Office of the President and CEO

June 25, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services

CMS-1694-P

Dear Administrator Verma:

The Robert Wood Johnson Foundation (RWJF) appreciates the opportunity to provide comments on this proposed rule related to both the online posting of standard charges by hospitals, and your request for information about transparency around out-of-pocket costs, particularly balance billing. For more than 45 years, RWJF has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. RWJF has been interested in price transparency for a number of years, and has funded studies of consumers’ use of information on health care cost and quality, initiatives to help health care providers and patients discuss costs of care together, challenges for developers making consumer decision support tools, and other analytical projects designed to increase information about variations in health care prices. We believe that improved transparency around quality is also important and must not be overlooked in any effort to increase consumerism in health care.

Last Spring, we collaborated with the Brookings Institution to release a white paper with policy recommendations about how to promote competition in health care markets. The report makes a number of recommendations for federal and state policymakers, including one about transparency which is very consistent with your objectives: “Create and publicly disseminate measures of cost, both total spending and the total amounts paid to providers for various procedures, potentially through all-payer claims databases or the creation of a national claims data repository that utilizes common (core) data elements and a common format.”

RWJF has supported several studies that demonstrate how important price information is to consumers. Many believe that government has a role to play in increasing transparency. In fact, one study found that 80 percent of Americans believe government should make the information
available. This is unsurprising considering the significant affordability problems that many consumers face with regard to health care.

Consumers are most interested in information about their own out-of-pocket costs, and value being able to discuss the cost of care with their clinicians. By implementing the current law about posting hospital charges, CMS is sending an important signal to industry participants about the value it places on price transparency.

We are glad to hear of your intention to implement and enforce the current law regarding the posting of "standard charges" by hospitals. This is a challenging undertaking, but we think it could be beneficial. We believe the potential audience for this information is not only consumers, but also third party payers, employers, state and local governments, and other industry stakeholders. We believe that price transparency is a necessary but not sufficient aspect of health care reform, and further believe that both maximizing the opportunities to inform consumers and facilitating the public identification of outlier prices can put downward pressure on health care cost growth.

Online Posting of Standard Charges

In health care, the concept of “standard charges” is somewhat elusive, since providers charge many different prices to different payers for the same service. Hospitals, for example, maintain a "chargemaster" (which is a list of maximum prices), negotiate rates individually with commercial insurers, and accept the lower rates set by government for Medicare and Medicaid. The chargemaster is sometimes used as a basis for negotiation with commercial payers, and is often used to bill uninsured patients that do not qualify for charity care. Regarding commercial rates, it should further be noted that: 1) negotiated rates are increasing in recent years relative to Medicare, 2) recent work has demonstrated that there is significant variation in negotiated commercial rates at the individual hospital level, and 3) hospitals and third party payers consider these negotiated rates to be proprietary—and in some states are allowed by law to treat them that way.

This complicates the determination of an appropriate "standard charge" to require hospitals to post. CMS already releases information on the chargemaster and Medicare rates for all Diagnosis Related Group Codes (DRG) at the individual hospital level, so there is no particular reason to ask hospitals to additionally post this information, unless there is a desire to make it more timely than the 2015 data which are already available. Since Medicare rates are not usually of direct interest to consumers and very few people pay the chargemaster, these rates are not the highest priority for consumers and others. Information about commercial rates is most helpful to all of these audiences, but here the challenge is that most individual hospitals have dozens, if not hundreds of negotiated rates for the same service. The posting of these rates will not necessarily provide consumers with direct information about their own out-of-pocket obligations, which depend on the nature of their benefit design, will impose burdens on hospitals to aggregate and post this information and will likely also face significant opposition from insurers who will not want their negotiated rates revealed for competitive reasons. Furthermore, consumers will struggle to navigate and assimilate this data if they have to obtain it from multiple different hospital websites instead of a single source. Since the posting of individual rates is not feasible
for the reasons listed above, we believe that requiring more disclosure about average negotiated commercial rates is the most beneficial way to implement this law.

