

January 28, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Transparency in Coverage (CMS-9915-P)

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the transparency in coverage proposed rule. **We appreciate the Departments of the Treasury, Labor, and Health and Human Services’ (collectively, the departments) effort to increase the availability of useful information for patients, specifically, the proposal to improve patient access to estimates of their individual cost-sharing liability prior to care. However, we strongly disagree with the proposal requiring health plans to publicly release all of their negotiated rates. This policy would lead to widespread confusion among patients, even greater consolidation in the commercial health insurance industry and other negative consequences for providers and consumers that AHA detailed in [previous comments](#) on similar proposals. It should be abandoned.**

Patients want access to timely, accurate and personalized cost-sharing information, and the AHA remains committed to working with the departments to achieve this shared goal. This information is important as patients prepare for medical care. Similar to understanding the expected course of treatment, knowing their cost-sharing information prior to receiving care allows patients in an informed manner to make prudent decisions. **Disclosing negotiated rates would not help patients or consumers make prudent decisions. That is because the information that is most meaningful to patients is their specific out-of-pocket costs for specific procedures. To that end, we again urge the departments to work cooperatively with providers, health plans, patients**



and other stakeholders to identify approaches that can better meet patients' needs.

Our detailed comments follow.

DISCLOSURE OF PERSONALIZED COST-SHARING INFORMATION

The departments seek comment on a proposal to require health plans to provide enrollees with individualized information on their expected cost-sharing for a health care event, as well as other important information about their coverage. **The AHA remains committed to helping patients gain better access to timely, accurate and personalized cost-sharing information and generally supports the departments' proposal.** In particular, we support the departments' attention to helping patients understand the full extent of their specific cost-sharing and coverage. With the rapid rise in deductibles,¹ it is important for patients to understand not only their copay or coinsurance obligations, but also where they are in their deductible. Having this information can help patients better understand their coverage and plan for their care financially. In addition, helping patients understand any coverage prerequisites prior to care, such as prior authorization, may help to eliminate some of the confusion and unnecessary administrative burden following care.

This proposal would require health plans to make more readily available information on an individual's health insurance coverage. In order to achieve this, providers and health plans will need to work collaboratively. Specifically, providers will need to convey information regarding the services anticipated for the patient's course of care. As currently written, the proposal requires patients to act as the intermediary between providers and health plans. For example, it would be up to the patient to obtain the service codes from providers to share with the health plan. To avoid that sort of cumbersome arrangement that could burden patients unnecessarily, **we, therefore, encourage the departments to also require that health plans make cost-sharing information easily accessible to providers so that they can better respond to patient inquiries.**

As we commented [previously](#), there should be no wrong door for patients to turn to in order to get estimates of their expected out-of-pocket costs. However, providers face barriers to accessing information about a patient's insurance to answer such inquiries in a timely and accurate manner. A simple solution to ensuring that providers' have the ability to respond to patient inquiries would be giving providers access to the same individualized information that patients would have under this proposal. In other words, health plans should be required to give providers access to their patients' specific benefit information via a secure website, subject to patient consent.

¹ Cox, C. et al. Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage. *Peterson-Kaiser Family Foundation Health System Tracker*. Aug. 2019.

Interestingly, in an effort to increase transparency for consumers, this proposed rule recognizes the opaque and confusing nature of prescription drug pricing. In its proposal, the agency expresses concern that disclosure of prescription drug negotiated rates, including pharmacy benefit manager-negotiated discounts and rebates, would only “perpetuate the lack of transparency around drug pricing.” While this analysis likely is accurate, the agency should apply the same thinking to the disclosure of negotiated rates for other health care services to ensure consumers are receiving the most beneficial information. The AHA understands the current drug pricing framework is not identical to that of other health care services; however, it is similar in that the disclosure of negotiated rates will not achieve the agency’s stated transparency goals nor will it aid consumers in a meaningful way. Rather, disclosure of these specific rates, both with drug pricing and with other health care services, only will result in increased confusion for consumers.

Finally, the AHA appreciates the departments’ acknowledgement that the estimates may not reflect the amount ultimately charged to the patient and supports the inclusion of this key point in the proposed model disclosure notice. As the departments note, additional, unplanned items or services may be required during a health care event. For example, providers often face quick decision points during complicated surgeries.

