September 27, 2019

Submitted Electronically Via Federal Rulemaking Portal: www.regulations.gov

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

Re: Medicare Hospital Outpatient Prospective Payment System for CY 2020

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the recently published Proposed Rule (the "proposal") regarding revisions to the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center payment system for CY 2020. [1] Our comments focus on the proposal's provisions that would establish requirements for all hospitals in the United States to publish hospital standard charges.

Pursuant to the Executive Order signed by the President on June 24th to improve price and quality transparency in American health care and to put Americans first, this proposal was published in the Federal Register on August 9, 2019, by the Department of Health and Human Service's ("HHS" or "the Department") Centers for Medicare and Medicaid Services ("CMS").[2] This proposal would require hospitals to post standard charge information in an effort to increase the availability of meaningful price and quality information for patients.

While the Chamber has long supported transparency in cost and quality information to better inform patients, the requirement that all hospitals post payer-specific negotiated rates for all items and services provided by the hospital is tremendously problematic. The proposal will not only fail to provide consumers with useful and meaningful information, it will lead to tremendous confusion as consumers are blanketed with rates not reflective of their out-of-pocket exposure. Further, the proposal will have significant economic and market ramifications, likely increasing prices and leading to anti-competitive behavior. Finally, we believe the Proposed Rule is unlawful in several respects. The proposal: exceeds the authority and scope of CMS, exceeds statutory authority by interpreting standard hospital charges in an excessively broad manner, and violates the Constitution's Taking Clause and the First Amendment. We urge CMS to postpone the effective date of the Proposed Rule so legal questions can be answered.

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[1] https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-16041.pdf
[2] https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/

LAUDABLE GOAL

The Chamber has long advocated for ensuring patients and employers have access to useful information on the cost and quality of health care services. For over a decade, we have trumpeted the opportunities Health Savings Accounts and various value-based insurance design models create to advance informed consumerism in health care. In a report issued in June of 2013, the Chamber identified four specific principles to improve our nation's health care system: (1) achieving meaningful transparency, (2) realizing greater value in health care, (3) supporting effective employer-sponsored coverage and private insurance offerings, and (4) reforming Medicare and Medicaid to drive greater value. We share these goals with the Administration. However, transparency and access to cost and quality information is only as useful as the information being provided.

IMPROPER APPROACH

Our concern with the Proposed Rule's approach are threefold. We believe the payer-specific negotiated rates are not going to be meaningful or helpful to consumers because the information this rule proposes to provide will lead to greater consumer confusion. More meaningful and consumer-specific private sector tools are already available for consumers and provide information pertinent to consumers' personal financial obligations. The Proposed Rule would only provide enormous amounts of data the consumer will have to navigate, sum the amounts provided, and then calculate their cost share obligations. This also assumes the consumers will know which codes they need to look up.

Payer-specific Negotiated Rates Are Not Helpful to Consumers

Individual consumers are interested in their specific out-of-pocket expenses and exposure. In order for an individual to accurately know what his or her out-of-pocket costs will be, it is necessary to also know that individual's standing in terms of satisfying his/her deductible. Posting payer-specific negotiated rates publicly will not inform consumers of their specific out-of-pocket costs and could adversely impact competition in the market place.

- Consumers are not going to be paying these negotiated rates; the carrier will be. It is far more useful and appropriate for a carrier to help a covered beneficiary assess out-of-pocket costs for receiving a service from one provider versus another and be able to further quantify that cost exposure given the specific beneficiary's deductible standing than for a consumer to see the various negotiated rates from carriers with whom they are not insured.

- In order for individuals to even find the correct payer-specific negotiated rate, they will have to know what particular service will be performed and/or item provided, their specific product type out of many, as well as know the corresponding code that reflects that service or item. This is not information that consumers will have or know. For example, there are multiple codes for a simple evaluation and management visit, also known as an office visit, which are based on the amount of time the provider spends with the patient. For more advanced care, there is significant variability in care complexity, which also affects which codes are billed.

- The rates publicly posted will be incomplete and misleading given that many services may also be provided by non-hospital employed physicians. Information about the cost of services administered by these providers is not covered by the proposal and means consumers would

really only see part of the picture. In addition, many services may be able to be provided in a physician's office or ambulatory surgery center at a lower cost.

Consumer Confusion Likely

Worse than being not helpful, this information is likely to confuse consumers and leave them frustrated when the negotiated rate they identify before the treatment varies tremendously from that paid by the insurer to the hospital afterwards.

- In looking at the negotiated rate for a particular service or item, consumers are likely to find the amount listed doesn't reflect the costs associated with their entire treatment. There will in many cases be ancillary services provided as well and the consumer may (in error) simply try to ascertain the cost of the primary service.

- The consumer may also find their costs are higher than those associated with the payer-specific negotiated rate due to comorbidities and complications.

