



## HEALTH CARE COST INSTITUTE

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September 25, 2019

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1717-P  
PO Box 8013  
Baltimore, MD 21244-1850

Delivered Electronically

Dear Ms. Verma:

Thank you for the opportunity to comment on the CY 2020 outpatient prospective payment services proposed rule (CMS-1717-P). The Health Care Cost Institute (HCCI) is a nonprofit organization striving to get to the heart of the key issues affecting the U.S. health care system by using the best data to get the best answers. HCCI looks for truth and consensus around the most important trends in health care, particularly those economic issues that are critical to a sustainable, high-performing health system.

We appreciate CMS's emphasis on price transparency and are encouraged that you have included proposals to increase transparency in the proposed regulation. We are concerned with the opacity in health care and believe more information about how money flows through the system – how much and to whom – can elucidate drivers of health care costs in a way that would allow decisionmakers (in the public and private sectors) to change structures and systems to lower costs.

The analyses and products we produce are indicative of how information and transparency can call attention to cost drivers and to highlight potential solutions. For example, our flagship report, the [Health Care Cost and Utilization Report](#), provides annual and cumulative trends in health care spending for people who get health insurance through work.<sup>1</sup> Our [Healthy Marketplace Index](#) (HMI) explores variation in health spending across cities and has looked at price, utilization, and market concentration.<sup>2</sup> HMI exemplifies how important meaningful prices are to any transparency effort. In [one study](#), by looking at negotiated prices for six common services, we found wide variation in prices paid for those services. For example, the median price for a C-section in the San Francisco metropolitan area was nearly 4.5 times that in Knoxville, TN. A common blood test

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<sup>1</sup> <https://healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report>

<sup>2</sup> <https://www.healthcostinstitute.org/research/hmi>

in Beaumont, TX, costs nearly 25 times more than the same test in Toledo, OH.<sup>3</sup> We also have done studies looking at the [price of insulin](#) and the [impact of high deductible health plans](#) on people with chronic conditions.<sup>4,5</sup> This and all of our work equips public and private policymakers with information to change the systems and structures of health care that are leading to higher costs.

Too frequently, efforts to improve transparency are linked to policies primarily focused on consumers and increasing consumer engagement in health care. For example, in the preamble to this proposed rule, you aspire to have consumers “lead the drive towards value.” There certainly are specific use cases for which consumer-focused transparency has value, for example helping to assess treatment options. However, we believe that systemic transparency holds more promise to keep stakeholders other than consumers accountable for cost and quality benchmarks for care. To that end, our comments suggest ways to build on and improve the elements of the proposal that would improve system-wide transparency without putting the full onus on consumers.

### **Definitions of Hospital and Items and Services**

We support the proposed definitions of “hospital” and “items and services.” In particular, we appreciate the breadth of both definitions. Better understanding of the costs of services for an individual provider will create a more comprehensive view of the system. In fact, limited access to health care data is a current impediment to improved transparency. Defining “hospital” as only those that participate in Medicare would be too narrow and would leave out key providers. Similarly, defining “items and services” broadly is important to glean information about as much of the health care landscape as possible.

Ideally, transparency initiatives would capture prices of all practitioners providing services in hospitals, even those who are not employed by the hospital. This need is particularly acute in light of the financial impact they have on patients. For purposes of the proposed regulation, CMS’s rationale and approach for excluding non-employed practitioners seems reasonable. HCCI will continue to offer analysis and information on out-of-network costs, particularly those that lead to unanticipated expenses for families as a way to highlight this critical issue. (See, for example, [this analysis](#) of surprise out-of-network bills by state and specialty.)<sup>6</sup>

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<sup>3</sup> Kennedy, K., Johnson, W., Rodriguez, S. and N. Brennan. (2019, April 30). Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area [Blog Post]. Retrieved from <https://www.healthcostinstitute.org/blog/entry/hmi-2019-service-prices>.

<sup>4</sup> Fuglesten Biniek, J. and W. Johnson. (2019, January 21). Spending on Individuals with Type 1 Diabetes and the Role of Rapidly Increasing Insulin Prices [Blog Post]. Retrieved from <https://www.healthcostinstitute.org/research/publications/entry/spending-on-individuals-with-type-1-diabetes-and-the-role-of-rapidly-increasing-insulin-prices>

<sup>5</sup> Johnson, W. and A. Milewski. (2019, May 2). Lower Health Care Spending and Use for People with Chronic Conditions in Consumer-Directed Health Plans [Blog Post]. Retrieved from <https://www.healthcostinstitute.org/research/publications/hcci-research/entry/lower-health-care-spending-and-use-for-people-with-chronic-conditions-in-consumer-directed-health-plans>

<sup>6</sup> Kennedy, K., Johnson, W., and J. Fuglesten Biniek. (2019, March 12). Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016 [Blog Post]. Retrieved from <https://healthcostinstitute.org/blog/entry/oon-physician-bills-at-in-network-hospitals>

**Definition of Standard Charge**

We appreciate CMS's recognition that there is not a single standard charge for hospital services and support the proposal to have two components to the definition of "standard charge."

