, in Office	\$225.00
Deep Cleaning (Per Quad)	\$75.00
Emergency Treatment for Dental Pain	\$50.00
Filling	\$75.00 - \$125.00

Optometry Services	Price
Routine Vision Exam	\$45.00
Contact Lens Fitting	\$55.00

As of 9/11/2019

## **APPENDIX B**

### **Ability for HHS to Achieve Timely Implementation of Negotiated Rate Disclosure Using Existing Examples**

#### **Background**

Recently, the Centers for Medicare and Medicaid Services (“CMS”) has moved to require health insurance companies and health care providers to make public their contracted rates, affording the public a more transparent picture of the ‘true cost’ of the health care services they receive. Both health insurers and providers are opposing the proposed rulemaking requiring the publication of contracted rates, arguing that the information is proprietary and a release would violate contractual confidentiality provisions.

Another argument made by stakeholders in opposition is that disclosing the information will be overly burdensome, difficult to standardize, and result in additional consumer confusion. It will be important for policymakers to address this point, both as they look to enhance transparency, but also as they design a framework that proves effective in providing consumers accurate information to assist in making health care purchasing decisions.

#### **Hospital and Physician Groups Mergers and Acquisitions (M&A): Examples of Negotiated Rate Disclosures**

Each year hospitals and health systems, physician groups, and other health care providers engage in M&A activity. Over the last decade, activity in the hospital and physician practice sector has been at all-time highs, with more than 100 hospital deals each year, on average, and significant interest in physician practices by health systems, private equity firms, and large strategic acquirers (e.g., Optum). Other than in cases where a potential antitrust issue may be raised, almost all of these transactions result in the exchange and analysis of proprietary rate information prior to consummation.

The exchange of this information, which occurs in the later stages of a M&A process, could provide a framework for disclosure that seeks to provide greater consumer transparency, also dispelling the notion that obtaining such information is ‘difficult if not impossible.’ Rate information disclosure in an acquisition process generally follows a pattern, as follows:

- A party that is being acquired will post its rate card information and contracts to a data room, where the acquiring party can access the information
- The acquiring party will run an assessment of how the rates compare to market level health insurance reimbursement, or to the actual rates that the acquiring entity is being paid by health insurers—if applicable market overlap exists. This assessment will often be done by a third party firm (e.g., Big Four accounting firm or leading consulting firm)
- This assessment will inform the final purchase price, or at a minimum, inform go-forward decisions around capitalization and revenue growth opportunities

In the context of a M&A transaction, rate information is generally disclosed in a time efficient manner. While it may take additional effort from finance executives, it is neither impossible nor prohibitive to produce. Further, the ability of third party firms to quickly assess the disclosed negotiated rate information and create go-forward financial models is well established.

## APPENDIX C

### How Third Party Technology Developers will Aggregate Pricing Data

Innovative technology companies have told us that they are highly supportive of the proposed requirement for an open, standard API through which members or authorized third parties can access negotiated rates and other benefit information:

- Payers will have a challenging time designing high-quality tools that will enable their members to shop effectively for different services. An API requirement would allow third party developers to build a variety of high-quality tools for patients to identify best-fit providers and predict out of pocket expense;
- Third party developers could also supplement this data with e.g. map coordinates associated with various NPIs to enable shopping by price and location -- as one example;
- In the longer run, this proposal could pave the way to a requirement that private insurance expose historical claims through an API, similar to the [Blue Button 2.0 API](#) for Medicare.

To enable shopping, it is essential to offer prices for groups of codes representing an actual episode of care vs. individual codes:

- The way the rule is currently written, prices and patient responsibility estimates are largely being provided for individual service codes: CPTs, HCPCS, DRG, etc. but for e.g. a knee replacement, an episode of care will consist of many of these codes. To answer the question "how much will my knee replacement cost me", app developers will bundle together the codes we expect for a given episode and then calculate total patient responsibility;
- This episodic grouping -- mapping the relevant individual codes to a given episode of care, like a knee replacement -- can be done with historical claims data. Medicare claims from CMS could work, or any private payer databases;
- There are a few different ways to analyze the data to come up with the set of codes relevant to an episode, e.g.:
  - Look for an index event in the claims data (e.g. a specific DRG), then add all claim lines with the same dates of service, as well as all claims from 30 days post procedure with the same NPI;
  - There are multiple approaches to take. As a starting point, tech companies should identify common episodes of care that patients are likely to shop for, determine which codes typically comprise these episodes through historical claims analysis, and require that estimated patient responsibilities also be made available for these "bundles."

Volumes of different procedures performed by providers should be included as a quality metric:

- Most quality metrics create an incentive to "game" performance and select risks to maximize score;

- As a result, it is right to be suspicious of precisely how well metrics map to actual outcomes and how much we can conclude based upon performance;
- Volume of performing specific procedures is frequently cited as one of the strongest measures of provider quality. The more you perform, the less likely a slip up will be;
- We suggest including volume as a quality metric. While data on volumes across payer types will be hard to come by, an app with wide penetration could largely gather and / or extrapolate this data.

## APPENDIX D

### Implementation Suggestions for Sections 3(a) and 3(b) of the Executive Order on Improving Price and Quality Transparency

Only when taken together can Sections 3(a) and 3(b) of the Executive Order on Improving Price and Quality Transparency deliver systemwide real price transparency across all hospitals, providers, insurance issuers, and self-insured group health plans. Implementing negotiated rate and net cash price disclosures across providers and plans will put the patient first, enable a functional, competitive marketplace in healthcare, and significantly reduce the cost of healthcare and health plans nationwide.

Patients, employers, and other plan sponsors need to see the complete real prices, not just out-of-pocket costs, to shop for the best quality of care at the lowest possible price. Further, in order to understand alternative options, patients need to see all pricing information, including cash price and net negotiated price across all providers and plans. Readily searchable real prices, adjudication, and Explanation of Benefits (EOBs) can be delivered prior to receiving care. Finally, billing and payment to match these prices and benefits can be delivered through free, open, standard APIs.

Federal agencies have broad authority to require healthcare providers and insurers to disclose real price information to the public through free, open, standard APIs and through using existing financial transaction standards. Implementation suggestions are as follows:

- 1. Healthcare Provider Requirements:** Require healthcare providers to publicly disclose their cash prices and negotiated rates real-time with all plans, bundled and unbundled, by CPT, DRG codes, and other commonly used service billing codes.
  - In order to shop for care, patients and employers need access to not only their out-of-pocket cost but also the real prices – both negotiated rates and cash prices – to reduce their costs of care and coverage. These data exist digitally nationwide in the hands of plans and providers, and can be sorted readily by National Provider Identifiers and existing coding (e.g. rate cards).
  - Estimates and averages are dysfunctional, not reflective of the true, negotiated price, and obfuscate the lower price options for the same quality of care. Egregious price gouging is often incorporated into estimates, leading to market distortions, and ultimately, higher prices. In functional marketplaces like grocery, retail, and travel, consumers do not make purchases based on average prices.
  - Innovative employers today incentivize employees to choose lower cost, price transparent providers by offering no copay, no deductible, cash bonuses, HSA deposits, gift cards, and wage increases, all as a means to share savings.
- 2. Plan Requirements:** Require plans to publish their negotiated rates, real-time, bundled and unbundled, by CPT, DRG code, and other commonly used service billing codes for all providers and services in free, open, standard APIs in machine-readable format, utilizing existing financial transaction standards, and consistent with ONC health IT standards, including FHIR.

- Patients can shop when they can see complete pricing — whether it be net cash prices or negotiated rates, and their EOB before they receive care. Today, the negotiated rate is only released to patients after care through their EOB, and they do not know if bills are correct or match the price. Because the EOB is provided to the patient and employer, it is not proprietary. In fact, EOB information belongs to the patient prior to care, as information relating to “future payment for the provision of health to an individual” is considered Health Information belonging to the patient under the Health Insurance Portability and Accountability Act (HIPAA).<sup>16</sup>
- 3. Electronic Data Requirements:** Require providers and plans to update these electronic data in real-time through free, open, common standards-based APIs in machine-readable format, utilizing existing financial transaction standards, and consistent with ONC health IT standards, including FHIR. These free APIs will enable technology companies to provide helpful, consumer-friendly tools and apps to compare services and prices. Data must be easily searchable online, printable, and provided in hard copy upon request.
- This functionality is consistent with CMS’s and ONC’s proposed interoperability rules and will minimize burden by not requiring plans to develop tools, but by providing access to data through mechanisms needed for compliance with the interoperability rules.
- 4. Comment Period Requirements:** Enable a comment period for 60 days, and then require implementation within 60 days.
- Negotiated price information can be disclosed timely: Pricing is readily available today for shared rate cards, claims processing, EOBs, and is utilized in due diligence for hospital and physician practice mergers and acquisitions.
- 5. Billing and Payment Requirements:** Provide patients with digital billing and payment information in real-time, as in other functional industries (e.g. grocery, retail, travel, and financial services).
- Today, all payment information exists digitally. If prices can be known upfront before care, providers and insurers can easily provide digital billing information to the patient immediately, like in all other competitive marketplaces. Patients can then confirm that the bill matches the quoted price, and hospitals and providers can be paid timely by employers, insurers, and patients. This knowledge can provide the patient with negotiating leverage and recourse.
  - Costs associated with the many layers of administrators and middle players will be eliminated. Efficiently paying providers by the insurer and by the patient will remove much of the waste, fraud, and abuse in our healthcare system, and reduce costs for providers and plans related to resolving billing disputes.
  - Real-time digital billing and payment information will allow patients to avoid erroneous, unnecessary medical debt and collections, and their credit scores will be protected. Patients will no longer be sent to collections during the time it takes for insurance to adjudicate claims and pay the provider.

<sup>16</sup> Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR 160.103

## **APPENDIX E**

### **How Full Contracted Rate Transparency Effects Healthcare Decisions (Not Just Out of Pocket Costs)**

Transparency into systemwide real prices will allow patients to shop for and choose lower cost, higher quality providers and drive down the cost of their care and premiums, ultimately allowing employers to put more money back into employees' wages, and allowing patients to keep more money in their wallets.

We have filmed several innovative employers who successfully utilize a price transparent model and have driven down their total healthcare costs by nearly half, offering no copay, no deductible, and even cash bonuses to employees who choose lower cost, price transparent providers:

[Stauffers of Kissel Hill](#) grocery store in Pennsylvania  
[HB Global](#), HVAC company in Pennsylvania  
[Employee Solutions](#), Staffing company in Texas  
[BevCap Management](#), captive insurance program in Texas  
[Surgical Center of Oklahoma](#), price transparent surgical center in Oklahoma

Averages and out-of-pocket cost estimators don't work: If a patient knew that the cost of childbirth was \$7,000 for one Boston hospital and \$42,000 for the same quality at a nearby hospital, why would she choose the price-gouging option?

With premiums increasing by 8-12% per year, the only way to reverse the runaway costs of healthcare is through competition, choice, and real price transparency.