- In addition, consumers need information about the quality of the services they will receive in order to make informed care decisions.

Private Sector Solutions Better Drive Consumer Empowerment

There are already tools available to consumers to help them ascertain their out-of-pocket costs which renders CMS's proposal unnecessary. In fact, insurance companies and third party administrators more effectively provide individualized information about out-of-pocket costs. Here are a few examples of tools many insurance providers offer:

- Insurer cost tools provide real-time, personalized out-of-pocket estimates for the most common medical, non-emergency, in-network health care services, including those offering the biggest opportunity to save on health care expenses and are likely to cause members to comparison shop.

- Some insurers provide tools giving members an estimate of the average in-network versus out-of-network cost of an episode of care, or overall average cost for certain diseases and conditions, for approximately 200 types of office visits, diagnostic tests and vaccines, surgical and scope procedures, dental services, and diseases and conditions

- Insurers offer beneficiaries the ability to review and compare cost ranges for medical procedures among participating facilities: inpatient, outpatient, and other facilities (e.g., free-standing radiology centers). Insurers regularly provide the following individualized information: all costs from admission to discharge, facility-specific information—not regional averages—for more than 30 common medical procedures (e.g., maternity care, MRIs, CT scans, colonoscopies, and mammograms). Displayed costs are broken down into managing physician charges and ancillary charges, as well as cost ranges.

- Tools allow beneficiaries to calculate personal financial responsibility by allowing members to search the most common elective inpatient, outpatient, and imaging services by facility, as well as the most common physician office visits. All costs are displayed at the episodic level (i.e.,

all cost rendered for a normal, uncomplicated procedure), including everything from admission through discharge. These costs are the insurer's contracted allowed amounts and are shown in a narrow range from minimum, to likely, to maximum costs. The likely amount is displayed as equaling the employer share (if the member is part of a self-insured plan) and the out-of-pocket amount. This "out-of-pocket amount" is further broken out by co-pay, coinsurance, and so forth, and each line item has context to educate the member on what these amounts mean and how each amount is calculated. Members are also presented with alternative treatment options depending on the procedure of interest and the available options.

- Other tools provide consumers with a view of how treatment costs differ from doctor to doctor, in addition to delivering personalized cost estimates for various treatment options. This tool serves as an online resource that supports the evaluation of specific care, quality, and cost estimates for providers and facilities. The data support more reliable cost and quality information for a specific service provided by a specific doctor or hospital—the level of detail most consumers are looking for. Empowering consumers with this information allows them to be more confident about the quality of their care, as well as be in control of the economics surrounding it.

Many providers also prepare individualized information on cost and provide good faith estimates to patients ahead of time which are far more accurate and helpful as consumers assess their financial exposure and obligation. There are a myriad of examples of provider efforts on this front. For example:

- Patients are often able to discuss cost estimates directly with their provider, speak with providers telephonically, or utilize web portals established at a growing number of hospitals. In these interactions, provider representatives are able to ask probing questions in order to best narrow down the likely services and reimbursement based on that individual's specific plan and benefits. In addition, this method of providing support for patients allows for education to occur, dialogues around a patient's ability to pay, alternatives available for payment, discussion around other likely bills the patient will receive, and more.

- Hospitals and health systems help patients obtain answers to these questions by working with insurers. Specifically, once a provider has identified the patient's need for a specific diagnostic service or care protocol, hospital financial counselors help patients work with their insurer to establish what the patient's cost-sharing obligation may be. Financial counselors may need to repeat this process multiple times, as the course of care may change for any number of reasons. This is largely a hands-on process today with hospital staff connecting with insurers via their websites and call centers to obtain patient-specific information. Many hospitals and health plans, however, are working on ways to leverage web-based technology to streamline these processes for patients.

- For the 10 percent of the population that is uninsured, availability of standard pricing information can be helpful and is already available consistent with federal law. Providers can and do respond to inquiries from uninsured individuals with information on their standard charges. Many of these patients are of limited means and also will not pay the standard charge, as hospitals and health systems provide billions of dollars of charity care each year. Part of the

discussion between providers and uninsured patients on price estimates includes information on any financial assistance policies the hospital may offer.

As with requirements to post charges, a requirement to post payer-specific negotiated rates would be confusing to patients and inferior to developments already occurring within the provider industry.

Unintended Economic and Market Consequences

Posting publicly the negotiated rates between hospitals and competing insurers will lead to anti-competitive behavior and ultimately increase premiums.

- The Federal Trade Commission and the Organization for Economic Cooperation and Development have produced analyses of comparable proposals indicating CMS' Proposed Rule is likely to result in higher prices to consumers.[1] Higher-priced hospitals could use the competitively sensitive rate information to increase rates to the highest price the market will bear, while lower-priced providers could use the competitively sensitive rate information to raise rates even more quickly to the prices charged by the higher-priced providers. This could result in market chaos and harm competition.