PUBLIC DISCLOSURE OF NEGOTIATED RATES AND ALLOWED AMOUNTS

The departments seek comment on their proposal to require health plans to make their negotiated rates and allowed amounts publicly available. As the AHA has commented [previously](#), such a public disclosure of this sensitive information would confuse – not help – patients in understanding their potential cost-sharing liability and would severely disrupt private contract negotiations between providers and health plans. In addition, the departments’ proposal to require health plans to broadly and publicly disclose negotiated rates information violates both the Affordable Care Act (ACA) and the Administrative Procedure Act (APA).

On its face, the departments’ proposal suffers from a clear, basic and overriding flaw: the absence of a nexus to the primary statutory authority under the ACA on which the departments purport to rely. The proposed disclosure requirement does not further the statutory objective of promoting transparency in *coverage*. The departments, therefore, lack the legal authority to compel the public disclosure of such highly sensitive and confidential pricing information.

In addition, the reasoning on which the departments rely in support of their proposal reveals that the proposal is arbitrary and capricious in violation of the APA. The departments rely on five justifications for requiring broad and public disclosure of negotiated rates information:

- First, the departments assert that uninsured consumers will use negotiated rate information to select health care service providers.²
- Second, the departments assert that negotiated rate information will be used by individuals who wish to “evaluate available options [in the] group or individual market.”³
- Third, the departments assert that public disclosure of negotiated rates “is necessary to enable consumers to use and understand price transparency data in a manner that will increase competition, reduce disparities in health care prices, and potentially lower health care costs.”⁴
- Fourth, the departments assert that requiring public disclosure of negotiated rates will help employers that sponsor group health plans in rate negotiation.⁵
- Fifth, the departments assert that requiring public disclosure of negotiated rates will “assist health care regulators in . . . oversee[ing] health insurance issuers.”⁶

None of these justifications passes muster under the APA. All rely on statutorily improper considerations or are otherwise indefensible.

What is more, the departments’ proposal is improper for an additional reason: The First Amendment to the United States Constitution does not permit compelled public disclosure of such confidential and trade secret pricing information.

For all of these reasons, the departments may not, as a matter of law, finalize their proposal.

A. The statute does not permit the departments to require disclosure of negotiated rates because disclosure of such confidential pricing information does not further the statutory objective of promoting transparency in coverage.

The departments’ proposal to require non-grandfathered health plans to broadly and publicly disclose negotiated rates finds no basis in the statutory provision in which it is purportedly grounded: Such disclosure of negotiated rates does not further the statutory objective of promoting transparency in *coverage*. The departments, therefore, lack the authority to compel the public disclosure of such highly sensitive and confidential pricing information.

² 84 Fed. Reg. 65,464, 65,477 (Nov. 27, 2019).

³ *Id.*

⁴ *Id.* at 65,478.

⁵ *Id.*

⁶ *Id.* at 65,479.

The departments rely in the first instance on section 1311(e)(3) of the ACA as the basis of their purported authority to compel broad and public disclosure of negotiated rates information.⁷ Section 1311(e)(3) is titled “Transparency in coverage” and provides that 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 statutorily enumerated types of information related to coverage (e.g., claims payment policies and practices, periodic financial disclosures, data on enrollment).⁸ Section 1311(e)(3) also includes a catch-all provision that requires disclosure of “[o]ther information as determined appropriate by the Secretary.”⁹ The departments assert that negotiated rates are “other information” that is a proper subject of disclosure under the catch-all provision.¹⁰

As section 1311(e)(3)’s heading, as well as its context, make clear, however, *all* of the information subject to disclosure under section 1311(e)(3) must be related to “[t]ransparency in coverage.”¹¹ This means that, where the Secretary designates “other information” for disclosure under section 1311(e)(3)’s catch-all provision, that other information must further transparency in coverage, just as the statutorily enumerated types of information do. As courts have explained, “where general words follow an enumeration of two or more things, they apply only to persons or things of the same general kind or class specifically mentioned.”¹² In other words, by enumerating eight specific types of coverage-related information for disclosure, Congress restricted the “other information” that may also be required to be disclosed to similar types of information.¹³

⁷ A separate statutory provision at section 2715A of the Public Health Service Act (PHSA) provides that all other non-grandfathered health plans must also “comply with the provisions of section 1311(e)(3) . . . except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.” PHSA § 2715A (codified at 42 U.S.C. § 300gg-15a). As discussed below, this provision does *not* expand the scope of the disclosures that may be required under section 1311(e)(3).