#### **10 reasons patients need access to contracted rates across providers and plans**

1. So that patients can choose and reward the lowest price / best quality providers by patronizing those who are lower cost overall.
2. So that patients can use the information to negotiate. For example, if a provider would take less than the contracted rate if the patient paid cash upfront. Or, if an out-of-network provider might not want to contract with the insurer, but would be willing to accept a contracted rate for a specific patient who asked, using the full negotiated rate.
3. To facilitate plan sponsor efforts to incentivize lower price / higher quality choices by engaging patients in knowing the full price and incentivizing them through shared savings programs, zero cost-sharing, and other incentives.
4. To reveal price information into the marketplace and start to balance the asymmetrical market - in other words, so that they can share that information with friends, neighbors, and family and begin market-moving through word of mouth.
5. To help patients plan ahead, before they may know their deductible status.



6. To help patients see when and why they should complain to employers or set up new arrangements in the face of price gouging, such as with drugs or DME, when the out-of-pocket share of the contracted rate is often higher than the full-cash price at the pharmacy or on Amazon, CraigsList, or eBay.
7. To help patients understand that higher prices lead to higher premiums, paid by both the employers and the patients through premiums, copays, deductibles, and ultimately stagnated wages. This enrollee engagement is being used by an increasing number of employers to build support for more disruptive and innovative models that require employee buy in.
8. To facilitate patient conversations with their providers about their prices, put pressure on providers, and raise their awareness about affordability issues. Being asked to justify their higher prices will empower providers to pursue changes and lower their prices to remain competitive.
9. To facilitate patient conversations with physicians at the point of referrals.
10. To help those patients who end up in collections to negotiate more effectively using the knowledge of competitive pricing.

**Non-patients need much better access to the contracted rates in the marketplace across multiple insurers (not just the ones they selected)**

1. To facilitate innovators and disrupters like Sano Surgery, Surgiprice, Zero Card and others who use negotiated rates to direct contract with providers for zero-cost-sharing bundles.
2. To help those who advocate for others, such as churches and other charities, case workers, friends and family to negotiate with providers to serve a patient or multiple patients at a lower rate by asking them to do it for, say, 75% of what BCBS would pay, and so forth.
3. To help providers engage in cash price setting and other disruptive approaches whereby they go outside the third party system.
4. To help employers cut out insurers and go directly to providers to direct-contract, using price information, or to help them band together with other employers to do so.
5. To help policy makers and researchers do better evaluations and make better policy.

## APPENDIX F

### **Benefits of Issuers Full Contracted Rate Transparency (Not Just Out of Pocket Costs) in Addition to Provider Price Transparency**

Real negotiated price disclosure by the issuer to the consumer is critical: Issuers, either offering fully insured plans or administering self-insured plans, have all of the real price and claims data across providers. They can easily post all of their real, contracted rates by provider by plan. The real price is what is responsible for the premium hikes patients and their employers are suffering each year, ultimately impacting their wages and wallets. Requiring issuers to post these real prices is the only way to enable a trusted, competitive marketplace. Should their contracted rate be higher than a fair amount, the consumer would be empowered to request a reasonable price, cash price, or shop with their feet.

The specific reasons the **ISSUER** needs to disclose contracted prices include:

1. Issuer contracted rate transparency allows consumers to see prices at the vast array of non-hospital providers: [ambulatory surgery centers](#), outpatient clinics, labs, stand-alone imaging centers, urgent cares, private practice groups, assisted living facilities, durable medical equipment (DME) dealers, etc.
2. Many of these non-hospital providers are often the most cost-efficient, meaningful competitors that buyers of healthcare would want to compare against to the hospitals' prices required by the hospital transparency proposed rule, particularly in a highly consolidated marketplace, even in different states.
  - This type of broad transparency by issuers would facilitate national competition, even in consolidated markets that are not competitive.
  - For example, [Dr. Keith Smith of the Surgery Center of Oklahoma](#) speaks of a patient who used his website surgery price of \$3,600 to negotiate with the sole hospital in a consolidated market in Georgia who was charging \$40,000 for the same surgery. That hospital matched Dr. Smith's price, and the patient saved \$36,400 for his employer and himself.
3. Transparency from both providers and issuers would provide helpful accountability, because their work will be checked by each other.
4. Issuer contracted price transparency allows consumers to obtain the prices for drugs and DME that (a) can be obtained or are obtained outside of hospital settings, and (b) empower them with information to help them make choices about drugs and DME that are either not offered in a hospital setting or that are offered but could be obtained for a lower price elsewhere.
  - As an example of how these requirements could work together, after an ACL tear where an orthopedic surgeon in a hospital setting prescribed a knee brace, if the patient purchased the brace at the hospital, the price of \$1,500 would be disclosed per the hospital rule. However, it would not show that the patient could find a lower price at a separate, free-standing DME provider. Furthermore, an enterprising patient could find the same brace for \$150 on Amazon, saving for

both herself and her employer. Think of how much this could save CMS if seniors were incentivized to shop for the best priced DME.

5. Issuer contracted price transparency for drugs lets patients see drug pricing outside the hospital setting to make choices, lower costs, and budget.
6. Issuer contracted price transparency allows patients to see real-time rate card changes for services and goods provided in a hospital setting. The proposed hospital transparency rule only requires annual updates.
  - As an example, for drugs administered in the hospital setting, issuer contracted price transparency allows patients to see mid-year formulary changes that affect prices.
7. Insurers and many non-provider actors (employers, pharmacies, etc) work together to create bundled services beyond the healthcare provider, such as transportation, health coaches, drug adherence packages, and meals on wheels. The prices of these services can be incorporated into bundled prices that the issuer can provide through transparency.
8. Employers, employees, and the public would be empowered to see systemwide contracted prices. They currently are not able to extract real pricing information from their insurers, even in the case of self-insured employers.
  - Many of the largest self-insured employers complain they are not able to get their own pricing and claims data in a timely, comprehensive way. Issuers administering these plans can erect obstacles to fulfilling these requests, preventing employers from shopping, changing benefit design, [direct contracting](#), and removing out the middle man. This problem is even more dire for the smaller and mid-market self-insured employers who employ a large number of American workers.
  - Fully-insured employers, in the large or small group market, who are paying just as much, if not more, for health benefits for their workers as self-insured employers, typically have no itemized price information. Issuers argue that they are not entitled to this information. However, the employer and employee/consumer need to be in the driver's seat.
  - Throughout the healthcare system, the consumer needs full price discovery across issuers and providers to be able to compare plans and care. Both issuers and providers can deliver complete price transparency together and create a functional, competitive marketplace.
9. Complete contracted price transparency requirements for issuers utilizes different authority which can prevent or inhibit legal challenges.
10. By requiring all providers (including those out-of-network) and issuers to post their real prices in advance of care, will benefit consumers, employers, and even issuers will benefit from no surprises and universal price transparency.

Imagine the impact of potential savings on hundreds of millions of transactions on the wallets of Americans, the businesses that employ them, and the economic growth for our nation that would be enabled.

### Case Study: Why Issuers Need to Post Complete, Contracted Prices

A recent college graduate is still on her family's health plan, sponsored by their self-insured business. She needed simple blood tests to become a healthcare worker. Without the ability to shop, she went to her hospital-owned primary care practice and was referred to the hospital-owned lab. She was shocked when she received her "real-world" medical bill showing a total price of \$4,300, with the issuer's contracted price of \$2,100, and \$700 out-of-pocket cost – more than 11 times the Medicare price.

After the fact, she was inspired to do due diligence. The issuer initially would not provide the real, negotiated prices for other labs. It required her using the leverage of the fact that her family owned the 2,000+ employee plan to extract comparative prices for these common tests from the issuer. After several weeks of back and forth, she found the cheapest contracted price to be \$300, with only \$30 out-of-pocket. Had she been able to shop through her insurer, she could have saved her family's own business \$1,800, and saved \$670 for herself. If she had been able to see other issuers' pricing or cash prices, she may have had negotiating leverage to reduce the cost further.

## APPENDIX G

### ERISA Can Be Used to Promote Meaningful Healthcare Price Transparency

Jeffrey Harris, Esq.

The Employee Retirement Income Security Act of 1974 (ERISA) contains powerful tools that can be used to help ensure all employees have access to the information needed to make informed decisions about their health care. Under the dysfunctional status quo, many employees do not have access to critical information about the prices being charged for health care services under employer-sponsored health plans. In particular, employees are often left in the dark about the specific prices for health care services that are negotiated between insurance companies and providers. Indeed, many employees do not learn the price of such services until *after the fact* when they receive an “explanation of benefits” weeks or months after receiving the service. As a result, consumers are unable to shop for services based on their price, even though participants who have not yet met their plan deductibles will often be paying for these services out-of-pocket.

ERISA can be used to remedy these information asymmetries. *First*, 29 U.S.C. §1024(b)(4) requires a plan administrator to provide upon request “a copy of ... any ... contract, or other instruments under which the plan is established or operated.” The government could interpret this provision to mandate disclosure of all negotiated prices between insurance companies and providers, since these prices involve a “contract” “under which the plan is ... operated.” *Second*, even apart from this express statutory requirement, ERISA’s duties of care and loyalty require plan fiduciaries to provide “complete and accurate” information to participants upon request. If a plan participant requests information about the prices of certain services to enable him or her to make informed purchasing decisions, it is difficult to see how a fiduciary could reject that request consistent with the duties of care and loyalty. These provisions of ERISA could be used, individually or collectively, to bolster the legal authority for the Administration’s price transparency initiatives.

\* \* \*

“[T]he duties charged to an ERISA fiduciary are the highest known to the law.” *Chao v. Hall Holding Co., Inc.*, 285 F.3d 415, 426 (6th Cir.2002). The text of 29 U.S.C. § 1104(a) sets out ERISA’s basic fiduciary duties of loyalty and care, *see Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985), but courts also look to the common law of trusts to inform the application of those duties. *Pegram v. Herdrich*, 530 U.S. 211, 224 (2000); *In re Unisys Sav. Plan Litig.*, 74 F.3d 420, 434 (3d Cir. 1996).

**Duty of Loyalty.** The duty of loyalty requires that ERISA fiduciaries “shall discharge their duties with respect to a plan ‘solely in the interest of the participants and beneficiaries,’ §1104(a)(1), that is, ‘for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan,’ § 1104(a)(1)(A).” *Pegram*, 530 U.S. at 223–24. The central aim of the duty of loyalty is to compel the fiduciary to avoid self-interested or conflicted transactions. *Id.* at 224; *Perez v. Bruister*, 823 F.3d 250, 261 (5th Cir. 2016).

**Duty of Care.** ERISA’s duty of care (sometimes called duty of prudence) further requires fiduciaries to act with the “care, skill, prudence and diligence ... that a prudent man ... would use in the conduct of an enterprise of a like character and with like aims.” 29 U.S.C. §1104(a)(1)(B). The duty of care is an objective standard “focusing on a fiduciary’s conduct in arriving at a[] ... decision, not on its results, and asking whether a fiduciary employed the appropriate methods to investigate and determine the merits of a particular [decision].” *In re Unisys Sav. Plan Litig.*, 74 F.3d 420, 434 (3d Cir. 1996) (collecting cases).

