January 29, 2020

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

Re: CMS-19915-P, Transparency in Coverage

Dear Ms. Verma,

The Children's Hospital Association (CHA) appreciates the opportunity to comment on the Departments of the Treasury, Labor, and Health and Human Services joint proposed rule, Transparency of Coverage. CHA supports the proposal in this rule to require individual and group health plans and issuers to disclose cost-sharing information, upon request, to patients and their families. However, we are strongly opposed to the proposed requirement that health plans publicly release their provider-specific negotiated rates and urge you to withdraw these provisions.

The nation’s 225 children’s hospitals account for less than 5% of hospitals in the United States, but they care for almost one-half of children admitted to hospitals. Children's hospitals are regional centers for children’s health, providing care across large geographic areas, and serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services.

As essential pediatric providers, the nation’s children’s hospitals share the departments’ interest in providing meaningful information to patient families to help guide their care decisions. The public disclosure of negotiated charges would, in contrast, represent extraneous information that would be confusing for families and potentially harmful to patients. Furthermore, required public disclosure of confidential contractual arrangements would interfere with competition in the health insurance marketplace. Therefore, we respectfully urge you to work with providers and payers to ensure that families have access to useful information specific to their out-of-pocket costs.

Our more detailed comments on both aspects of this proposed rule can be found below.

Proposed Requirements for Disclosing Cost-Sharing Information to Participants, Beneficiaries or Enrollees

We support the departments’ proposal to require health plans to provide patients and families with estimates of their cost-sharing liability upon request—and prior to their receipt of covered items and services—and ask that health plans be required to make this information available to providers at the same time. The commercial insurance landscape is full of a dizzying array of benefit design permutations as a single insurer may offer different products that provide different benefit levels, benefit carve-outs, provider network coverage, utilization management, pharmaceutical formulary design, and patient cost-sharing—just to name a few variables. Insurers are responsible...
for the design and nuances of their products, including out-of-pocket costs, and are—and should be—the ultimate source of such information for their patients and their families/guardians.

At the same time, we know that many patient families turn to their providers for information about their out-of-pocket obligations when scheduling or planning a procedure. The added requirement in this rule that insurers make patient-specific health benefit information available to providers via a secure website, would simplify inherently complex payment and benefit structures and allow for the provision of meaningful out-of-pocket cost information. Children’s hospitals are committed to helping families understand their financial obligations, but absent this requirement, do not always have timely access to the necessary specifics about patients’ plans and plan use to enable them to do so.

Finally, we are pleased that the departments acknowledge in the proposed rule that any estimates of out-of-pocket costs are just that—estimates. We encourage you to include a requirement in the final rule that insurers inform patient families/guardians of the limitations of the estimates prior to care delivery. As you know, the provision of health care is complex and difficult to predict, which makes it extremely difficult to provide a definitive estimate of total out-pocket costs in advance. For example, a seemingly minor physical discomfort may mask significant medical issues that are revealed only after thorough examination and testing. Even after a condition is diagnosed, complications may occur that require an unanticipated intervention that increases the total cost of care and, as a result, changes the out-of-pocket obligation.

Proposed Requirements for Public Disclosure of Negotiated Rates and Historical Allowed Amount Data for Covered Items and Services from Out-Of-Network Providers

CHA opposes the proposal to require health plans to make their provider-specific negotiated rates and allowed amounts publicly available. The proposed requirement would not result in the provision of meaningful information, may confuse patients and their families/guardians, and could cause families to delay necessary care. Furthermore, we believe that the departments have exceeded their statutory authority through this proposal, with the potential of undermining the health care marketplace.

The proposed disclosure requirement does not provide meaningful information and may result in delayed care. As we have stated previously, CHA shares the administration’s interest in transparency and in helping patients better understand their financial obligations. However, as we have also stressed, transparency must be limited to meaningful price information, as extraneous information is confusing and potentially harmful to patients.