⁸ Section 1311(e) of the ACA is codified at 42 U.S.C. § 18031(e)(3).

⁹ 42 U.S.C. § 18031(e)(3)(ix).

¹⁰ 84 Fed Reg. at 65,477.

¹¹ 42 U.S.C. § 18031(e)(3) (emphasis added); see generally *Almendarez-Torres v. United States*, 523 U.S. 224, 234 (1998) (“[T]he title of a statute and the heading of a section’ are ‘tools available for the resolution of a doubt’ about the meaning of a statute.”) (citing *Trainmen v. Baltimore & Ohio R. Co.*, 331 U.S. 519, 528–29 (1947)).

¹² *Int’l Broth. of Elec. Workers v. Pub. Serv.*, 773 F.3d 1100, 1108 (10th Cir. 2014) (quoting Scalia & Garner, *Reading Law: The Interpretation of Legal Texts* 199 (2012)); see also Scalia & Garner, *Reading Law: The Interpretation of Legal Texts* at 199 (“When a drafter has tacked on a catchall phrase at the end of an enumeration of specifics, as in *dogs, casts, horses, cattle, and other animals*[,] . . . the phrase *and other animals* . . . implies the addition of *similar* after the word *other*.”) (emphasis in original).

¹³ Courts have applied this limitation across multiple canons of statutory interpretation, including the *noscitur a sociis* canon (for interpreting the meaning of an ambiguous statutory word) and the *eiusdem generis* canon (for interpreting the scope of statutory lists). Across all such canons, the limitation is important “to avoid the giving of unintended breadth to Acts of Congress.” *Wash. State Dep’t of Health*

The departments cannot lawfully require disclosure of negotiated rates information under section 1311(e)(3) because it relates to *price* – not coverage. The departments tacitly acknowledge this fact by recognizing that there is no linkage between the negotiated rates information subject to their proposed disclosure requirement and enhanced transparency in coverage.¹⁴ The departments nonetheless attempt to cobble together a tenuous tie between the two by stating that “[n]egotiated rates are an essential *input* for the calculation of . . . *cost-sharing liability*.”¹⁵ Their attempt fails for two reasons.

In the first place, the departments’ explanation effectively concedes that disclosure of negotiated rates information, in and of itself, furthers only *price* transparency, as opposed to the statutorily required objective of promoting *coverage* transparency. The departments’ proposal, therefore, violates the basic precept of administrative law that “[a]n administrative agency’s power to regulate . . . must always be grounded in a valid grant of authority from Congress.”¹⁶ Simply put, the departments may not interpret a statutory provision intended to promote coverage transparency to grant *sub silentio* the agency a new authority to mandate price disclosure.¹⁷ If Congress had intended the provision to encompass authority to mandate sweeping disclosure of confidential and highly sensitive negotiated rates information, Congress surely would have said so explicitly.¹⁸ Agencies simply do not have the interpretive authority to “[e]xtend the scope of [a] statute beyond the point where Congress indicated it would stop.”¹⁹

Moreover, the departments *separately* propose to mandate disclosure of estimated cost-sharing liability and accumulated financial responsibility.²⁰ Accordingly, the required price disclosure proposed here does *nothing* to further promote cost-sharing

Serv. v. Guardianship Estate of Keffeler, 537 U.S. 374, 384 (2003) (quoting a discussion of the *noscitur a sociis* canon of interpretation in *Jarecki v. G. D. Searle & Co.*, 367 U. S. 303, 307 (1961), and suggesting the rationale also applies to the *ejusdem generis* canon of interpretation).

¹⁴ See 84 Fed. Reg. at 65,472.

¹⁵ *Id.* (emphasis added).

¹⁶ *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 161 (2000) (internal citation and quotation omitted).