We would like to point to a few examples of strategies employed elsewhere that we think may prove helpful. The most promising development along these lines is the transparency tool being developed in Florida. The FloridaHealthPriceFinder (which does not yet contain facility data) will allow consumers to see average commercial prices at the state, county, and individual facility level for common bundles of care, enabling consumers to identify hospitals that have relatively higher and lower prices. The Health Care Cost Institute, a non-profit multi-payer, claims database, is creating the Florida tool under contract to the Florida Agency for Health Care Administration.

The FloridaHealthPriceFinder user interface is consumer friendly, and includes a survey to see whether consumers found the information that they needed. The full tool with the facility specific information is scheduled to be released later this year. Needless to say, it is too soon to know whether or how this will impact consumer behavior or market prices, but this appears to be the leading edge of state efforts to provide information to consumers about hospital prices. We urge CMS to consider ease of use for consumers and beneficiaries when implementing the current law, and for that reason we encourage a standardized tool that facilitates comparison. Permitting hospitals to take non-standardized approaches to comply will result in limited impact and consumer confusion.

Like the Florida tool, the very recently released transparency tool from the Massachusetts’ CHIA (Center for Health Information Analysis), focuses on allowed amounts or negotiated rates, and directs consumers to insurance websites for information about their out-of-pocket costs. However, in the current version, price data is from 2015. The redirections to the insurance websites are also quite intrusive and detract from the appeal of the tool.

While the Florida tool seems most directly apropos to the current law that CMS wishes to implement, a few other state efforts deserve mention. One is New Hampshire HealthCost, which is the state's All Payer Claims Database (APCD). This is probably the most consumer-facing and sophisticated of all state APCDs. It provides information on the cost of all kinds of health care services, and focuses more on out-of-pocket costs to consumers. In addition to providing useful information to consumers, New Hampshire’s APCD has allowed payers more leverage in negotiating with higher priced providers.

Further, while total or average cost data may in many cases not be immediately actionable for consumers, public information also allows intermediaries (such as researchers, journalists, policymakers, and advocacy groups) to put pressure on outlier providers. For example, the state of California is currently suing Sutter Health over what it views as unwarranted pricing variation that was revealed by a claims data study.

While both are important, information about consumer out-of-pocket costs and information about how much health care providers charge are two quite different potential objectives for a transparency tool. Provider price information is more appropriate for a public reporting environment, because the information is more universally relevant, while information about
patient obligations is better suited to more individualized communications. We believe it can muddy the waters to try to combine both objectives in a single, public-facing tool. This distinction is explicitly acknowledged in very useful recent report from the Shoppable Care Work Group in Pennsylvania, which makes separate policy recommendations about transparency tools that provide out-of-pocket cost information and other data collection efforts such as All Payer Claims Databases that would provide public information on provider prices.

There are a few other activities around provider prices that merit some mention. There are a very small number of facilities that practice a strategy of “radical transparency” where they post universal prices and operate on a purely retail basis. The Surgery Center of Oklahoma is the best example, and perhaps the only well-known example. They have a website where consumers can search for procedures and receive a total price. This may be an example of the exception proving the rule, because despite the considerable attention this facility has received, it does not seem to have resulted in a wave of copycats. Yet it may be of interest to learn more about their business model.

RWJF funds a few projects that seek to find other ways to draw attention to regional and facility differences in prices, with the goal of identifying outlier regions and/or providers. One example is the Healthy Market Place Index (HMI) which takes a regional approach, and provides price, utilization, and outcome information at the Central Business Statistical Area level.

Another project stems from a collaboration between a group of self-insured Indianapolis area employers and RAND, which resulted in the publication of facility-level negotiated rates. This project publicly identified outliers, i.e. specific health systems with rates above average rates, and also showed the rates as a ratio to Medicare. This tool has been very valuable to employers and third party payers, and we are considering ways to expand it.