**Disclosure obligations.** Part 1 of Title 1 of ERISA requires disclosure of certain information to plan participants and beneficiaries. In general, plan administrators are subject to two categories of express statutory disclosure obligations: (1) automatic disclosures; (2) disclosures upon request. *See* 29 U.S.C. §§1021—1031. The statutory disclosure obligation that is most likely to cover lists of negotiated prices between health benefit plans and providers is codified at 29 U.S.C. §1024(b)(4), which provides: “The administrator shall, upon written request of any participant or beneficiary, furnish a copy of ... any ... contract, or other instruments under which the plan is established or operated.” This provision offers a strong basis to compel the disclosure of negotiated prices between insurers and providers. Such agreements plainly constitute “contracts ... under which the plan is ... operated” because they dictate the prices that will be charged to participants who have not yet met their deductible. At least one federal appellate court has construed §1024(b)(4) broadly, holding that “all other things being equal, courts should favor disclosure where it would help participants understand their rights.” *Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1065-66 (6th Cir.1994).

In addition to ERISA’s express statutory disclosure obligations, courts have also held that plan fiduciaries have disclosure requirements that arise from their general fiduciary duties of care and loyalty. In *Pegram*, the Supreme Court noted that “it could be argued that ... [a fiduciary] is obligated to disclose characteristics of the plan and of those who provide services to the plan, *if that information affects beneficiaries’ material interests.*” *Pegram*, 530 U.S. at 228 n.8 (emphasis added) (citing *Glaziers and Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Securities, Inc.*, 93 F.3d 1171, 1179–1181 (C.A.3 1996) (discussing the disclosure obligations of an ERISA fiduciary) and *Varity Corp. v. Howe*, 516 U.S. 489, 505 (1996) (holding that ERISA fiduciaries may have duties to disclose information about plan prospects that they have no duty, or even power, to change)). Once again, it is difficult to imagine an aspect of a health plan that is more “material” to participants than the *prices* they will be charged for specific services.

Federal circuit courts have taken the same approach, and have often imposed affirmative disclosure obligations on fiduciaries for information that would be material to plan participants. *See, e.g., Krohn v. Huron Memorial Hosp.*, 173 F.3d 542, 551 (6th Cir. 1999) (faced with a participant injury, fiduciary had a duty under ERISA to convey to the participant complete and correct material information as to his eligibility for benefits and options under the plan); *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 750 (D.C. Cir. 1990 (same)); *Farr v. U.S. West*, 151 F.3d 908, 913 (9th Cir. 1998) (holding that a “fiduciary has an obligation to convey complete and accurate information material to the beneficiary’s circumstance, even when a beneficiary has not specifically asked for the information” where Summary Plan Description provided incomplete information on tax treatment of lump sum distributions); *Jordan v. Federal Express Corp.*, 116

F.3d 1005, 1016 (3rd Cir. 1997) (finding that participant's failure to inquire did not preclude suit for breach of fiduciary duty for failure to disclose material facts regarding irrevocability of retirement elections).

At a minimum, ERISA's duties of care and loyalty mandate that plan fiduciaries must provide accurate information about the plan in response to a request for information from a participant. For example, the Sixth Circuit has held that that "once an ERISA beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary's status and situation, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire." *Gregg v. Transportation Workers of Am. Int'l*, 343 F.3d 833, 845-46 (6th Cir. 2003) (collecting cases). At least six other circuits have endorsed the same rule. See *Watson v. Deaconess Waltham Hosp.*, 298 F.3d 102, 114-15 (1st Cir. 2002); *Bixler v. Cent. Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1300 (3d Cir. 1993); *Griggs v. E.I. DuPont de Nemours & Co.*, 237 F.3d 371, 381 (4th Cir. 2001); *Anweiler v. Am. Elec. Power Serv. Corp.*, 3 F.3d 986, 991 (7th Cir. 1993); *Barker v. Am. Mobil Power Corp.*, 64 F.3d 1397, 1403 (9th Cir. 1995); *Eddy v. Colonial Life Ins. Co. of Am.*, 919 F.2d 747, 750 (D.C. Cir. 1990). It would be a flagrant violation of a fiduciary's duty of care to refuse to provide material information about a plan that is requested by a fiduciary—especially when the requested information involves critical matters such as the prices that will be charged to participants for services provided under the plan.

\* \* \*

In sum, ERISA imposes on plan fiduciaries the "highest duties known to the law" to ensure that benefit plans are always administered and operated in the best interests of the employees. No prudent fiduciary could take the position that employees are not entitled to know the price of health care services *before* they purchase those services; such information is indispensable to a consumer's ability to make informed decisions. ERISA can thus be used to further bolster the legal authority for Administration's important price transparency initiatives.

## **Appendix H**

### **Federal Health Care Price Transparency Rules Are Lawful And Pro-Competitive**

Jeffrey Harris, Esq.

In November 2019, the Administration finalized critical regulations to implement pro-competitive reforms in the health care sector. *See* Final Rule, RIN 0938-AU22 (Nov. 15, 2019) (“Final Rule”); Proposed Rules, 49 Fed. Reg. 39,398 (Aug. 9, 2019). In particular, those regulations mandate that hospitals inform customers upfront about the *actual* prices they would be charged for all available services (*e.g.*, cash prices for walk-up patients, or prices negotiated between hospitals and insurers for patients using health insurance), focusing in particular on services that are “shoppable” across providers. These regulations will inject market-based reforms into a sector that is currently characterized by high prices, inefficiency, lack of transparency, and an inability for patients to meaningfully choose the most cost-effective provider.

Trade associations representing the powerful incumbents in the health care industry—hospitals and insurers—have objected to the Administration’s price transparency efforts, raising a host of policy, legal, and constitutional arguments. *See* Comments of America’s Health Insurance Plans (AHIP), Comments of American Hospital Association (AHA), Comments of Federation of American Hospitals (FAH), and Comments of America’s Essential Hospitals (AEH). Those arguments are without merit, and pose no obstacle to implementing the regulations.

#### **I. Negotiated Rates Or Cash Prices Are The Price That Many Customers Actually Pay And Thus Accurately Reflect “Out-of-Pocket” Costs.**

At the outset, the industry comments rest on a false assumption: namely, that the transparency regulations would be unnecessary or even counterproductive because they do not reflect “out-of-pocket” costs. For example, the AHA asserts that “hospitals and health systems focus on out-of-pocket costs estimates because this is the information that patients ask for and say they need.” AHA Comments at 24-25. The FAH similarly asserts that “consumers’ interests in provider prices is focused on the consumer’s out-of-pocket costs, not the cost to their health plan.” FAH Comments at 7; *see also* AHIP Comments at 6-8 (arguing that consumers “need to know” only “their own out-of-pocket costs”).

But this focus on so-called “out-of-pocket costs” is a red herring. For individuals in high-deductible health plans, the negotiated rates *are* the “out of pocket” costs that the customer will actually pay. Today, nearly 50% of adults between ages 18 and 64 with employer-based coverage are enrolled in a high-deductible health plan. *See* NCHS Data Brief, *High-deductible Health Plan Enrollment Among Adults Aged 18-64* (August 2018), *available at* <https://www.cdc.gov/nchs/data/databriefs/db317.pdf>. In a high-deductible plan, the patient typically pays all charges up to a specified limit and only then does the insurance coverage take effect. As HHS explained, “disclosure of payer-specific negotiated charges can help individuals with high-deductible health plans . . . determine the portion of the negotiated charge for which they will be responsible out-of-pocket.” Final Rule at 18; *see also* 84 Fed. Reg. at 39,572 (noting that “a study of high deductible health plan enrollees found that respondents wanted additional health care price information so that they could make more informed decisions about where to seek care



based on price”). The trade associations are thus correct that consumers care about their out-of-pocket costs but are demonstrably wrong that negotiated prices do not reflect the prices customers pay for their care. For customers who have not yet met their deductible, the negotiated prices *are* the out-of-pocket prices.

The final rule also requires hospitals to disclose their discounted cash prices, as “a self-pay individual may simply want to know the amount a healthcare provider will accept in cash (or cash equivalent) as payment in full.” Final Rule at 19; *see also* Final Rule at 120 (“the discounted cash price is a standard charge offered by the hospital to a group of individuals who are self-pay”). That requirement, too, is entirely reasonable and is directly relevant to “out-of-pocket costs.” Research has shown that hospitals often offer cash prices far below what they charge through insurance. *See, e.g.,* Melinda Beck, *How to Cut Your Health-Care Bill: Pay Cash*, Wall Street Journal (Feb. 15, 2016). When providers are paid in cash upfront, it eliminates the need for complicated billing and administrative tasks; low cash prices are also a way “to compete for business and assist patients who might otherwise have to forgo care.” *Id.* Moreover, technology companies (including Clear Health Costs) are now beginning to compile information about cash prices and make that information searchable across providers, thereby allowing patients to search for the best quality and value of care. The trade associations do not—and cannot—seriously contend that cash prices are irrelevant to patients’ “out-of-pocket” costs.

## **II. HHS Has Statutory Authority To Implement The Transparency Rules.**

The trade associations challenge HHS’s statutory authority to promulgate the transparency regulations, but the regulations fall comfortably within HHS’s discretion. Section 2718(e) of the Public Health Service Act (PHSA), 42 U.S.C. §300gg-18(e), provides: “Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital...” According to the trade associations, the phrase “standard charges” refers only to a hospital’s *chargemaster* and does not encompass negotiated rates for customers who use insurance to pay for their care. *See* FAH Comments at 3-6 (arguing that Section 2718(e) requires only “disclosure of a single list of standard charges but not payer-specific negotiated rates”); AHA Comments at 8-14; AHIP Comments at 10-13; AEH Comments at 21-22.

The text, purpose, and structure of the PHSA amply support the regulations. The trade associations may be correct that one *possible* interpretation of “standard charges” is the hospital’s *chargemaster*: the full list of non-discounted prices. But “standard charges” is not explicitly defined in the statute, and the trade associations’ interpretation is by no means the *only* permissible reading of this phrase. HHS could also reasonably interpret “list of the hospital’s standard charges” as meaning the “standard charges” *for each category of patient*. For someone who pays cash upfront, the relevant price is not the *chargemaster*, but the discounted cash price that the patient will *actually pay*. *See* Final Rule at 67 (“we are adding the discounted cash price as a third type of standard charge” because of “its greater applicability to self-pay individuals”). Similarly, for someone with employer-based health insurance, the *chargemaster* does not reflect the list of “standard charges” relevant to that patient. *See* 84 Fed. Reg. at 39,577 (“gross charges as reflected in hospital *chargemasters* may only apply to a small subset of consumers; for example, those who are self-pay or who are being asked to pay the *chargemaster* rate because the hospital is not

included in the patient’s insurance network”). Even the trade associations recognize as much, acknowledging that “[t]he price in the hospital [chargemaster] rarely reflects the amount for which a patient, or their insurer, is responsible.” AEH Comments at 19. It would be an odd and counterintuitive result to interpret the statute as requiring disclosure of a price list that “rarely” reflects what patients will actually pay.