¹⁷ As the Supreme Court has made clear, “[r]egardless of how serious the problem an administrative agency seeks to address . . . it may not exercise its authority in a manner that is inconsistent with the administrative structure that Congress enacted into law.” *Id.* at 125 (internal citation and quotation omitted).

¹⁸ “Congress . . . does not alter . . . fundamental details of a regulatory scheme in vague terms or ancillary provisions — it does not, one might say, hide elephants in mouseholes.” *Whitman v. Am. Trucking Ass’n*, 531 U.S. 457, 468 (2001).

¹⁹ *Brown & Williamson Tobacco Corp.*, 529 U.S. at 161 (quoting *United States v. Article of Drug . . . Bacto-Unidisk*, 394 U.S. 784, 800 (1969)); see also *Merck & Co. v. U.S. Dep’t of Health & Human Servs.*, 385 F. Supp. 3d 81, 84 (D.D.C. 2019) (“For a regulation to have the force of law, Congress must communicate through legislation, either expressly or impliedly, its intent for the agency to make rules in that specific area. When Congress has not communicated such intent, the agency has no power to act.”).

²⁰ See 84 Fed. Reg. at 65,472.

transparency in that regard. In other words, to the extent that negotiated rates are an “input” into cost-sharing information, which in turn furthers coverage transparency, disclosure of such rates is unnecessary to further the departments’ stated objective of promoting such transparency, in light of the departments’ independent cost-sharing proposal. Any suggestion by the departments to the contrary is “so implausible that it could not be ascribed to a difference in view or the product of agency expertise.”²¹ The departments’ proffered rationale, therefore, has no force.

There is yet another reason why the departments’ interpretation of 1311(e)(3) is impermissible: The departments are proposing to require public disclosure of information that the departments themselves are statutorily required to protect against such disclosure. As the departments themselves recognize,²² negotiated rates are typically held as “trade secrets” or other “confidential commercial information.” Congress has enacted robust statutory regimes, such as the Trade Secrets Act, the Privacy Act and the Freedom of Information Act (FOIA), that expressly protect such highly sensitive and confidential information from public disclosure when it is obtained by the government.²³ The departments are now proposing to require health plans to publicly disclose the very same types of information that the departments are statutorily prohibited from making public. This proposal is the height of unreasonable interpretation. The departments may not compel third parties to do indirectly what the departments themselves may not do directly.²⁴ It is inherently unreasonable to interpret section 1311(e)(3) in a manner that subverts the confidentiality protections guaranteed by Congress. The departments’ proposal to do so violates the basic and fundamental principle that statutes are to be interpreted, whenever possible, to be “in harmony with... other applicable statutes.”²⁵

B. The justifications proffered by the departments to support their negotiated rates proposal are arbitrary and capricious.

1. Four of the departments’ five proffered justifications are not grounded in statutorily cognizable considerations.

²¹ *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 44 (1983).

²² See 84 Fed. Reg. at 65,510.

²³ See, e.g., 5 U.S.C. § 552(b)(4) (exempting trade secrets and confidential commercial or financial information from public disclosure under FOIA), 5 U.S.C. § 552(a) (Privacy Act); 18 U.S.C. §1905 (Trade Secrets Act); see also 18 U.S.C. § 1836 (Defend Trade Secrets Act of 2016, recognizing the intellectual property rights of trade secret holders).

²⁴ Cf. *Cummings v. Missouri*, 71 U.S. 277, 288 (1867) (“[T]hat what cannot be done directly cannot be done indirectly; or as [Sir Edward] Coke has it, . . . ‘*Quando aliquid prohibetur, prohibetur et omne, per quod devenitur ad illud.*’”); cf. 82 Fed. Reg. 37,990, 38,499 (Aug. 14, 2017) (withdrawing a proposal to require third parties to disclose confidential survey reports because the proposal “may appear as if [the Centers for Medicare & Medicaid Services (CMS)] was attempting to circumvent the [statutory] provision” that prohibits the agency from directly disclosing such reports).

²⁵ *Kohler Co. v. Moen Inc.*, 12 F.3d 632, 642 (7th Cir. 1993).

