January 29, 2020

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

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9915-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Transparency in Coverage [CMS–9915–P]

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the recently published proposed rule requiring plans and insurers to disclose in-network provider negotiated rates and historical out-of-network allowed amounts through two machine-readable files posted on an internet website, thereby allowing the public to have access to health insurance coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending (the "Proposed Rule" or "proposal").[1] The Chamber has long supported efforts to provide individuals access to meaningful health insurance coverage information that can help consumers make informed decisions. However, we have serious concerns with the approach put forth in this Proposed Rule. We urge the Centers for Medicare and Medicaid Services ("CMS") to withdraw this proposal and work with stakeholders to focus on improving consumer access to information that is meaningful while not mandating the public disclosure of privately negotiated contract rates which will perversely increase costs.

In these comments, the Chamber reminds CMS that a myriad of consumer tools currently exists which provide enrollees with individualized information about out-of-pocket costs associated with services and items. Due to the availability of these tools, we question the value of publicizing the negotiated rates between providers and insurers for all services and items under the auspice of helping consumers shop when it is highly unlikely consumers will know which billing codes are appropriate. The Chamber takes issue with the assertion that providing information on negotiated rates will reduce costs, rather we remain concerned that rates will increase instead. Finally, the proposal fails to provide any meaningful regulatory impact analysis on the broader economic consequences – including potentially increasing consumer premiums. The proposal has the potential to impose tremendous regulatory burdens and will harm the ability

[1] 84 Fed. Reg. 65,464 (November 27, 2019), *available at* https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-25011.pdf

of consumer centric tools to evolve. CMS must perform a meaningful analysis of these impacts and subject it to public comment.

LAUDABLE GOAL

The Chamber has long advocated for ensuring that 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: achieving meaningful transparency, realizing greater value in health care, supporting effective employer-sponsored coverage and private insurance offerings, and reforming Medicare and Medicaid to drive greater value.[2] We share these goals with the Administration. However, transparency and access to cost and quality information is only useful if the information being provided enables consumers to make better health care decisions.

IMPROPER POLICY AND LEGAL APPROACH

As an initial matter, we do not believe CMS and the other agencies have statutory authority to mandate the disclosure of negotiated rates. The statutory authority underpinning this rule is not unlimited and, as discussed below, carriers cannot be required to disclose information that is subject to other legal protections, such as trade secrets. We also note that the statute cited in the proposed rule requires disclosures to be in "plain English" that will be suitable for the average user and the release of millions of data points of complicated negotiated rate information does not meet that test.

We also believe mandating the disclosure of negotiated rates will not be meaningful or helpful to consumers. Our specific concerns with the Proposed Rule's approach are five-fold.

First, more meaningful and consumer-specific private sector tools are already available. We fear that regulating the public disclosure of negotiated-rates on all items and services will jeopardize the ability of companies to continue to provide and develop those valued consumer-specific tools. Instead, companies should have flexibility to be innovative and cater consumer tools to the needs of those consumers based on feedback received from those using the tools – the consumers. Companies spend resources understanding the needs of their customers and are best able to develop tools specific to those needs.

Second, the Chamber takes issue with the claim that negotiated rates will be useful to consumers and that all items and services are shoppable. Instead, the provision of information as mandated under this proposal will lead to greater consumer confusion and will jeopardize the ability of companies to negotiate lower prices for their customers.

Third, as several analyses from the Federal Trade Commission, Department of Justice and the Congressional Budget Office on similar proposals have demonstrated, publishing negotiated rates will have the perverse and unintended effect of increasing rates and driving up both private

[2] U.S. Chamber of Commerce report "Health Care Solutions from America's Business Community: The Path Forward for U.S. Health Reform" (June 2018), *available at* *https://www.uschamber.com/report/health-care-solutions-americas-business-community-path-forward-us-health-reform*

sector and federal spending. This is the precise opposite outcome of that intended by the Proposed Rule.

Fourth, it is unclear whether the privacy protections under Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to this information once it is released publicly and/or when collected by third-party entities that may facilitate the collection of these data points. As data is collected by various applications, the privacy of the individual with regard to medical services received can be compromised fairly easily and re-identification is likely. This also raises questions of liability for the entities providing this information to the third-party applications.

Fifth and finally, the Proposed Rule does not include any meaningful regulatory impact analysis of the broader economic impact of disclosing negotiated rates, which is tremendously concerning given the significant regulatory burden that this proposal is likely to inflict.