- The overall cost and details of the negotiated rates with providers is confidential and proprietary and constitutes confidential trade secrets. Any required public disclosure of proprietary pricing between payers and providers would be contrary to long-established prohibitions on the forced disclosure of trade secrets. The effect would be a significant disincentive for health plans to compete in the formation and structure of their networks.

LEGAL CONCERNS

In addition to the policy and operational concerns, the proposal should be withdrawn because it suffers from significant legal flaws.

The Proposal Exceeds CMS's Authority Because "Standard Hospital Charges" Cannot Include "Payer-Specific Negotiated Rates"

The proposal must be withdrawn because it exceeds CMS's authority under the Public Health Services Act. CMS has no authority to require hospitals to publish confidential payer-specific negotiated rates, as proposed. Section 2718(e) of the Public Health Services Act, on which the proposal relies for authority, requires hospitals to publish an annual list of their "standard charges for items and services provided…" But the proposal is not focused on standard charges at all. Instead, it would require hospitals to publish their privately negotiated non-standard charges, which the agency now proposes to

[1] Letter from Marina Lao, Deborah Feinstein, & Francine Lafontaine, Federal Trade Commission, to Joe Hoppe & Melissa Hortman, Minnesota House of Representatives 7 (June 29, 2015), available at https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf and "There have been instances where government mandated increases in price transparency seemed to have produced higher rather than lower prices, probably because they facilitated anti-competitive co-ordination among sellers." Organisation for Economic Co-operation and Development [OECD], Price Transparency, at 9, OECD Doc. DAFFE/CLP (2001)22 (Sep. 11, 2001). See U.S. examples id. at 32-33.

call "standard" in order to shoe-horn them into the statute's objectives. Indeed, the proposal now uses the phrase "payer-specific" to describe the covered charges, which is a far cry from "standard."

The words of a statute generally must be given their ordinary meaning and an agency cannot assume ambiguity for the convenience of giving itself authority to achieve a policy goal. *See Gross v. FBL Financial Svc. Inc.*, 557 U.S. 167 (2009) ("Statutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose."); *Chevron U.S.A. v. Nat. Res. Def. Council*, 467 U.S. 837, 843 n. 9 (1984) (courts must exhaust all traditional tools of construction before concluding statute ambiguous). Here, by referencing "standard charges," Congress clearly referred to what hospitals "regularly" charge for items and services. *See https://www.merriam-webster.com/dictionary/standard.* By their nature, privately negotiated rates applicable only to the parties who negotiated them are not "standard;" they are "payer-specific," or even peculiar. Had Congress wanted CMS to require publication of *all* rates, or even the specific additional rates identified in the proposal, it would have said so. Instead, Congress very specifically required disclosure of "standard charges" and nothing more.[3] The proposal's attempt to define standard charges to include non-standard charges (*i.e.*, confidential payer-specific negotiated rates) grossly exceeds the language of the statute. The proposal must be revised to stay within the bounds of CMS' authority.

Beyond the improper extension of the term "standard" to include "payer-specific," the proposal further improperly extends the meaning of the word "hospital" standard charges to include "negotiated" rates. Negotiated amounts are not solely in the purview or control of a hospital. These amounts are the result of bilateral negotiations between two parties – an insurer and a hospital. Therefore, extending the term "hospital" standard rates to amounts that are instead "negotiated" exceeds the statute's authority.

Third, the Proposed Rule improperly extends the term "charges" to include "rates." There has been long-standing differentiation between "charges" – which a hospital sets for the services and items it provides to those not covered by a participating insurer and "rates," which are the allowed amounts resulting from a bilateral negotiation and contractual agreement.

Proposal Contravenes Constitutional Protections of the Takings Clause and the First Amendment

The proposal's definition of "standard charges" and attendant disclosure requirements raises significant Constitutional concerns, which must be avoided for the rule to sustain scrutiny. Requiring a party to publish confidential information it carefully guards as a trade secret without just compensation contravenes the Taking Clause of the Constitution. *See Ruckelshaus v. Monsanto*, 467 U.S. 986 (1984). Hospitals and insurance carriers treat their negotiated rates and payments as trade secrets, often contractually binding each other to prevent disclosure. Congress would not have authorized such a clear taking of those trade secrets without grappling with the costs to hospitals and insurers of releasing their closely guarded commercial information or the mechanism for compensating them.

In addition, the proposal threatens core First Amendment principles. The government may not compel commercial speech, like requiring disclosure of private rates, without first establishing that compelling the speech directly advances the government's purported goal. *See Nat'l Ass'n of Manufacturers v.*

[3] Even if "standard charges" could be given another meaning because of some contextual or other aspect of the statute, the proposal fails to provide sufficient details on what aspects of the statute create ambiguity, let alone sufficient ambiguity to make "standard charges" mean non-standard charges.