The five justifications that the departments have put forward to support their negotiated rates proposal are arbitrary and capricious. Indeed, the first four justifications proffered by the departments are not even grounded in statutorily cognizable considerations. All four justifications are ultimately premised on the departments' conjecture that the proposed disclosure of pricing information will better let consumers "judge the reasonableness of provider prices and shop for care at the best price."²⁶

First, as discussed above, the departments' reasoning proceeds from a flawed premise: It focuses on purported benefit of disclosing *price* information, without a nexus to the statutory objective of "[t]ransparency *in coverage*."²⁷ Indeed, the departments' own proposed rule makes abundantly clear that the departments' true overriding objective is "price transparency" for its own sake. The departments all but concede that any tenuous linkage that the departments draw between negotiated rates and coverage is mere pretense.²⁸ As the departments themselves explain, the true purpose of the proposed rule is not providing information helpful for evaluating *coverage*; rather, the departments believe that price disclosure is beneficial in and of itself. In the departments' own words, the proposed rule is intended to "fulfill the departments' responsibility under Executive Order 13877" to "support a market-driven health care system by giving consumers" greater information about *price* – because, "[t]he departments are of the view that . . . price transparency . . . will" help stabilize health care spending.²⁹ For example, the departments are requiring disclosure of negotiated rates with respect to drugs because "requiring the issuer to disclose *only* the . . . individual's cost-sharing liability estimate would perpetuate the lack of transparency around drug *pricing*."³⁰

The purported independent benefit of mandating price disclosures is simply not a valid factor for consideration under section 1311(e)(3) of the ACA, because such a consideration does not bear on "[t]ransparency *in coverage*."³¹ And, as discussed above, the departments may not transmute the statutory objective of promoting transparency in coverage into a separate – and statutorily baseless – goal of promoting transparency in price. Agencies are not "free to substitute new goals in place of the statutory objectives without explaining how these actions are consistent with [the] authority under the statute."³²

Second, the departments' first four justifications also are misplaced because they are not grounded in any rationale applicable to *qualified health plans* (QHPs). Section 1311(e)(3) of the ACA concerns transparency in coverage under health plans seeking

²⁶ 84 Fed. Reg. at 65,477.

²⁷ 42 U.S.C. § 18031(e)(3) (emphasis added).

²⁸ "An agency's actions are arbitrary and capricious under the APA if they are pretextual." *Saget v. Trump*, 375 F. Supp. 3d 280, 361 (E.D.N.Y. 2019).

²⁹ 84 Fed. Reg. at 65,465.

³⁰ *Id.* (emphasis added).

³¹ 42 U.S.C. § 18031(e)(3) (emphasis added).

³² *Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987).

certification as QHPs from a health insurance exchange.³³ Thus, any disclosure requirement must find a basis in furthering transparency in coverage under QHPs.

To be sure, section 2715A of the PHSA mechanically imports the disclosure requirements in section 1311(e)(3) to all other non-grandfathered health plans.³⁴ But that does *not* mean that section 2715A expands the scope of the Secretary's authority under section 1311(e)(3). It remains the case that the Secretary may invoke section 1311(e)(3) *only* on its own terms, to impose information disclosure requirements that are "appropriate" to further "transparency in coverage" for health plans "seeking certification as *qualified health plans*" from a health insurance exchange.³⁵ Through section 2715A, Congress has merely taken such requirements and automatically applied them to a broader universe of health plans. Such automatic application in no way relieves the requirements from being defined in the first instance by reference to their furtherance of transparency in coverage under QHPs.

Accordingly, the APA mandates that the departments furnish a reasoned justification that supports the exercise of *section 1311(e)(3)* authority in the first instance.³⁶ In other words, the departments must explain why it is reasonable to impose the proposed disclosure requirement on *QHPs* – because, by its terms, section 1311(e)(3) exclusively regulates QHPs, and such regulation of QHPs under section 1311(e)(3) authority must be justified *before* section 2715A is mechanically invoked to extend the requirements beyond QHPs. Therefore, the departments may *not* rely on their proffered rationales relating to the uninsured,³⁷ employers that sponsor group health plans,³⁸ consumers shopping more broadly for health insurance coverage beyond QHPs,³⁹ or governmental health benefit programs⁴⁰ – or vague and speculative pronouncements about alleged benefit to the health care system generally – to justify their proposal.⁴¹ These are statutorily irrelevant considerations because they have nothing to do with promoting transparency of coverage under QHPs. By seeking to rely on these statutorily irrelevant considerations to justify their proposal, the departments have violated the APA: It is hornbook law that "[a]gency rules" are "arbitrary and capricious if the agency [] relie[s] on factors which Congress has not intended it to consider."⁴²

³³ See 42 U.S.C. § 18031(e)(3) (requiring health insurance exchanges to impose requirements on "health plans seeking certification as qualified health plans").