To summarize, we agree that requiring hospitals to post standard charges on the internet would be a major step forward. We recommend you consider a strategy like that being pursued by the state of Florida that would allow consumers and other stakeholders to compare the commercial rates at the facility level, and recommend that you do not try to address patient obligations with this transparency tool. Publicizing non-compliance, as you suggest, would also provide an important signal that CMS values transparency. Perhaps compliance and overall stance toward transparency could be reflected in Hospital Compare or other quality ratings.

**Request for Information with respect to Surprise Billing**

The proposed rule also contained a request for information regarding barriers to improving consumer understanding of out-of-pocket costs. In recent years, with the advent of high deductible health plans and an increase in consumerism in insurance markets, health plans have made considerable efforts to educate consumers about benefit design. RWJF has supported a number of developer challenges related to consumer decision support around plan choice and remain interested in this area. Given the growth in patient cost-sharing, hospitals, motivated in large part by economic self-interest, have found it increasingly advantageous to be more transparent and provide consumers with accurate information about their obligations prior to
scheduled procedures, and have even begun to offer opportunities for financing or payment plans.

Yet despite this overall pattern of improvement, there is an important problem mentioned in the request for information – out-of-network or “surprise” billing. The difficulty comes from the fact that certain providers who practice within some hospitals are not hospital employees, and maintain their own set of prices and contract relationships with various payers. Therefore, while a hospital may be in-network with a health plan, certain providers that provide services to patients during a visit may not, resulting in a "surprise" out-of-network bill for some consumers. This also happens when hospitals contract the staffing of the emergency room to firms that do not enter into network relationships with health plans. A recent and widely reported study detailed the dramatic increase in patient bills when hospitals outsourced their emergency rooms to a particular firm. Consumers in most cases have no way to anticipate or avoid these charges.

While it would seem that this is an easy situation to resolve through state regulation or provider contracts, in fact it is not, since setting a maximum price for out-of-network rates is interpreted by providers as rate-setting, and medical societies fight these types of restrictions vigorously. Hospitals, for their part, often argue they are not responsible for this situation, and sometimes claim that labor shortages and their own lack of market power in negotiating with certain types of provider groups makes them unable to exclude providers who balance bill. While there may be some labor market issues at play, it is also true that hospitals often benefit financially by allowing providers to balance bill. Despite these challenges, many states have established balance billing legislation, most of which impose some type of arbitration process or maximum on the negotiation of balance bills. Yet an important limitation of these state laws is that they don’t apply to self-insured plans, increasing the potential usefulness of federal action.

One interesting proposal for the emergency department issue in particular has been to require hospitals to bill payers for bundles that include physician services, essentially putting hospitals at risk for the physician charges. So far this has been construed as an idea for state policymakers, but there may be some potential federal applications. The federal government may be able to use Medicare payment rules to require the bundled billing of emergency department services, and/or to combine radiology or anesthesiology with other procedures. Another possibility is that CMS could make hospital participation in the Medicare program conditional on notifying patients within some interval prior to a hospital service if there will be any out-of-network providers participating in their care, or relatedly, could condition participation on limiting out-of-network charges to some fixed ratio to Medicare rates. This would hopefully reduce the economic opportunities for medical providers that seek opportunities to engage in out-of-network billing practices. We recommend that CMS consider whether any of these strategies may be feasible.

In closing, we understand the skepticism that is sometimes expressed about price transparency as a solution to our nation’s health care problems. There are many factors that contribute to high health care spending, including upstream social and economic determinants, poor health behaviors, unnecessary care, expensive new treatments and therapies, high negotiated rates, and provider consolidation. We do not believe that consumer behavior or price transparency alone can bend the health care cost curve. But we also believe that opacity leads to inefficiency and
higher prices, and it hurts consumers. Transparency must be part of any significant attempt to reform our health care markets.

Thank you for providing us with the opportunity to make comments and as always, we are happy to continue conversations with CMS about what we are doing to help improve the health and well-being of individuals, families, communities, and the nation.

Sincerely,

Richard E. Besser, MD

President and CEO