Instead, the “standard charges” for a patient with health insurance are set forth in the list of negotiated prices between the hospital and the patient’s insurer. Two possible definitions of “standard” are “usual, common, or customary,” and “authorized or approved.” *See* Dictionary.com (definition of “standard” as an adjective). For a patient with insurance, it is the negotiated prices—not the chargemaster—that are the “standard” charges, *i.e.*, the “usual,” “authorized,” or “approved” charges. And, for a patient who pays cash upfront, the standard, authorized, and approved charges are set forth in the hospital’s list of discounted cash prices—not the chargemaster.

Although HHS’s interpretation of Section 2718(e) may not be the only possible interpretation, it is certainly a *reasonable* one and is well within the agency’s discretion under the statute. The “question in every case” involving an administrative agency’s authority is “whether the statutory text forecloses the agency’s assertion of authority, or not.” *City of Arlington v. FCC*, 569 U.S. 290, 301 (2013). The transparency rules fall comfortably within a plain-text interpretation of Section 2718(e) and nothing in the statute forecloses HHS’s assertion of authority. As HHS correctly explained, the statute can be interpreted to “permit disclosure of several types of charges that are standard for different identifiable groups of people.” Final Rule at 63.

The structure and purpose of the statute further support this interpretation of the text. Section 2718(e) is included in a section labeled “Bringing down the cost of health care coverage.” Chargemaster prices that are unrelated to the prices *actually paid* by patients would be meaningless in allowing customers to shop for the best value in health care services and thereby inject market forces into the bloated and inefficient health care sector. For patients who pay cash, the discounted cash prices are the prices actually paid, and for patients with health insurance who have not yet met their deductible, the negotiated prices are the prices actually paid. It would hardly serve the purpose of the statute to allow a hospital to meet its obligations merely by disclosing a list of fees that are irrelevant to the vast majority of patients.

### **III. Price Transparency Rules Are Entirely Consistent With The First Amendment.**

The trade associations also argue that HHS’s price transparency regulations violate the First Amendment, but those contentions are based on a selective and misleading interpretation of the relevant case law. *See, e.g.*, AHA Comments at 14-16 (arguing that transparency regulations would be unconstitutional “compelled speech”); AHIP Comments at 13 (arguing that regulation “unconstitutionally compels speech”); FAH Comments at 7-8 (describing transparency rules as unconstitutional “compelled disclosure”); AEH Comments at 22. No court has ever invoked the First Amendment to invalidate government efforts to provide truthful, accurate information to consumers about marketplace transactions, and for good reason.

The Supreme Court has emphasized that “[s]o long as we preserve a predominantly free enterprise economy, the allocation of our resources in large measure will be made through numerous private economic decisions.” *Virginia Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 765 (1976). It is thus “a matter of public interest that those decisions, in the aggregate, be intelligent and well informed.” *Id.* “To this end, *the free flow of commercial information is indispensable.*” *Id.* (emphasis added); *see also Snyder v. Phelps*, 131 S. Ct. 1207, 1215 (2011) (First Amendment reflects “a profound national commitment to the principle that debate on public issues should be uninhibited, robust, and wide open”).

In *Virginia Board of Pharmacy*, the Supreme Court struck down as unconstitutional a state law that prohibited pharmacists from advertising the prices of prescription drugs. As the Court explained, the suppression of information about health care prices “hits the hardest ... the poor, the sick, and particularly the aged,” who spend a significant part of their income on health care but “are the least able to learn ... where their scarce dollars are best spent.” 425 U.S. at 763. The Court emphasized that, given the “striking” variations in the cost of different prescription drugs, “information about who is charging what [is] more than a convenience,” and “could mean the alleviation of physical pain or the enjoyment of basic necessities.” *Id.* at 763-64. At a more general level, there is a powerful public interest in “the free flow of commercial information.” *Id.* at 764. The Court thus concluded that any attempts to stifle the publication of information about prices would violate the First Amendment. *See also Bates v. State Bar of Arizona*, 433 U.S. 350 (1977) (holding that state’s prohibition on attorneys advertising their fees violated First Amendment); *44 Liquormart v. State of Rhode Island*, 517 U.S. 484 (1996) (holding that ban on price advertising for alcoholic beverages violated First Amendment).

Just as the Supreme Court has struck down laws that seek to *prohibit* the disclosure of information about prices or costs, it has also upheld laws that seeks to *promote* public access to pricing information. In *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985), the Court rejected a First Amendment challenge to an Ohio regulation that required attorneys to disclose in their advertisements certain information about their fee arrangements. As the Court explained, there are “material differences between disclosure requirements and outright prohibitions on speech.” *Id.* at 650. A disclosure requirement does not “prevent” anyone from “conveying information to the public”; instead, it merely “require[s] them to provide somewhat more information than they might otherwise be inclined to present.” *Id.* The Supreme Court thus applied a rule under which the relevant First Amendment rights “are adequately protected as long as disclosure requirements are reasonably related to the State’s interest in preventing deception of consumers.” *Id.* at 651. Applying that standard, the Court upheld an Ohio law that required attorneys to disclose in their advertising if clients in contingent-fee cases could be forced to pay costs following an unsuccessful suit. *Id.* at 652.

Price transparency rules are common in other industries, and—consistent with the Supreme Court’s decision in *Zauderer*—those laws have never been found to violate the First Amendment. For example, to enable comparison shopping, the Department of Transportation requires all airlines to prominently advertise the all-in price of a ticket that shows *what the customer will actually pay*—*i.e.*, the fare charged by the airline plus all applicable taxes and fees. The U.S. Court of Appeals for the D.C. Circuit rejected a First Amendment challenge to that regulation, holding that it was merely “a disclosure requirement rather than an affirmative limitation on speech.” *Spirit*

*Airlines v. Dep't of Transp.*, 687 F.3d 403, 412-13 (D.C. Cir. 2012). As the court explained, “the Airfare Advertising Rule does not prohibit airlines from saying anything; it just requires them to disclose the total, final price and to make it the most prominent figure in their advertisements.” *Id.* at 414. In short, the rule did not violate the First Amendment because it “is aimed at *providing accurate information*, not restricting it.” *Id.* (emphasis added).

Similarly, the Federal Trade Commission has promulgated a “Funeral Rule” that imposes extensive price-transparency rules on providers of funeral-related goods and services. *See* Final Rule, *Funeral Industry Practices*, 47 Fed. Reg. 42,260 (Sept. 24, 1982). A key provision of that rule requires funeral providers to give their customers an itemized price list that displays “standardized price information” for each available service, thereby “enabl[ing] consumers to weigh the costs and benefits both of the various alternatives to a traditional funeral and of the individual items which they might select for use with a traditional funeral.” *Id.* at 44,272. The concerns that led to the adoption of the Funeral Rule apply with full force in the health care context: both situations involve expensive, often one-time transactions that are necessarily undertaken during a stressful and emotional time for the consumer. No court has ever so much as suggested that the Funeral Rule’s disclosure requirements violate the First Amendment, and the same underlying interests would justify transparency regulations in the health care context as well.

In raising First Amendment objections to price transparency regulations, critics have pointed to cases such as *R.J. Reynolds Tobacco Co. v. FDA*, 696 F.3d 1205 (D.C. Cir. 2012), *Am. Meat Institute v. USDA*, 760 F.3d 18 (D.C. Cir. 2014) (en banc), and *Am. Beverage Ass’n v. City & Cnty. of San Francisco*, 916 F.3d 749 (9th Cir. 2019). But none of those cases casts doubt on the constitutionality of price disclosure requirements. For example, in *American Meat Institute*, the D.C. Circuit *rejected* a First Amendment challenge to the Department of Agriculture’s country-of-origin labeling requirements for food products, holding that the rules were permissible under *Zauderer* because they merely sought to ensure that consumers had accurate information about the products they were purchasing. And, although the court in *R.J. Reynolds* had struck down as unconstitutional a requirement that cigarette companies put graphic images of smoking-related health conditions on their packages, the D.C. Circuit *overruled* that decision in *American Meat Institute*. *See* 760 F.3d at 23. Finally, the Ninth Circuit’s decision in *American Beverage Association* is also readily distinguishable. That case did not involve disclosure rules regarding prices. Instead, it involved a San Francisco ordinance that forced soft-drink makers to include government-written warnings in their advertisements about the alleged health effects of their beverages. Because San Francisco required the warnings to occupy at least 20% of the space of the advertisements—thereby commandeering a significant portion of the companies’ message—the court found that these regulations were “unduly burdensome when balanced against [the] likely burden on protected speech.” 916 F.3d at 757. But that reasoning would have no application to regulations that merely required accurate disclosure of *prices*.

The trade associations argue that HHS’s transparency regulations serve no legitimate government interest because negotiated prices are so complex that public disclosure would merely lead to consumer confusion. *See* FAH Comments at 7 (arguing that disclosure of negotiated rates is “likely to confuse consumers”); AHA Comments at 15 (“the disclosure of negotiated charges between hospitals and health plans is more likely to *confuse* patients than to ameliorate any existing lack of information”). But the Supreme Court has rejected this “highly paternalistic approach” to

the First Amendment. *Virginia Bd. of Pharmacy*, 425 U.S. at 770. Rather than assuming that consumers will be confused by too much information, the First Amendment assumes “that people will perceive their own best interests if only they are well enough informed, and that the best means to that end is to open the channels of communication rather than to close them.” *Id.* As between “the dangers of suppressing information” or “the dangers of its misuse if it is freely available,” the First Amendment counsels in favor of openness and transparency. *Id.* In sum, the government has no legitimate interest in any policy that “rests in large measure on the advantages of [the public] being kept in ignorance.” *Id.* at 769.

#### **IV. Negotiated Prices Are Not Confidential Trade Secrets, And Gag Orders Or Confidentiality Clauses In Providers’ Contracts Pose No Obstacle To Implementing Price Transparency.**

The trade associations further contend that the transparency regulations would require the disclosure of trade secrets or confidential commercial or financial information. *See* FAH Comments at 6-7 (arguing that “[p]ayer-specific negotiated rates are a paradigmatic example of confidential commercial or financial information” and are “confidential trade secrets that derive value from not being known to competing providers and payers”); AEH Comments at 22 (“The charges negotiated between hospitals and health plans are confidential trade secrets.”); AHA Comments at 16-17; AHIP Comments at 11.

Those arguments fail at the outset for the simple reason that this information is not “confidential” or “secret” at all. Each time an insured patient uses a service from a health care provider, that patient later receives an “explanation of benefits” from the insurer showing the amount billed by the provider, the amount paid by the insurer, and any amount that is the responsibility of the patient. *See* Final Rule at 214 (noting that “[t]he payer-specific negotiated charge is a critical data point found on a patient’s EOB”); Final Rule at 83 (rather than being a trade secret, negotiated price information “is already generally disclosed to the public in a variety of ways, for example, through State databases and patient EOBs”). In short, the insurer sends the patient billing information that explicitly lists the negotiated charges between the provider and the insurer.