³⁴ See PHSA § 2715A.

³⁵ 42 U.S.C. § 18031(e)(3) (emphasis added).

³⁶ See *Mass. v. EPA*, 549 U.S. 497, 533–34 (2007) (even if an agency offers a "laundry list of reasons" for its decision, this does not "amount to a reasoned justification" where the agency's proffered reasons are not based on statutorily cognizable considerations; an agency always "must ground its reasons for action or inaction *in the statute*") (emphasis added).

³⁷ 84 Fed. Reg. at 65,477.

³⁸ *Id.* at 65,478–79.

³⁹ *Id.* at 65,477.

⁴⁰ *Id.* at 65,477–78.

⁴¹ See, e.g., *id.* at 65,465–68, 65,477–78.

⁴² *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43.

Third, the departments cannot rationally conclude that their proposal will benefit health care consumers. If anything, requiring disclosure of negotiated rates information is likely to *compound* confusion among consumers rather than promote more informed decision-making. Consumers do not have any need for negotiated rates information to make informed decisions, because negotiated rates do not necessarily reflect the costs that consumers actually bear.⁴³ Indeed, requiring disclosure of negotiated rates is likely to confuse consumers – who may, for example, erroneously believe that negotiated rates reflect their expected out-of-pocket expenses.⁴⁴ The negotiated rates information subject to the departments’ proposal simply does not provide consumers with any information that they need to make more informed health care decisions, and it is arbitrary and capricious for the departments to purport to justify their proposal based on such a rationale. Moreover, the departments acknowledge in the proposal that premiums will increase due to the additional cost on insurers to comply with this rule,⁴⁵ and that this policy could lead to narrower networks.⁴⁶ Neither of these outcomes will benefit health care consumers.

2. The departments’ fifth proffered justification regarding purported benefits to state insurance regulators cannot rationalize *public* disclosure of negotiated rates.

The departments’ fifth proffered rationale, i.e., purported benefits to state insurance regulators, also is invalid. The departments cannot justify *public* disclosure of highly sensitive and confidential pricing information on the grounds that state insurance regulators might find such information helpful.

In the first place, the proposed disclosure requirements will not serve as a benefit to state regulators: The departments concede that state insurance regulators “*already* have access to the information proposed to be made public.”⁴⁷ Indeed, state regulators have broad authority to regulate health insurance issuers. There is no reason to think that such regulators do not have existing authority to compel disclosure of such information from issuers if such information is necessary or helpful for rate review or other purposes.

⁴³ As discussed above, negotiated rates information is unnecessary to further the departments’ stated objective of informed decision-making as to out-of-pocket costs—because the departments are separately proposing to require disclosure of expected cost-sharing information.

⁴⁴ For the uninsured, there is no basis for concluding that negotiated rates information is helpful to understanding out-of-pocket costs. In other contexts, the Government itself has tacitly acknowledged that both negotiated rates *and* chargemaster charges are poor proxies for the uninsureds’ out-of-pocket costs: Indeed, this was CMS’s proffered rationale for requiring the disclosure of discounted cash price standard charges in its separate hospital standard charges rulemaking. See 84 Fed. Reg. 65,524, 65,552–53 (Nov. 27, 2019).

⁴⁵ 84 Fed. Reg. at 65,493.

⁴⁶ *Id.* at 65,495.

⁴⁷ 84 Fed. Reg. at 65,479 (emphasis added).

What is more, the departments do not explain how an interest in providing relevant information to state regulators justifies broad disclosure of highly sensitive and confidential information to the public at large, especially where such disclosure is entirely avoidable.