1. Current Consumer-Specific Tools Are Superior

Many carriers and third-party administrators ("carriers/TPAs") already provide member consumers with individualized out-of-pocket estimated costs on shoppable services. Currently, these transparency tools are driven by the market demand for information on beneficiaries' out-of-pocket exposure while reflecting where an individual/family is with respect to satisfying any-out-of-pocket costs including his/her/its deductible/deductibles. These tools are continuously evolving and serve as a way for carriers/TPAs to continue to innovate and improve the information available to member consumers. The cost tools include many of the following features:

- The cost tools provide real-time, personalized out-of-pocket estimates for the most common medical, non-emergency, in-network health care services, including those that may offer the biggest opportunity to save on health care expenses and are likely to cause member consumers to comparison shop.
- Some carriers/TPAs provide tools that give enrollees 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 treatments for diseases and conditions.
- Carriers/TPAs offer enrollees 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). Carriers/TPAs regularly provide the following individualized information: all costs from admission to discharge, facility-specific information—not regional averages—for 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.
- The cost tools allow enrollees to calculate personal financial responsibility by searching services such as physician office visits and the most common elective inpatient, outpatient, and imaging services by facility. All costs are displayed at the episodic level (i.e., all costs rendered for a normal, uncomplicated procedure), including everything from admission through discharge. These costs are the 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, with each line item containing greater context to educate the member consumer on what these amounts mean and how each amount is calculated. Enrollees are also presented with alternative treatment options depending on the procedure of interest and the available options.

We urge CMS to evaluate the individualized tools currently available rather than proceeding with the proposal to mandate public disclosure of negotiated rates because we believe these existing tools provide more relevant and actionable information to beneficiaries. We also believe that if requirements for cost-estimator tools are adopted, they should give carriers/TPAs maximum flexibility. Cementing what information must be provided by carriers/TPAs and in what format through regulation will harm the creation and evolution of highly valuable tools. This will tie the hands of innovators looking to respond and build off of the rapidly evolving market to satisfy consumer demands for individualized information.

2. Negotiated Rates Are Not Helpful to Consumers

Individual consumers are interested in their specific out-of-pocket expenses and exposure for a given episode of care. For an individual to accurately know what his/her out-of-pocket costs will be, it is necessary to also know that individual's standing in terms of satisfying his/her deductible. Publicly posting negotiated rates for myriad services and items will not inform a consumer of his/her specific, expected out-of-pocket costs.

- Consumers are not going to be paying these negotiated rates. It is far more useful and appropriate to help a covered beneficiary assess out-of-pocket costs for receiving a service from various providers and 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 consumer to even find the correct negotiated rate, he/she will have to know what particular service(s) will be performed and/or all item(s) provided. In addition, the consumer also would have to know the corresponding code(s) off the service(s) and/or item(s) (as well as any billing modifiers that may apply to multiple codes billed on the same date of service). This is not information that consumers will have, be able to obtain or know how to use.
- In looking at the negotiated rate for a particular service or item, consumers are likely to find that the amount listed for that service or item does not reflect the costs associated with their entire treatment (i.e., their episode of care). In many cases, there will 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 that their costs are higher than those associated with the payer-specific negotiated rate due to comorbidities and complications.
- The negotiated rate information does not inform consumers about any quality measures associated with a particular provider.

Beyond being simply unhelpful, this information is likely to confuse consumers and leave them frustrated when the negotiated rate they identify prior to treatment varies tremendously from

what is charged afterwards. Until episodes of care become standardized for pricing comparison, negotiated rates on specific billing codes do not provide meaningful information to consumers.

3. Unintended Economic and Market Consequences

Posting publicly the negotiated rates will lead to anti-competitive behavior that will ultimately increases rates and, in turn, premiums.

- The Federal Trade Commission along with the Organization for Economic Cooperation and Development have produced analyses of comparable proposals, both of which indicate that CMS' Proposed Rule is likely to result in higher prices to consumers.[3] Higher-priced hospitals will use the competitively sensitive rate information to increase rates to the highest price the market will bear, while lower-priced providers will use the competitively sensitive rate information to raise rates so as to match the prices charged by the higher-priced providers.
- The Federal Trade Commission and the Department of Justice, the two agencies tasked with regulating anti-competitive behavior and potential anti-trust violations, have stated clearly that where markets are concentrated and subject to exclusive behavior, greater price transparency leads to less competition.[4] This Proposed Rule will create such behavior.