That disclosure is fatal to any claim that negotiated price information is a trade secret. “The single most important requirement of the trade secret law is the obvious one which deserves continuous emphasis—that *the trade secret must in fact be secret*. Without satisfying this condition precedent, all other requirements of the trade secret law become irrelevant.” Jager, Trade Secrets Law §5:15 (Oct. 2019) (emphasis added). Although insurers and hospitals may not publish full lists of their negotiated prices, those prices are sent every day to tens of thousands of patients who use the relevant services when they receive bills or explanations of benefits. Given those disclosures, the trade associations cannot plausibly contend that their pricing information attains the full protections that apply to trade secrets. For the same reasons, the trade associations are wrong to suggest that mandating disclosure of negotiated prices would result in a taking of private property without just compensation. *See* AHIP Comments at 12-13. That argument is premised on the incorrect assumption that negotiated prices are trade secrets and is wrong for the reasons noted above.

The trade associations have further argued that federal price transparency rules are unlawful to the extent they require the disclosure of price information that is deemed confidential under a contract between hospitals and insurers. *See* AHIP Comments at 11 (“hospitals are often contractually obligated to protect [negotiated rates] from disclosure”). Those contracts often contain gag orders providing that the negotiated prices for certain services must be kept confidential; those confidentiality clauses may also apply to employers who contract with the health insurers for coverage.

Any self-imposed gag orders or confidentiality clauses pose no obstacle to federal price transparency regulations. All contracts “must necessarily be regarded as having been made subject to the possibility that, at some future time, Congress might so exert its whole constitutional power in regulating interstate commerce as to render that agreement unenforceable, or to impair its value.” *Louisville N. & R. Co. v. Mottley*, 219 U.S. 467, 482 (1911). That is, “contracts must be understood as made in reference to the possible exercise of the rightful authority of the government, and no obligation of a contract can extend to the defeat of legitimate government authority.” *Id.* The Supreme Court has emphasized that it would be “inconceivable” that the federal government’s authority “may be hampered or restricted to any extent by contracts made between individuals or corporations.” *Id.* In short, “parties cannot remove their transactions from the reach of dominant constitutional power by making contracts about them.” *Norman v. Baltimore & O. R. Co.*, 294 U.S. 240, 308 (1935).

The Supreme Court has applied those general principles in countless contexts. In *Norman*, the Court held that “gold clauses” in private contracts were invalid to the extent they interfered with federal power to regulate the currency and establish a monetary system. *Id.* at 311. Similarly, a contract between a shipper and a common carrier for transportation at certain rates is invalid if federal regulators have prescribed different rates, *even if the rates were lawful when the contracts were made.* *Id.* at 308; *see also New York v. United States*, 257 U.S. 591, 600-01 (1922); *United States v. Village of Hubbard*, 266 U.S. 474, 477 (1925); *Armour Packing Co. v. United States*, 209 U.S. 56, 80-82 (1908). And, in the antitrust context, “no previous contracts or combinations can prevent the application of the Sherman Act to compel the discontinuation of illegal combinations.” *United States v. Southern Pac. Co.*, 259 U.S. 214, 234-35 (1922).

These cases foreclose any suggestion that federal price transparency regulations can be evaded through private confidentiality clauses or gag orders. Federal regulations carry the same “force of law” as federal statutes, and federal agencies have the power to promulgate “binding legal rules” pursuant to their statutory grants of authority. *See Mayo Foundation for Medical Educ. & Research v. United States*, 562 U.S. 44, 57 (2011). Price transparency regulations would thus take precedence over any contractual gag orders to the contrary.

## **V. The FTC’s 2015 Blog Post And Letter Provide No Basis For Opposing The Proposed Transparency Regulations.**

The trade associations—powerful incumbents who dominate the health care sector—also argue that price transparency would facilitate collusion by allowing providers to see the prices that competing providers are charging. *See* FAH Comments at 6, 8-10 (arguing that disclosure of

negotiated rates is “very likely to be considered anticompetitive”); AHIP Comments at 8-10 (arguing that transparency will likely lead to higher prices); AEH Comments at 22-23.

In making that argument, the associations rely heavily on a [2015 blog post](#) and [letter](#) from the Federal Trade Commission. At the outset, those materials merely reflect staff-level guidance—they do not purport to reflect the authoritative views of the full Commission and should thus be entitled to little deference beyond their persuasive force. *See United States v. Mead Corp.*, 533 U.S. 218, 230 (2001) (agency action generally eligible for deference only when promulgated through “a relatively formal administrative procedure” such as “notice-and-comment rulemaking or formal adjudication”).

In all events, the FTC’s 2015 blog post and letter have minimal persuasive force and should pose no meaningful obstacle to implementing price transparency. This analysis suggests that disclosure of negotiated fee schedules could lead to collusion or coordinated pricing. But that argument proves far too much, as it would justify suppression of price information in other industries as well. Gasoline stations, airlines, retailers, and countless other businesses prominently advertise their prices—notwithstanding the potential for collusion or coordination—so there is no reason to believe that disclosure of health care prices will lead to rampant collusion. Indeed, collusion and price-fixing are criminal violations of the federal antitrust laws, so it should not be lightly assumed that disclosure of prices will lead health care providers to enter into criminal conspiracies to fix prices. And, in the event that collusion among health care providers does occur, it can be addressed by the FTC, DOJ, and private litigants through the Sherman Act or FTC Act—just as in all other industries.

Contrary to a key assumption of the 2015 blog post and letter, there is no legitimate government interest in keeping consumers in the dark merely because they might be confused or overwhelmed by too much information. Rather than assuming that consumers will be confused by too much information, our Constitution assumes “that people will perceive their own best interests if only they are well enough informed, and that the best means to that end is to open the channels of communication rather than to close them.” *Virginia Bd. of Pharmacy*, 425 U.S. at 770. As noted above, in *Virginia Board of Pharmacy*, the Supreme Court struck down under the First Amendment a state law that barred pharmacists from advertising their prices. The Court reasoned that the government has no legitimate interest in any policy that “rests in large measure on the advantages of [the public] being kept in ignorance.” *Id.* at 769.

Perhaps the clearest sign that the FTC’s analysis would hinder, rather than promote, competition is the fact that it is now being cited by the hospitals and health insurers in an attempt to maintain the dysfunctional status quo. The FTC’s mission is supposed to be the protection of *consumers* and *competition*. *See* <https://www.ftc.gov/about-ftc>. It is thus surprising and counterintuitive that powerful interests with a vested stake in the current system are pointing to the FTC’s analysis in an attempt to advance their own parochial interests and to stifle transparency and much-needed price competition. *Cf. North Carolina State Bd. of Dental Examiners v. FTC*, 135 S. Ct. 1101, 1114 (2015) (noting the “structural risk of market participants’ confusing their own interests with the State’s policy goals”). The FTC’s 2015 staff-level discussion of the effects of price transparency has little persuasive force and should not be used to obstruct critical market-based reforms in the health care sector.

Finally, nothing in the FTC’s analysis suggests that there would be any competitive concerns with requiring hospitals or providers to publicly list their *cash* prices for patients who self-pay. As noted above, research has shown that there is increasing competition among providers for walk-in customers who simply pay upfront for services that they believe provide the best value. In that situation, the FTC could not seriously contend that price transparency would hinder competition. Transparency requirements for cash-paying customers (such as the requirement in HHS’s final rule that hospitals provide a list of discounted cash prices for walk-in customers) are no different from requiring businesses in any other sector of the economy to post their retail prices for each product or service. Those are paradigmatic examples of pro-competitive, rather than anti-competitive, regulations that allow consumers to make informed choices and thereby invite robust price competition.

## **VI. The Trade Associations’ Practical Objections Are Misplaced.**

The trade associations also object to what they call the “operational challenges” of implementing the transparency regulations. *See* AHIP Comments at 13-15; AHA Comments at 20-22; FHA Comments at 10-15. At the outset, this objection gets things backwards: the transparency regulations are intended to shine light onto the convoluted and byzantine pricing practices of the health care industry, so the industry should not be able to object to these rules based on that very same complexity. Complexity in pricing is the *problem to be solved*, and should not be used as an excuse to block the implementation of regulations that would promote simpler and more streamlined pricing for patients.

In all events, as HHS explained, hospitals likely “face only a limited burden to make publicly available these types of standard charges because good business practices necessitate that these charges be available, maintained, and in use in hospital billing and accounting systems.” Final Rule at 65. Moreover, the trade associations’ complaints about complexity ignore the dynamic and highly adaptive technology sector (often backed by venture capital or private equity resources) that would have little difficulty operationalizing the relevant data. In virtually all areas of commerce—including “complex” transactions such as buying a home or car—online tools facilitate customers’ ability to comparison shop and obtain the best products or services at the best prices. There is no question that the same services would become available in the health care sector *once the relevant raw data is available* about options and prices—especially given the size of this market and the massive amounts of money at stake. Indeed, some companies (such as Clear Health Costs) are already beginning to offer this information for cash prices, and these technologies will only continue to improve as more data about pricing becomes available.

Again, if the complexity of pricing could be used as a justification for avoiding transparency obligations, then the effect would be to maintain the status quo in perpetuity, to the detriment of patients and consumers and to the benefit of powerful incumbents. We applaud HHS’s decision to finalize the transparency regulations and look forward to working with HHS to implement and expand these critical reform measures.



## APPENDIX I UmpScores App Screenshots

**Umpire**  
**Lance Barksdale**  
 #23 | A: 52 | E: 15  
 Rating: ★★★★★  
 Crew Rank: 13/19

2019 Summary      Historical Stats

Season	Bad Call Ratio™	CCBC
2019	8.35	81
2018	8.05	74
2017	8.82	86
2016	10.02	81
2015	9.80	77
2014	10.59	105
2013	10.73	106

**Rankings**

2019  
 Full-time

Name	BCR™	BCPG	BCPI
Pat Hoberg	6.92	10.43	1.16
Will Little	6.97	10.86	1.21
Tripp Gibson	7.55	11.68	1.30
Alan Porter	8.20	12.53	1.39
John Tumpane	8.20	11.96	1.33
Chad Fairchild	8.24	11.97	1.33
Jordan Baker	8.25	12.61	1.40
Mark Ripperger	8.27	12.55	1.39
Chris Conroy	8.28	12.38	1.38

**Umpire**  
**Lance Barksdale**  
 #23 | A: 52 | E: 15  
 Rating: ★★★★★  
 Crew Rank: 13/19

2019 Summary      Historical Stats

Status: Full-Time

Bad Call Ratio™: 8.35%

BCR™ Rank: 11/76

BCPG: 12.31

BCPI: 1.37

Favors: Pitcher (slider)

Call Consistency: High (slider)

**Umpire**

Pitches Called: 4,278

HP Appearances: 29

Game Length Avg: 3 hrs 3 min

Crew: S

Best Month: August

Worst Month: May

Best Season: 2018

Best Game Time: Night

Best Weather: Drizzle

Best Park: Great American Ball Park (OH)

Worst Park: Angel Stadium (CA)

**Umpires**

Search for umpires...

Sort by

- Sean Barber (#29)
- Lance Barksdale (#23) Crew: S
- Ted Barrett (#65) Crew: S
- Lance Barrett (#94) Crew: O

**UmpScores**

- GAMES
- UMPIRES
- RANKINGS
- UMP FACTS

## APPENDIX J

### Price Transparency in Health Care: MYTHS v. FACTS

**MYTH 1: Price transparency won't lower prices – it might even cause patients to choose the highest priced service thinking that it's the best.**

**FACT:** All the published data show the opposite. Transparency almost always leads to at *least* modest savings. The amount of savings are directly associated with the presence and extent of incentives that are given to patients to use the information. When employers or plans offer zero/low cost-sharing for high-value care, or share savings with patients, uptake in usage of the tools increases significantly.