To the extent that there is an interest in providing such information to state regulators, the Secretary may invoke alternative authorities to do so that avoid public disclosure. Sections 1311(c)(1) and 1321(a)(1) of the ACA grant the Secretary rulemaking authority that can be deployed in a more tailored manner to require information of relevance to state insurance regulators to be disclosed to such regulators – and such regulators only. Doing so would accomplish the departments’ stated objective of helping regulators without unnecessarily also requiring disclosure of such confidential information to the public at large.

Further, even under section 1311(e)(3) authority, the departments must explain why it is “appropriate” to make the negotiated rates information available to the public at large – where the departments’ only potentially cognizable rationale for requiring such disclosure relates exclusively to state regulators. On its face, section 1311(e)(3) grants the Secretary authority to “make available to the public...other information as *determined appropriate* by the Secretary.”⁴⁸ The Secretary, therefore, must limit any required disclosure to the public to “appropriate” circumstances. Where the rationale for disclosure is limited to a segment of the public (e.g., state regulators), it necessarily follows that disclosure is appropriate *only* as to such segment – especially where, as here, the information subject to disclosure is highly sensitive and confidential. Accordingly, here, any requirement under section 1311(e)(3) authority to make available the pricing information at issue is necessarily circumscribed to *state regulators* – because the Secretary has made no cognizable determination that disclosure is appropriate beyond this segment of the public.

Thus, it is not rational or defensible for the departments to mandate broad public disclosure of the contemplated information based on a supposition that state regulators may benefit from such information. Agencies may not rely on a sweeping and overly broad policy approach, while “cavalierly sidestep[ping their] responsibility to address reasonable alternatives” that are tailored to satisfying the agencies’ stated objectives.⁴⁹

C. The departments’ proposal to mandate disclosure of negotiated rates is compelled speech in violation of the First Amendment.

The departments’ proposal to mandate the disclosure of highly confidential and commercial sensitive negotiate rate pricing information also constitutes compelled

⁴⁸ 42 U.S.C. § 18031(e)(3) (emphasis added).

⁴⁹ *Delaware Dep’t of Nat. Res. & Env’tl. Control v. EPA*, 785 F.3d 1, 17–18 (D.C. Cir. 2015) (holding that a nationwide rule that carried the potential to distort organized markets was arbitrary and overbroad agency action in violation of the APA).

speech in violation of the First Amendment to the United States Constitution. Government regulation of non-misleading commercial speech is unlawful unless it “directly advances” a “substantial” governmental interest, and is no “more extensive than is necessary to serve that interest.”⁵⁰ Here, the departments’ proposal to mandate public disclosure of negotiated rates does not advance any substantial governmental interest, much less in a narrowly tailored way.

At bottom, the departments have asserted that their proposal will “empower a more price-conscious and responsible health care consumer, promote competition in the health care industry, and lower the overall rate of growth in health care spending.”⁵¹ While the AHA respects and endorses the goal of increasing information where it would be of actual material benefit to consumers and the health care marketplace — the departments offer no plausible explanation for why disclosure of *negotiated rates* information will materially further the departments’ stated goals. As discussed above, the mandatory broad disclosure of confidential negotiated pricing information will not assist consumers in understanding their out-of-pocket costs. Similarly, disclosure of negotiated rates will not help promote competition or curb health care spending: As the Federal Trade Commission (FTC) has explained, “classifying plan provider contracts as public data would offer little benefit but could pose substantial risk of reducing competition in health care markets.”⁵² Indeed, the departments concede that the proposed disclosure requirement “may dampen each competitor’s incentive to offer a lower price or result in a higher price equilibrium,” while creating a “disincentive for plans and issuers to establish a contractual relationship with a provider (including in narrow networks).”⁵³

Any beneficial linkage between the compelled disclosure of negotiated rates information and the departments’ stated objectives are thus, at best, “tenuous” and “highly speculative,”⁵⁴ which even the departments’ own analysis concedes. Such “conditional” and “remote” considerations “cannot justify” infringement on the First Amendment rights of health plans and hospitals – especially here, where the departments are proposing to infringe upon intellectual property rights by mandating the disclosure of highly confidential negotiated rates, which are safeguarded as trade secrets under federal and state law.⁵⁵

⁵⁰ *Central Hudson Gas & Elec. Corp. v. Public Serv. Comm’n of New York*, 447 U.S. 557, 566 (1980). Certain uncontroversial commercial disclosures may be required consistent with *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985). But the departments have failed to identify a sufficient predicate to justify the application of *Zauderer* to the facts presented here. In any event, the proposed rule here would fail under either test. Even under *Zauderer*, a disclosure requirement cannot be “unjustified or unduly burdensome.” *Id.* at 651.