S.E.C., 800 F.3d 518, 527 (D.C. Cir. 2015). And the government may not rest on "speculation or conjecture" to establish that fact. *Id.* Although the proposal references some experience at the state level with rate disclosure, it fails to provide or rely on a sufficient study of the impact of broad disclosure of the private information addressed here to demonstrate any final rule would advance the government's purported goal. It thus violates hospitals' and insurers' First Amendment rights to be free from most compelled speech.

In short, the proposal suffers from significant legal flaws, which must be corrected before any final rule could be finalized.

REGULATORY PROCESS OBLIGATIONS INSUFFICIENTLY SATISFIED

The Chamber is dismayed that the Department chose to truncate the appropriate 60 day comment period prescribed by the Paperwork Reduction Act and believes the economic analysis provided is not sufficiently supported or accurate.

Improperly Abbreviated Comment Period

As HHS notes on p. 39610 – "Under the Paperwork Reduction Act of 1995, we are required to provide a 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget for review and approval," and the Department then lists the four issues for which the Paperwork Reduction Act ("PRA") requires that comment be solicited. The Department further states that "In this proposed rule we are soliciting public comment on each of these issues…" However, here the Department issued the notice for public comment on this Proposed Rule on August 9, 2019 with a comment due date of September 27, 2019, a period of 49 days, far less than the 60 day comment period required by the PRA.

The Department's decision to issue this Proposed Rule with comment period shorter than 60 days truncates the public's comment rights under the PRA. The prospective publication in the Federal Register of a "60 day PRA information collection burden comment notice" after a final rule is decided, would reduce the PRA requirements to a pro forma exercise without real effect. The critical decisions will have already been made in the final rule, and nothing the public could offer then would be capable to altering the pre-ordained course determining the information collection burden. Consistency with both the spirit and letter of the PRA, the law requires that the Department provide the mandated 60 day comment period at this proposed rule stage, allowing the public the opportunity through timely and well-considered comments to influence the actual decisions that will be made to affect the information collection burden.

The information collection control number 0938-1109, currently effective until March 31, 2019, covers only the Hospital OQR Program's current information collection burden established by currently effective rules. The proposed changes, regardless of whether they increase or decrease the estimated burden will invalidate the previously approved information collection when a final rule is published that revises any of the relevant current requirements. At that point, unless a new information collection burden has been approved, no information requirement will be valid. It is therefore necessary that the public comment period requirements of the PRA be respected and implemented fully in advance in order to ensure no lapse in the statutorily required authorization.

Flawed Cost Analysis

The Department asserts that the hourly wage of a Medical Records and Health Information Technician (updated to $18.29 per hour) is the appropriate measure of the labor cost of compliance with the Hospital OQR Program. However, the information collection requirement does not appear to be supported by any reasonable assessment of the responsibilities and knowledge required for the task. The accuracy and completeness of the information submitted under the Hospital OQR program have serious financial implications for both hospitals and patients. We do not believe that it is reasonable for the Department to assume that such responsibility would be left to be performed by a worker at this rate of pay. Review and supervision by executive, administrative, and professionally trained financial and legal staff whose rates of pay are five to ten time higher is essential to avoid liability for errors and omissions. The Department's under-estimation of the hourly compliance labor costs permeates every element of the information burden cost estimate. The Department should not be granted information collection clearance based on this flawed cost estimate.

The Department also asserts a compliance burden of 1 hour per hospital for each of a lawyer and a general operations manager to review the rule prior to implementation. No empirical or rational basis for this time estimate is provided. Hospitals are large, complex institutions, and it seems unreasonable to assume that such a brief period of time by only two individuals would be sufficient to preform diligent review of such a complex regulation on behalf of such an institution. We urge the Department to conduct surveys or listening sessions with experienced hospital administrators and legal counsels to find reasonable ranges of time burden calculation assumptions.

CONCLUSION

The Chamber commends CMS' efforts to improve transparency and provide additional information to consumers on cost and quality. However, we have a multitude of concerns with the Proposed Rule's approach. Mandating payer-specific negotiated rates be posted by hospitals will not help provide meaningful or useful information to consumers. Instead, it will lead to significant confusion and operational complexity which is unnecessary given the tremendous private sector transparency tools consumers already use and enjoy. Beyond these policy points, the Chamber has strong economic and legal concerns as well. We urge CMS to postpone the Proposed Rule's effective date until the myriad of legal questions can be fully addressed. CMS should also consider alternative approaches such as the development by Federal health care programs of real-time benefit tools similar to those that will be utilized in the Medicare Part D program beginning in 2021. We remain committed to the employer-sponsored system and appreciate the Department's consideration of the effects that various implementation choices have on businesses.

Sincerely,

Katie Mahoney
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U.S. Chamber of Commerce