New Hampshire launched a crude public price transparency tool in 2007 (displaying just average prices), and on one category of services alone (imaging), patients saved almost \$8 million and other payers (employers and taxpayers) saved \$36 million over a five-year period. By year 5, out-of-pocket costs for consumers had dropped by 11%, and for people with deductibles, they saw almost double that in savings.<sup>17</sup> Those are good results among the general public. But the state took it a step further for its own state employees by creating an incentive program that provided financial rewards to employees who used the transparency tool to choose higher-value care. Within three years, the program has saved \$12 million and paid out \$1 million to employees. 90% of enrollees have used the tool, and 2/3 of them repeat shop and save each year, saving on average over \$600 each time they use the program. In 2015 alone, the program produced a 13:1 return on investment.<sup>18</sup> Kentucky started paying state employees shared savings incentives to use a price-shopping tool in 2013 and the state's taxpayers saved more than \$13 million, and the enrollees themselves received almost \$2 million in incentive payments.<sup>19</sup>

Some studies found that price transparency reduces prices by 10-17%<sup>20</sup>, up to 14%<sup>21</sup>. Other results are more modest when financial incentives are not provided to patients to shop, but they are never zero.<sup>22</sup> With health care consuming a fifth of the economy, even the most modest results could make a huge difference. Employers who use "steering," that is, incentivizing enrollees through zero cost sharing for using the lower-cost, high-quality providers, save on average double digits in the first year, and up to 60% several years in.<sup>23</sup>

**MYTH 2: Patients don't need prices because health care is different – the third party system means that patients don't really shop when they need care.**

**FACT:** Every time tools are made available to patients that align price transparency with incentives for choosing higher value care, patients do in fact shop and they choose higher value care, often saving millions for themselves and their employer.

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<sup>17</sup> <https://revcycleintelligence.com/news/healthcare-price-transparency-in-nh-reduced-out-of-pocket-costs>

<sup>18</sup> [https://comm.ncsl.org/productfiles/83101945/Costs5\\_FGA-Forbes-Shop-LS16.pdf](https://comm.ncsl.org/productfiles/83101945/Costs5_FGA-Forbes-Shop-LS16.pdf)

<sup>19</sup> <https://thefga.org/research/kentucky-health-care-savings-vitals-smartshopper/>

<sup>20</sup> <https://pubs.aeaweb.org/doi/pdfplus/10.1257/pol.20150124>

<sup>21</sup> <https://jamanetwork.com/journals/jama/articlepdf/1917438/joi140130.pdf>

<sup>22</sup> <https://www.sciencedirect.com/science/article/pii/S0167629618310476>

<sup>23</sup> Chase, Dave (2017). *CEO's Guide to Restoring the American Dream*. Seattle, WA. Health Rosetta Media, p. 81.

<sup>24</sup> <https://revcycleintelligence.com/news/healthcare-price-transparency-in-nh-reduced-out-of-pocket-costs>

paid out \$1 million to employees. 90% of enrollees have used the tool, and 2/3 of them repeat shop and save each year, saving on average over \$600 each time they use the program. In 2015 alone, the program produced a 13:1 return on investment.<sup>25</sup> Kentucky started paying state employees shared savings incentives to use a price-shopping tool in 2013 and the state's taxpayers saved more than \$13 million, and the enrollees themselves received almost \$2 million in incentive payments.<sup>26</sup>

The retiree health program for California public employees (CalPERS) started using price transparency to develop reference prices in their benefit design. Providers quickly responded by lowering prices to compete for enrollees.<sup>27</sup> The system saw a 9-14 point increase in enrollees using the more competitively-priced providers<sup>28</sup>, and an overall reduction in prices by 17-21%.<sup>29</sup>

Each of these examples, and dozens more from both public sector and private employer experiences with transparency initiatives within an insurance plan, proves that the third party system does not have to be a barrier to consumerism. When purchasers of care have incentives, through benefit design and cost-sharing structure that reward higher-value care, enough people respond to those incentives to deliver meaningful price reductions.

This trend will expand, particularly led by millennials, the largest generational cohort in the U.S., 51% of whom surveyed by United Healthcare shopped for care online.<sup>30</sup>

### **MYTH 3: Patients only need to see their own out-of-pocket costs, not the full contracted rate for all payers made public.**

**FACT:** First, patients are bearing the entire cost of care out-of-pocket, due to the increase in deductibles over time. On exchange plans, deductibles can be as high as \$10,000. Employer-sponsored deductibles have tripled in the past 10 years.<sup>31</sup>

Second, employee share of premiums is very often the highest or second-highest out-of-pocket cost for patients. also out-of-pocket costs, and high priced care is what has driven and is continuing to drive premiums for Americans through the roof.

At the time of service, depending on the patient's deductible status, an over-priced claim may not be entirely paid by the patient, but if not, it's paid by the self-insured employer or the issuer for fully-insured plans. That cost history is what's used to determine premium rates the next year. So high prices on the total health service, regardless of the patient's immediate out-of-pocket share of that price, affects that patient's out-of-pocket exposure through premium hikes the following year.

We see this phenomenon with painful clarity in the fact that exchange premiums doubled in the first five years of ACA implementation, such that almost everyone who isn't eligible for federal subsidies has fled this unaffordable marketplace. Employer-sponsored plans are also unaffordable - premiums have increased 55% in the past decade.<sup>32</sup> The number one driver of premium hikes each year are increasing prices –

<sup>25</sup> [https://comm.ncsl.org/productfiles/83101945/Costs5\\_FGA-Forbes-Shop-LS16.pdf](https://comm.ncsl.org/productfiles/83101945/Costs5_FGA-Forbes-Shop-LS16.pdf)

<sup>26</sup> <https://thefga.org/research/kentucky-health-care-savings-vitals-smartshopper/>

<sup>27</sup> Robinson CR, Brown TT, Whaley C. Reference pricing changes “choice architecture” of healthcare for consumers. *Health Aff.* 2017;3:524-530. doi: 10.1377/hlthaff.2016.1256.

<sup>28</sup> Ibid.

<sup>29</sup> Reforming America's Healthcare System Through Choice and Competition, U.S. Department of Health & Human Services, U.S. Department of the Treasury, U.S. Department of Labor, Dec. 3, 2018. <https://www.hhs.gov/about/news/2018/12/03/reforming-american-healthcare-system-through-choice-and-competition.html>

<sup>30</sup> <https://newsroom.uhc.com/consumer-sentiment-survey-2018.html>

<sup>31</sup> <https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-executive-summary/>

<sup>32</sup> <https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-executive-summary/>

hospital prices increased 42% between 2007-2014<sup>33</sup>, and drug prices have increased more than the rate of inflation for each of the last 10 years.<sup>34</sup> It's these increasing prices driving up the premiums, not alternative explanations such as increased utilization (which has stayed largely flat or decreased<sup>35</sup>) or underlying costs of care (refuted by the fact that self-paying cash prices for most services have stayed relatively stable<sup>36</sup>).

**MYTH 4: Public transparency isn't necessary, as long as patients have access to the prices on their own plans.**

**FACT:** Without the ability to compare the prices offered under their own plan versus other plans, patients and their employers have no way to know whether their plan is giving them the best deal. What's more, there are a number of situations where the cash price of certain health care services is less expensive than the patient's share of the insurance-contracted rate.<sup>37</sup>

**MYTH 5: Health care prices are trade secrets, proprietary between providers and insurers.**

**FACT:** In every other business, the final price that a consumer pays for each item or service, or a bundled package of them, is not considered a trade secret – our economy would collapse if this maxim were applied to other services and products. Insurers and providers often argue that their contracted rates are proprietary information. But they provide that information to every patient, millions of times a day, *after* the patient is already on the hook financially, in the form of an Explanation of Benefits. Patients are under no obligation to protect that information, indeed, it's considered by HIPAA to be part of their own health information to which they have an absolute right. They certainly could post it on Facebook or publish it on a web site with legal impunity if they so chose. Policies promoting price transparency merely demand that patients have access to this exact same information *before* they're on the hook for it.

**MYTH 6: If patients see prices, they'll be scared to get care they really need.**

**FACT:** Patients shouldn't have to choose between avoiding financial ruin and health care. But the solution to this Sophie's choice isn't to trick patients into getting care they can't afford by hiding upfront prices. A key reason why prices are so financially ruinous in the first place is precisely because they *can* be – because of this deceptive, after-the-fact surprise attack billing strategy. What's more, patients who experience a ruinous bill after the fact for a routine procedure might just learn that they should avoid care, even when that care is not routine but lifesaving. Further, this argument conveniently protects providers, sworn to do no harm, from having to admit the financial harm they're inflicting on patients and competing openly and honestly for their business on the basis of price and quality. Practice standards require providers to tell patients up front about the clinical risks of procedures they're about to undergo, sometimes even requiring that patients signing off in writing that they have been so advised. Why should the financial risks of the procedures be exempted from this disclosure? Providers worried about the good of their patients should make sure that their prices are fair and affordable in the first place rather than ambushing patients with catastrophic costs after it's too late or a patient to object, negotiate or shop elsewhere.

<sup>33</sup> <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05424>

<sup>34</sup> <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05147>

<sup>35</sup> [https://www.healthcostinstitute.org/images/easyblog\\_articles/276/HCCI-2017-Health-Care-Cost-and-Utilization-Report-02.12.19.pdf](https://www.healthcostinstitute.org/images/easyblog_articles/276/HCCI-2017-Health-Care-Cost-and-Utilization-Report-02.12.19.pdf)

<sup>36</sup> <https://clearhealthcosts.com/blog/2017/03/cash-prices-stay-level-overall-costs-continue-rise/>

<sup>37</sup> <https://www.latimes.com/business/healthcare/la-fi-medical-prices-20120527-story.html>

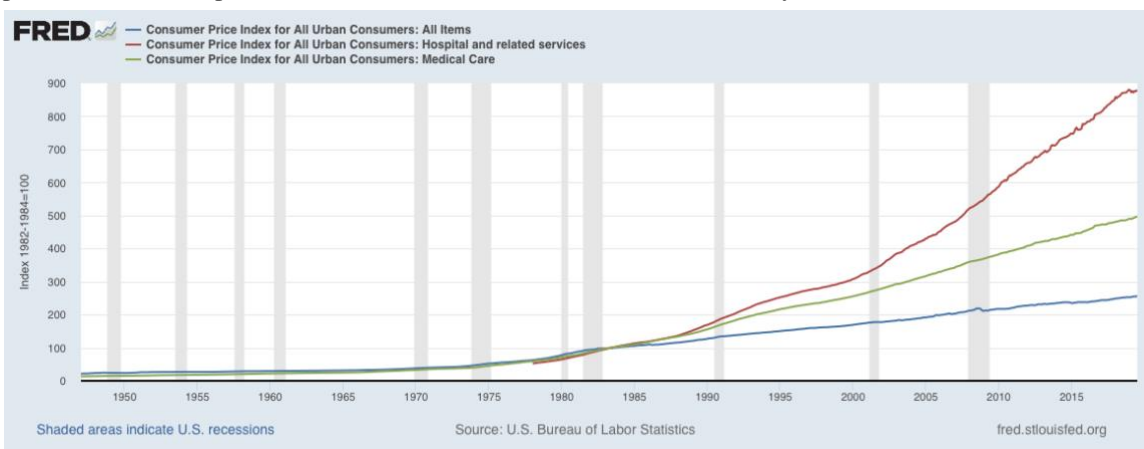
**MYTH 7: Transparency will lead to higher prices because not every provider can afford to give their lowest price to all payers, and so they'll raise prices for some payers (usually the ones with the most volume, that is, the most patients).**