This proposed rule is particularly concerning as it requires insurers to produce two machine-readable files with information regarding rates for each covered item or services furnished by in-network providers based on billing codes (“Negotiated Rate File”) and each unique out-of-network allowed amount in connection with covered items or services furnished by a particular out-of-network provider (“Allowed Amount File”). This detailed information will be incomprehensible to patient families/guardians as it will generate a massive list with innumerable charges. Patient families are likely to have difficulty identifying the correct procedure from this labyrinth, and even if they successfully do so, they probably will not find the information useful to them. A family’s ultimate concern when deciding about health care coverage or services, is their financial obligation for a particular item or service, which for the most part cannot be deduced from information about negotiated charges.

The proposed rule may also potentially mislead patients. For example, neither the Negotiated Rate File nor the Allowed Amount File would meaningfully convey the price of a drug administered to a patient in a hospital setting. Charges for drugs are typically presented for a specific unit dosage, but the actual amount administered to a patient
will depend on a number of factors, including the patient’s weight. A patient family/guardian could mistake the charge listed as the amount they would be responsible for, without realizing that the actual amount will be different as it depends on the amount administered.

Finally, we respectfully remind the departments that some children in low-income families and children with a serious, chronic or complex medical condition may be covered by Medicaid in addition to private insurance. The proposed public disclosure requirements will not only be irrelevant to these patients’ families/guardians, but might deter families from seeking necessary care due to the confusion caused by the posted negotiated charges.

The departments do not have the statutory authority to require the display of provider-specific negotiated rates. CHA believes that the proposed requirement that insurers publicly display negotiated and allowable rates does not align with statutory authority. In particular, the departments base their proposed requirements for price disclosure on Section 1311(e)(3) of the Affordable Care Act, titled “Transparency in Coverage.” Under Section 1311(e)(3), each health insurance Exchange must “require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, [and] the State insurance commissioner, and make available to the public,” eight types of information related to coverage—e.g., claims payment policies and practices, periodic financial disclosures, data on enrollment, etc. However, according to the rule’s preamble, the proposed requirement that insurers disclose negotiated rates is based on a goal of increasing price—not coverage—transparency as required under the statute. For example, the preamble states, “the public availability of such information would create price transparency for persons who are uninsured, as well as insured persons who are considering coverage alternatives.”

Furthermore, negotiated charges are proprietary trade secrets in the health care industry and several federal statutes\(^1\) expressly protect this information from public disclosure when it is obtained by the government. We respectfully note that, in the event this rule is finalized, it would effectively be requiring insurers to reveal information that the departments cannot directly reveal themselves under existing law. In addition, it is widely recognized that such information is highly confidential and is also closely protected by both payers and providers. This requirement could necessitate payers to violate their contractual arrangements with providers as many provider-payer contracts expressly prohibit the disclosure of negotiated charges without prior consent.

Finally, public disclosure of provider-specific negotiated charges may be damaging to the health care marketplace. In a 2015 letter to members of the Minnesota House of Representatives, the staff of the United States Federal Trade Commission (FTC) concluded that public disclosure of information like negotiated charges “may chill competition by facilitating or increasing the likelihood of unlawful collusion.”\(^2\) The FTC recommended that the Minnesota legislature consider limiting transparency to the types of information important to consumers, such as specific out-of-pocket expenditures for specific procedures and services.\(^3\) CHA believes that if Congress wanted to mandate the disclosure of closely guarded trade secrets that may have anti-competitive market implications, it would have articulated its intent clearly and explicitly. The inclusion of provider-specific negotiated charges exceeds congressional intent and we urge the departments to rescind the proposed disclosure requirements.

\(^1\)Specifically, the Trade Secrets Act, the Privacy Act, and the Freedom of Information Act.


\(^3\) Id. at 5.
In conclusion, CHA shares the departments’ interest in ensuring that patient families are well-informed of their financial obligations, particularly their out-of-pocket costs. Conversely, we believe that public disclosure of provider-specific negotiated charges and allowable rates would not provide meaningful information, may confuse patients and their families, and could cause them to delay necessary care—this runs counter to the intent of this rule. Therefore, we urge you to work collaboratively with payers, providers and families to advance policies and innovations that focus on enhancing families’ understanding of their out-of-pocket obligations without finalizing the public disclosure requirements.

Thank you again for the opportunity to comment on the proposed rule. Please feel free to contact Jan Kaplan at jan.kaplan@childrenshospitals.org if we can provide additional information.

Sincerely,

M. James Kaufman, Ph.D.
Vice President, Public Policy