Although, as noted in the preamble, gross charges reflected in chargemasters are not the most frequently used, they do offer a worthwhile baseline datapoint. As such, we support including gross charges as one element of the definition of "standard charge."

We also wholeheartedly agree that "standard charge" should include an element that more accurately reflects what hospitals are being paid. It would be nearly impossible to understand or address drivers of health care costs without this more meaningful metric. We imagine CMS will receive significant pushback from both payers and providers regarding the proposed requirement to make payer-specific negotiated rates available. We do not think, however, that the negotiated rates have to necessarily be payer-identified to be useful. In fact, HCCI's data is provider, plan, and patient de-identified, and our analyses use procedure-specific charges and allowed amounts to understand cost and utilization trends.

**Requirements for Public Disclosure of all Hospital Standard Charges for all Items and Services**

As noted above, requiring hospitals to disclose meaningful price information about all the items and services they provide can be an important step in increasing understanding of trends in price and utilization that lead to higher health care costs in the US health care system. Anchored in the belief that robust analytics allow all stakeholders to drive improvements in quality and value, HCCI works to use the best data to generate the best answers to critical policy questions. Accordingly, we support the principle of putting into the public domain broad, meaningful price information.

We support the proposal to have hospitals disclose meaningful information on the items and services they provide. Because it is often possible to obtain the same information from multiple participants in the health care system, as you work to finalize this rule, we encourage you to evaluate alternative approaches to compiling and disclosing the required information, including requiring payers rather than hospitals to submit data to CMS who then makes a single comprehensive resource available. Such an approach is likely to be more administratively efficient.

**Requirements for Consumer-friendly Display of the Payer Specific Negotiated Charges for Selected Shoppable Services**

Information and tools that help consumers navigate the health care system can serve an important purpose for patients and their families. It is less clear that they can or should be the main pathway to controlling health care costs. The structures that underpin the US health care system have created the costs and outcomes. We do not believe that individual consumers navigating through health care decisions should be responsible for bending the cost curve.

Evidence of the impacts of existing consumer-facing price initiatives offers additional reasons for skepticism. Studies suggest that fewer than 1 in 10 individuals offered price transparency tools use them, and the few who use them do not necessarily save money.<sup>7</sup> As such, we recommend

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<sup>7</sup> Desai S, Hatfield LA, Hicks AL, et al. [Association between availability of a price transparency tool and outpatient spending](#). *JAMA*. 2016;315(17):1874–1881.

CMS focus on improving transparency system wide. These efforts can help public and private decisionmakers better understand what is causing health care costs in the US to be so high and to identify and develop solutions. The requirements to publicly disclose meaningful price information for all items and services is a step toward that goal.

The additional requirement for hospitals to create consumer-facing tools would be less useful and adds to administrative burden. We believe robust consumer-facing tools could be more easily and effectively developed by other parties that possess broader and richer data about the full cost of care. Therefore, we do not recommend finalizing the proposals related to the consumer-friendly display of information. Finalizing only the full disclosure proposals will allow hospitals to focus their efforts on activities most useful to public and private decisionmakers.

**Monitoring and Enforcement of Requirements for Making Standard Charges Public**

For the proposed requirements to have their intended effect, CMS will need to have in place structures to monitor and enforce compliance. As a general matter, the approach described in the preamble seems reasonable. The monitoring methods and proposed actions to address noncompliance are appropriately varied and iterative. We are concerned, however, that the proposed civil monetary penalties may not provide sufficient incentive for hospitals to comply. With a maximum daily dollar amount of \$300, a hospital's maximum annual liability for noncompliance is slightly higher than \$100,000, a small fraction of a typical hospital's revenue. We worry that many stakeholders will view the noncompliance penalty as a new business expense rather than an incentive to comply with the transparency requirements.

Thank you for considering our feedback and for the opportunity to comment on these proposals. If you have any questions about our comments and recommendations or if additional information may be helpful, please let me know.

Sincerely,

A handwritten signature in black ink, appearing to read "Niall Brennan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Niall Brennan  
President & CEO