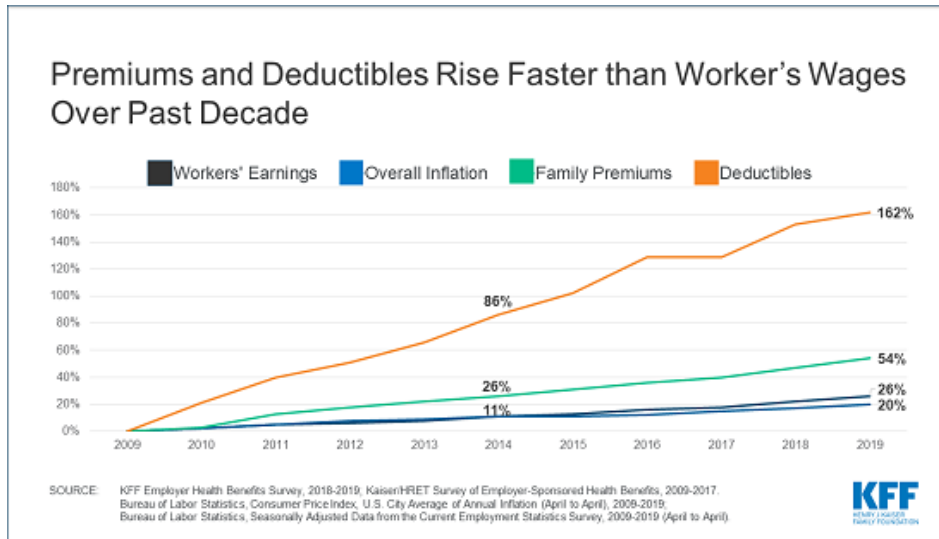
**FACT:** Americans understand volume discounts, and if the bigger “discounts” off the bloated sticker prices received by some insurance companies are due to high volume, providers should have nothing to fear from openly disclosing that fact. On the other hand, certain insurance companies are getting price “concessions” from providers due to less justifiable reasons, such as anti-competitive gag clauses, anti-steering clauses, best-price guarantees, and other reasons that run counter to the interests of patients, their employers, and other purchasers of care. Price transparency exposes that the “discount” is really just an anti-competitive pay-off for steering patients to those high-priced provider systems rather than lower-cost alternatives.

Independent of anti-competitive practices, it is true that a law of economics is that price competition will lead to convergence around a competitive price for services of similar quality. In other words, the staggering and irrational variability in prices for health care that leads to massive gouging of patients and other payers, will end. Sellers of care will then start to compete not only on price, but also on quality, convenience and other factors to differentiate themselves in the marketplace - just like in every other business.

**MYTH 8: Transparency will lead to higher prices because providers have been offering lower prices out of fear that their competitors were undercutting them. Once they see that their competitors charge more than they do, they'll raise their prices to match.**

**FACT:** If this were true, we would expect to see a race to the bottom in health care prices, as hospitals and insurance companies scramble to undercut each other, not knowing if the other guy down the street is offering a lower price. Instead, growth in prices for health care has outpaced inflation every year in recent memory, especially for hospitals. See graphs below comparing the annual price increases for all goods/services compared to medical care, including hospitals, and another graph showing how insurance prices (as shown in premiums and deductibles over time) behave similarly.





**MYTH 9: Transparency will lead to higher prices because providers will engage in anti-competitive collusion to fix prices at a higher rate than they're offering now.**

**FACT:** Sure, some providers, upon seeing the prices of their competitors, could call up those competitors and plot to all offer the same price. Of course, that would be illegal collusion under our current anti-trust law. This argument is like saying that glass storefronts facilitate looting by tempting looters with a better view of what they might steal. The solution is to enforce laws against stealing and looting, not paint every window black. Under this logic, we should end the public display of prices at grocery stores, movie theaters, real estate listings and every other industry, because it might just facilitate illegal price-fixing among the sellers of these products. By the way, health care providers and health insurers, are incredibly sophisticated market actors. They already know what their competitors charge.

**MYTH 10: Health care prices are too complex for patients to understand and respond to rationally.**

**FACT:** Americans engage in complex commerce all the time, including comparing and choosing cell phone plans, trading stocks, buying and selling houses, comparing cable TV bundles to streaming options, selecting car insurance and then figuring out when and when not to use their insurance for repairs, and more. While all Americans might not use transparent price information, enough of them will. What's more, employers and others who have influence over patients' health care decisions will be able to use the information to design benefits, including cost-sharing, reference pricing, and formularies around that information. In this way, they could help patients make high-value decisions without having to independently analyze all the information themselves.

An example would be a self-insured union retiree health plan that uses price transparency in to analyze the prices of imaging centers. Some are contracted with the union plan, some aren't. But even the out-of-network centers would have price variation around them. The union plan could then offer zero cost-sharing for lower cost MRIs at freestanding imaging centers, compared to a \$100 copay for the pricey hospital-based center, regardless of network status. Patients wouldn't have to analyze the prices of each center, they would just respond to the simpler decision between copay or no copay.

By the way, this strategy would mean that network status wouldn't matter nearly as much, just the price and quality of the provider. Over time, the union would rely on the insurance company's network negotiations less and less, and instead steer patients on the basis of transparent price and quality rather than

network status of providers. This would increase the union's ability to cut the middleman insurance plan out altogether and save enrollees even more.

**MYTH 11: Most health care is essential and emergency. Patients can't shop when they're in pain or unconscious.**

**FACT:** The vast majority of health care services are routine or elective (meaning, they're scheduled in advance and not emergencies). Fewer than half of all hospitalizations originate from an ER visit.<sup>38</sup> More than 70% of emergency room visits could be treated in a different setting, such as an urgent care or outpatient clinic. ER spending accounts for only 6% of all health care spending.<sup>39</sup> Given these numbers, it would seem that most care is not the sort where a patient is utterly incapable of making judgments about where to receive care. Given how few ER visits are actual emergencies, it's even likely that many patients who visit the ER are aware that their condition isn't a life-threatening emergency, and are choosing the ER for other reasons, such as cost (you don't have to pay before being treated), or convenience (24-7 access).

When health plans or their plan sponsors design benefits to give patients an incentive to use non-ER settings when appropriate, such as round-the-clock, zero-cost nurse lines or telemedicine, low-cost urgent care, walk-in or same-day primary care appointments, nurse midwives or chronic disease health coaches, ER visits have been shown to decrease and health outcomes improve. Even in cases of urgent conditions that do require an ER visit, most patients are conscious and able to make choices about which ER they prefer. In cities where there is more than one option and the situation is emergent but not life-threatening, such as broken bones or unmanaged pain in cancer patients, there is evidence that patients often choose to visit the hospital where their specialists have privileges or which are closer to their home, even if that is not the closest ER from where they're starting.

**MYTH 12: Most patients just go where their doctor refers them.**

**FACT:** Sure, because patients have very little other information with which to make judgments other than a doctor's referral. Before Yelp, Amazon reviews, Consumer Reports or Kelley Bluebook, customers for many other types of goods and services also only relied on word-of-mouth from trusted friends and authorities, such as their mechanic (for car purchases) or a chef friend (for restaurant recommendations). With the introduction of online shopping to obtain price information and crowd-sourcing tools such as Yelp and Kelley Bluebook to compile quality information, consumers are less likely to just take one friend's word for it. This is especially true for homogenous services such as lab tests.<sup>40</sup> Relying solely on word-of-mouth persists only in markets where reliable price and quality information is not otherwise available.

It is true that, even as other tools become available, a doctor's referral is still one of the most powerful steering tools for patients, because of the trust relationship between doctor and patient. That is why, when price and quality information is baked into the referral work-flow, doctor referrals are one of the best ways to help patients find their way to high-value care. Innovative employers have found ways to harness the steering power of physicians by using on-site or near-site clinics, direct contracts and Centers of Excellence for specialist and complex care, with payment structures for providers that align physician referrals with the patient and employer goals of lower cost and high quality care. These models have shown double digit savings, with equal or usually better health outcomes.

<sup>38</sup> Morganti KG, et al. The Evolving Role of Emergency Departments in the U.S. 2013. RAND., p.4.

<sup>39</sup> Lee MH, Schuur JD, Zink BK. Owning the cost of emergency medicine: beyond 2%. *Ann Emerg Med.* 2013;62(5):498-505.

<sup>40</sup> <https://www.sciencedirect.com/science/article/pii/S0167629618310476>

**MYTH 13: Employers already have price information and they're the main consumers anyway – patients don't need it.**

**FACT:** Although self-insured employers pay all the claims for their workers, they do so through a third-party administrator (TPA), usually one of the major health insurance companies, who serves as the claims processor and help to administer the plan, manage open enrollment, and so forth. These TPAs have every incentive to keep employers in the dark about the prices they pay, because revealing prices in a timely fashion would enable employers to evaluate whether their administrator is a good deal and to solicit better offers. TPAs often throw out the canard that HIPAA prevents the employer from seeing their own claims. What's more, almost all insurance brokers, who sell themselves as the buyer's agent, are actually paid by insurance companies to renew the employers' plan, and they receive large end-of-year bonuses, usually undisclosed to their clients, if they deliver a certain size book of business to a particular insurance company. In other words, they market themselves as a buyer's agent, but they are actually merely the marketing department and sales force for insurance companies. As such, the majority of these employers have trouble overcoming the barriers and bureaucracy erected by these middlemen to prevent them from analyzing their own costs effectively, comparing prices between plans, between providers, understanding the types of care that drive premiums up each year, and so forth.

For all these reasons, most self-insured employers are not actively managing their costs, or even aware of the facts and patterns driving their skyrocketing claims each year. They often do not know about the staggering price and quality variability between different hospitals and other providers in their area and the amount of savings and better clinical outcomes that could be achieved by steering workers to the highest-value care. Those employers that do want to make these changes must fight to overcome the obstacles erected by the middlemen who benefit from keeping their clients in the dark, and then they must have the HR bandwidth to be able to analyze and make actionable intentionally complex and technical data.

Transparent price information for all providers and all payers would allow easier analysis by an employer's HR department. What's more, it would allow apps and other tech innovators to scrape up all the complex data, analyze it for employers (and patients) and present it in clearer and more actionable ways so that employers don't need to be actuarial scientists in order to identify the best deal for their workers.