Further, the overall cost and details of the negotiated rates are confidential, proprietary, and constitute confidential trade secrets. Any required public disclosure of that proprietary pricing between payers and providers would be contrary to long-established prohibitions on the forced disclosure of trade secrets. The cost and details of a health plan's negotiated rates constitute confidential trade secrets protected from disclosure under the Defend Trade Secrets Act, as well as property interests protected under the Fifth Amendment to the U.S. Constitution.[5]

4. Privacy Concerns

The Chamber is concerned that information will be mined by third-party entities, which are not subject to the HIPAA privacy and security protections. If information is provided to these entities under the guise of analyzing the costs associated with employer-sponsored coverage, it is unclear what liability exposures may exist for plan sponsors in the event of a data breach. In an era when

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[3] 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.

[4] *See, e.g.*, FTC and Department of Justice, *Antitrust Guidelines for Collaborations Among Competitors 15* (2000), available at https://www.ftc.gov/sites/default/files/attachments/press-releases/ftc-doj-issue-antitrust-guidelines-collaborations-amongcompetitors/ftcdojguidelines.pdf; FTC and Department of Justice, *Statements of Antitrust Enforcement Policy*, Statement 6 (1996), available at https://www.ftc.gov/sites/default/files/attachments/competitionpolicy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.

[5] *Ruckelshaus v. Monsanto*, 467 U.S. 986, 1003 (1984) (holding that cognizable trade secrets are protected by the Takings Clause).

"data is king" and technology is used to analyze information, the unforeseen implications and litigation that may ensue when this information is used improperly or re-identified are significant risks. We urge CMS to more carefully explore privacy vulnerabilities before proceeding.

5. Legal Concerns

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

The proposal's disclosure requirements raise significant Constitutional concerns that must be avoided for the rule to sustain scrutiny. Requiring a party to publish confidential information that it carefully guards as a trade secret without just compensation contravenes the Taking Clause of the Constitution.[6] 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.[7] And the government may not rest on "speculation or conjecture" to establish that fact.[8] 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 that any final rule would advance the government's purported goal. It thus violates insurers' First Amendment rights to be free from most compelled speech.

LACK OF IMPACT ANALYSIS DESPITE SIGNIFICANT REGULATORY BURDEN

CMS's attempted analysis of the economic impact of the Proposed Rule is wholly inadequate and demonstrates that the Department has simply not performed the basic fact-gathering and analysis that an agency is expected to undertake before burdening the public with the task of commenting on a rulemaking proposal. The material that CMS presents under Section VII, "Economic Impact Analysis and Paperwork Burden" is a patchwork of speculation and assumptions without any grounding in empirical data or analysis. The impression is of an analysis to justify a pre-ordained regulatory conclusion instead of the fact-based objective analysis prescribed by Executive Order 12866.[9]

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[6] *See Ruckelshaus v. Monsanto*, 467 U.S. 986 (1984).

[7] *See Nat'l Ass'n of Manufacturers v. S.E.C.,* 800 F.3d 518, 527 (D.C. Cir. 2015).

[8] *Id.*

[9] See Executive Order 12866, the "Presidential Executive Order on Reducing Regulation and Controlling Regulatory Costs" (January 30, 2017), available at https://www.whitehouse.gov/presidential-actions/presidential-executive-order-reducing-regulation-controlling-regulatory-costs/

1. Inadequate Consideration of Compliance Costs.

CMS presents (Section VII, Table 1[10]) monetized annual estimates of compliance costs for the Proposed Rule at $231.8 million to $298.4 million per year over a four-year analysis period (2020-2024). These estimated costs clearly place the Proposed Rule in the category of an "economically significant" rulemaking as defined by Executive Order 12866 and as a "major rule" as defined by the Congressional Review Act. These estimated costs represent only the most obvious direct cost elements for building and maintaining the required information dissemination systems covered by the information collection burden estimates, which are mandatory under the Paperwork Reduction Act. CMS's own analysis reveals that these monetized costs represent only the "tip" of the adverse economic cost impact of this proposed regulatory "iceberg."

- CMS lists 10 specific cost elements that it did not attempt to quantify;
- Also, CMS failed to include any consideration of regulatory familiarization costs—a key cost impact that should be included in any competent regulatory impact analysis. Simply put, it requires time and resources for the targets of regulations to assess the content of a new regulatory mandate and to determine what obligations and alternatives they have. Familiarization costs often are the largest single component of the initial year costs of any regulation;
- CMS omitted consideration of training costs for both government employees who will be charged with enforcing the regulation and for the staff of regulated insurers and plan sponsors who will be responsible for compliance. In addition to this major first-year cost, training is also a continuing cost element because of inevitable staff turnover and because of the need to refresh training for existing enforcement and compliance staff; and
- CMS failed to account for the impact of the litigation burden on regulated insurers and plan sponsors, as well as on the public judicial system.