Self-insured plans are regulated by ERISA, which requires that plan trustees – the employers themselves – manage the plan assets, that is, the premium revenue and expenditures prudently and solely in the interest of the beneficiaries. Courts have suggested that this fiduciary duty is of the highest possible standard of prudent stewardship. Employers not only have the right to pricing data, they have the absolute obligation to know it and use it to benefit their workers.

**MYTH 14: Showing all prices for all payers is a massive regulatory burden on providers and insurance companies.**

**FACT:** Providers and issuers already have price information, as parties to the pricing contracts with each other, and they transmit it electronically as part of the claims process millions of times a day. For self-paying patients, they know the cash price that they charge patients, because they manage to find a way to bill those patients later.

“It's hard” or “but, complexity” is no excuse to continue hiding prices from the purchasers of care. Issuers and providers have weaponized their pricing complexity against patients and employers for too long. The fact that pricing schemes are too complex for normal people to understand only serves the sellers of care and not the buyers. Nobody is holding a gun to the head of insurers and providers and forcing them to create an irrational, indecipherable and indefensible pricing scheme. The proposed transparency requirements will reward market actors who simplify and rationalize their pricing structures, and will disadvantage those whose pricing structures serve to keep purchasers of care in the dark – that is, it will disadvantage those responsible for the total market failure in health care. The proposed requirements will



finally equalize the power of the purchasers of care, who for too long, have been victims of the asymmetric, secrecy-enabled market power of the sellers of care, that is, the insurers and providers.

**MYTH 15: Price transparency is impossible when you don't know which services a patient will need in advance.**

**FACT:** Saying that hospitals can't tell patients prices upfront because they don't know the specific combination of services a patient might receive is tantamount to a restaurant refusing to show customers a menu because they don't yet know what the customer will order or what coupons they'll bring with them.

Customers face this type of business transaction all the time in other industries and it creates no impediment in those industries to providing upfront price lists, even in the face of uncertainty about the exact combination of services that will be provided. Industries like this include law, body shops (who also have separate prices for different insurance companies), consultants, graphic designers, plumbers, general contractors, and others who combine hourly labor rates with add-ons for certain projects and parts/equipment. Health care is not unique in this way and its practitioners deserve no special exemption from disclosing to consumers their prices.

**MYTH 16: Rural hospitals will have to shut their doors, because they won't be able to offer competitive prices in a transparent world.**

**FACT:** From a fairness standpoint, patients receiving care in a rural hospital are just as deserving as all other patients to know how much services costs ahead of time, especially if they are expected to pay a portion of those prices in the form of cost-sharing. Those with chronic conditions need to stay engaged in seeking value, regardless of the location where they receive care, otherwise they may forgo medically necessary care.

Some may argue that real price transparency may reveal that certain "vulnerable" institutions are not price competitive. While that may be true for some services, extensive experience at the state level shows that many community, safety-net or rural facilities are excellent values and price competitive. In fact, real price transparency is an opportunity for these facilities to attract additional higher reimbursing privately insured patients seeking high-value care whose plans will pay more than the publicly-funded Medicaid and Medicare programs that many of these facilities so heavily rely on now. What's more, with the movement among employers toward incentivizing enrollees to select higher-value providers, such as with lower cost-sharing or even incentive payments, reasonably-priced rural hospitals that could benefit from price transparency, attracting new business from employers who discover their competitiveness and steer patients toward them with financial incentives.

**MYTH 17: Price transparency turns insurers and providers into fee-for-service commodity traders – they should be able to compete for business by designing unique products instead.**

**FACT:** Price transparency actually helps businesses compete on quality and convenience, because it exposes exactly what patients get for a price. If an insurer or a hospital wants to make the case that it's offering the best value for patients because of the uniqueness of its product offering, price transparency will only validate that for consumers when they compare prices of competitors who are not offering those bells and whistles.

Medicare Advantage and Medicaid Managed Care offer a useful illustration of this principle. Actual allowed costs for health care services or coverage are set by formula by the government for all providers. The only differentiator is the additional package of offerings the plans create to serve patients. They manage to do this successfully – so much so that most American seniors can choose among several dozen

Medicare Advantage plans. Price transparency allows for an even more vibrant and competitive marketplace – by allowing for *different* prices for the same services AND the diversity of offerings. Plans and providers will have to actually design products that appeal to consumers on the price and offerings that meet their needs.

**MYTH 18: Price is not the most important, quality is.**

**FACT:** *Value* is the most important. Value is the unique combination of price and quality that meets a consumer’s needs. To allow for consumers in a market to assess value, they must have both. And by the way, we don’t have quality transparency either, so this isn’t an either-or, we need both!

**MYTH 19: Hospitals need higher reimbursement rates from insurance companies than do independent facilities to run 24-hr emergency rooms, research and training, and to treat uninsured patients.**

**FACT:** Hospitals have a number of federal funding streams designed precisely to compensate them for those costs, including the CMS uncompensated care payment, 340B program (for safety net hospitals), DSH (for hospitals who treat a disproportionate share of low-income people), GME (for training medical students), NIH (for research), CAH (critical access hospitals), and many, many more. What’s more, hospitals’ emergency departments generate more than 40% of their inpatient admissions, meaning the ER is actually a loss-leader for hospitals, generating revenue rather than net costs.<sup>41</sup>

There is often little relationship between prices charged by hospitals and the amount of uncompensated care or community benefit they provide. Recall the arguments for the ACA – covering the uninsured through subsidized exchange plans or Medicaid expansion would offset the cost of uncompensated care for hospitals and they would be able to lower their prices for commercial patients. Indeed, the amount of uncompensated care delivered by hospitals has dropped significantly since passage of the ACA. But prices in the commercial market have only gone up even more dramatically. Enough crying wolf – no amount of public funding to hospitals for any purpose has managed to prevent commercially insured patients from ever-increasing hospital prices.

The cost of training, research and uncompensated care is low compared to hospitals’ operating margins, which are over 8% on average, a figure that outpaces the profit of insurers, pharmacies and PBMs.<sup>42</sup> What’s more, residents at teaching hospitals make substandard wages and bill millions per resident for the hospital. They are not a cost center, they are a gold mine for academic medical centers.

Finally, this argument is not an argument against price transparency per se, it’s a preemptive defense against the embarrassment that price transparency will create when hospital gouging is exposed. If hospitals want to concede that they are gouging, but justify that gouging because they deserve more public funding to support the extra activities they perform, price transparency should actually help them make their case more effectively with policy makers and public opinion. Their resistance suggests that they know that exposing the truth about revenue, expenses, and prices would actually sway public opinion in the opposite direction.

**MYTH 20: Don’t some hospitals have such high quality that higher prices are justified?**

<sup>41</sup> Morganti KG, et al. The Evolving Role of Emergency Departments in the U.S. 2013. RAND., p.4.

<sup>42</sup> <https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/>

**FACT:** Is our quality science good enough to know if that's true? Without price and quality transparency, these are just unsubstantiated assertions. The only way to verify if prices are justified by quality is to be transparent about both and compete on that basis.

**MYTH 21: You can't have transparency in an ACO world.**

**FACT:** Actually, ACOs are based on transparency to the purchaser of care (though not the public). They don't bill on a fee-for-service basis, but their prices are still agreed to in advance by at least one of the purchasers (though not necessarily the patients). It is similar to the difference between paying for a cell phone plan on a subscription basis or on a pre-paid phone card basis. Most of us choose a bundle that includes a monthly price for a certain amount of data, texting and talk minutes, the cost of the phone, and so forth. This is like an ACO that includes total case management of a patient or population for a per member per month fee, or for a bundled price for a certain procedure and all its sequelae. Others prefer to purchase a phone and then buy minutes later with a pre-paid phone card (similar to the fee-for-service model in health care). Both models are fully transparent to at least the non-patient purchaser such as an employer, or government program. However, ACOs are not necessarily transparent to patients about the total cost of care, or their own cost-sharing, so transparency is still essential and possible in an ACO world.

Just like cellular phone companies post their prices if you choose a monthly subscription model or if you choose a pre-paid card on top of the cost of a phone, so providers who participate in both FFS and in ACO models can publish their different price structure for the different types of care, episode or bundle, or for patients who are part of an ACO.

**MYTH 22: Price transparency doesn't work in a consolidated market where there's one dominant health care provider system.**

**FACT:** Consolidated health systems often are formed by acquiring one hospital, facility or physician practice at a time, sometimes preserving unique pricing structures between that facility and insurance carriers. This means that prices can still vary between different entities within a single health system.

Price transparency actually creates a national or regional market and helps overcome local monopolies. The way this works is that patients can see lower-priced providers in the next town over, or even further away, and choose to travel, since most care is not an emergency. Alternatively, they can obtain the lower prices of a more distant provider and ask their local system to match that price in order to keep their business. An example of the game-changing competitive effect of price transparency is described in this [video](#) about the price-transparent Surgery Center of Oklahoma (SCO), where a patient in a consolidated market in Georgia took SCO's price to her local monopoly hospital and asked if they'd match it. They agreed to the price in order to keep her business – this is how you bust up a local consolidated market with national competition from price-transparent providers.

Disruptive startups like Carrum Health, Redirect Health, SurgiPrice, and SANO Surgery, Zero Card, and non-profit alliances of employers such as the Employer Centers of Excellence Network and The Alliance are all developing networks of direct contracts with price-transparent providers across the country. They offer those discounts to their customers or members, usually employers and other plan sponsors, who will often achieve major savings, even with covering travel and lodging for patients and their companion to visit these remote providers. Broad-based price transparency will facilitate even more of this disruptive competition in the face of local monopolies without needing a mediating startup or organization to facilitate that competition.

**MYTH 23: Self-insured employers don't have the wherewithal or the will to comply with the Tri-Department transparency proposed regulation.**

**FACT:** Self-insured group health plans are capable of complying with the proposed regulation and have long cried out for a fairer and more competitive health care market. They can enter into agreements with their third-party administrators or other expert vendors to comply with the requirements in the proposed regulation. The costs or burdens of compliance by self-insured employers are far less onerous than the grave costs and consequences of the broken status quo. What's more, plan sponsors have an ERISA fiduciary obligation to know and use price information, in order to manage plan assets solely in the interest of plan beneficiaries, including paying only reasonable fees to their plan's service providers. It's not good enough for plan sponsors to only see out-of-pocket costs, estimates or averages, or merely the price information from their current plans. They must be able to compare the deal they're getting now with the deal they could be getting from other plans. Real price information will help plan fiduciaries evaluate the performance and cost-effectiveness of their brokers, TPAs, PBMs and other vendors, as well as the provider network provided by their ASO/TPA. It's essential for plan sponsors, brokers, or other vendors serving self-insured employers to see prices paid by all payers to all providers if they are to effectively negotiate direct contracts, reference-based prices, reductions in balance bills and other essential tasks required to get high quality and lower cost care for plan beneficiaries.

The proposed rule includes a request for comment on whether the transparent price information should be made available by standard, open APIs rather than the monthly file-posting. APIs would make compliance easier, because third party innovators would be more easily able to scrape up the pricing information on behalf of self-insured employers, and present it to plan sponsors, patients and regulators with less effort and time.