Besides omission of significant quantifiable cost elements, the costs that CMS does quantify in Section VII, Table 1 and in Section VIII, "Collection of Information Requirements," appear to be grossly underestimated.[11] The quantified costs are associated with designing and building information dissemination systems to comply with the regulatory mandate and to update ("maintain") the content that the systems deliver as relevant information changes. CMS quantifies these costs by multiplying estimated labor hours requirements by estimated costs per labor hours. For both elements of the calculation, CMS relies on arbitrary assertions of parameters without presenting an empirical basis for the values presented.

- CMS presents Bureau of Labor Statistics data from the Occupational Employment Survey[12] as the basis for its hourly cost estimation, which is an acceptable starting point for such analysis, but CMS then arbitrarily selects an 100% mark-up factor to derive the

[10] See "Table 1" found on pages 65,492-93 under *Section VII. Economic Impact Analysis and Paperwork Burden*, included in 84 Fed. Reg. 65,464 (November 27, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-25011.pdf

[11] See *Section VIII. Collection of Information Requirements* found on pages 65500-13, included in 84 Fed. Reg. 65,464 (November 27, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-25011.pdf

[12] See U.S. Bureau of Labor Statistics, Occupational Employment Statistics "May 2018 National Occupational Employment and Wage Estimates: United States", available at https://www.bls.gov/oes/current/oes_nat.htm

necessary total for labor, fringe benefits, and overhead. A cursory examination of the federal government's own accustomed allowed overhead markup rates for similar occupational services offered by government contractors available on the U.S. General Service website would have revealed that overhead markups of 200% to 300% are the conventional standard. This correction alone would raise the limited total of annual quantified costs as shown in Table 1 to over $500 million per year.

- CMS' quantified cost assessments are under-estimated due to the arbitrary distribution of burden hours across occupations for tasks shown in Tables 3A, 3B, 4A, 4B, 4C, 5A and 5B. [13] In each case relatively low hours are associated with the highest hourly cost occupations and the bulk of hours are assigned to the lowest cost per hour occupations. No empirical evidence is cited to justify either the total hours, nor the distribution between higher and lower cost/skill occupations.

None of the omitted or under-estimated compliance cost items are trivial. Each could have been quantified to some extent, if CMS had chosen to allocate the time and resources to do so. Taken together, the items that CMS failed to quantify in its impact cost analysis could readily put the Proposed Rule well over the billion-dollar annual compliance cost level.

2. Inadequate Consideration of Benefits.

To ensure the proposed regulatory approach maximizes net benefits, Executive Order ("EO") 12866 requires agencies proposing economically significant regulations to quantify (to the extent feasible) both the costs and the benefits of each considered alternative. This EO then requires the agencies to select the regulatory approach that maximizes net benefits. The CMS analysis is entirely lacking in any quantitative assessment of benefits and lacks any credible demonstration of why quantification of benefits might be difficult. At the very least, CMS could have presented an estimate of what the benefit per person affected would need to be to offset the putative costs. Such a calculation would have provided a framework for a qualitative discussion of conditions by which unquantified benefits might be large enough to meet the specified threshold. Ultimately, the CMS analysis provides no basis to support its conclusion that the benefits of the Proposed Rule may offset the large likely costs. Indeed, the opposite seems likely: This proposed regulation will impose large costs without commensurate offsetting benefits.

3. Inadequate Opportunity for Public Comment.

A notable feature of CMS' presentation in Section VII, is the frequent resort to requests for regulatory commenters to provide data that CMS clearly should have compiled and presented but did not. These requests for public input are contradicted, however, by the unreasonably constrained comment period that CMS provided for this notice of proposed rulemaking. If CMS is sincere in its request for public input to compete its inadequate research and data record for this rulemaking, CMS should provide a comment period of sufficient length to make detailed comment possible.

[13] See Tables 3A, 3B, 4A, 4B, 4C, 5A, and 5B found on pages 65502-04 under *Section VIII. Collection of Information Requirements*, included in 84 Fed. Reg. 65,464 (November 27, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-25011.pdf

CONCLUSION

While the Chamber has long supported transparency in cost and quality information to better inform patients, the regulatory mandate that negotiated rates for all items and services be publicly posted is tremendously problematic for a multitude of reasons. 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 that do not reflect their out-of-pocket exposure. Furthermore, the proposal will have significant economic and market ramifications that are likely to increase prices and foster to anti-competitive behavior.

We appreciate the goal of improving transparency and efforts to provide additional information to consumers on cost and quality. However, because of our concerns and the currently available consumer-centric tools, we urge CMS to withdraw the Proposed Rule and work with the private sector to learn what information is valued and currently available before proceeding further.

Sincerely,

Katie Mahoney
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U.S. Chamber of Commerce