⁵¹ 84 Fed. Reg. at 65,486.

⁵² Letter from FTC to the Honorable Joe Hoppe, Minnesota House of Representatives 3 (June 29, 2015) (internal quotation marks omitted), available at <https://tinyurl.com/u7fryu8>.

⁵³ 84 Fed. Reg. at 65,495.

⁵⁴ *Central Hudson*, 447 U.S. at 569.

⁵⁵ *Id.*

REQUEST FOR INFORMATION: PROVIDER QUALITY MEASUREMENT AND REPORTING IN THE PRIVATE HEALTH INSURANCE MARKET

The proposed rule also includes a request for information soliciting feedback on how public and private sector quality measurement and reporting initiatives could complement its efforts to provide pricing information. As longstanding supporters of quality transparency, America's hospitals and health systems believe that patients, families and communities should have valid, clear and important quality information to help them make important health care decisions. In fact, a voluntary effort led by hospitals ultimately led to the creation of the *Hospital Compare* website that has been the backbone of quality transparency efforts for over a decade. Thus, in concept, the AHA agrees that patients should have a combination of both quality and out-of-pocket cost data available to them to inform their care decisions.

However, as a general principle, the AHA urges the departments to recognize how much quality reporting already is required of hospitals and health systems. We strongly urge the departments to first leverage data available from existing efforts before creating any new requirements related to price transparency. The AHA's 2017 *Regulatory Overload* report found that an average community hospital spends over \$700,000 per year just to meet the Department of Health and Human Services' (HHS) quality measurement requirements. This amount does not include the substantial reporting requirements hospitals often face from private payers, state agencies and others. In fact, one large academic medical center reported spending nearly \$15 million annually in quality measure reporting across federal, state and private payer measure reporting activities.⁵⁶

Furthermore, we strongly urge that any quality measurement and reporting requirements serve the departments' quality and patient safety priorities, and not simply their price transparency agenda. Indeed, the AHA is concerned that quality measurement requirements that are too narrowly focused on the price transparency agenda could hamper the federal government's commitment to and progress on using "meaningful measures" in its programs. For too long, measures proliferated without a tie to concrete quality priority areas. When the measures in programs are too numerous, data collection activities can overwhelm hospital staff and limit their ability to do what matters most – improving care. Moreover, as noted above, such reporting activities come at a substantial cost. For these reasons, the AHA has strongly supported HHS's Meaningful Measures initiative that has resulted in an approximately 30% reduction in the number of measures used in its hospital programs. As the departments consider the role of quality information in the price transparency agenda, we strongly urge them to ensure that any new requirements align with HHS's Meaningful Measures framework.

⁵⁶ Blanchfield BB et al. The Cost of Quality: An Academic Health Center's Annual Costs for Its Quality and Patient Safety Infrastructure. *Joint Commission Journal on Quality and Patient Safety*. Vol. 44, Issue 10. Oct. 2018.

We urge the departments to continue engaging with efforts that aim to align more effectively measure requirements across the public and private sectors. The current lack of alignment across public and private payers has led to hospitals reporting overlapping and redundant measures. For example, multiple payers and HHS may ask a health system to report on diabetes control, but each may use a different measure definition, leading hospitals to report multiple versions of the same thing. Such duplication adds waste, does not improve quality and makes it far more challenging for providers to track their own progress. We are pleased that HHS has engaged with the Core Measure Quality Collaborative (CQMC) led by America's Health Insurance Plans (AHIP) and the National Quality Forum (NQF), an effort that is seeking to better align physician-level measurement. The AHA also is working with other national groups on recommendations for stronger public/private sector alignment in hospital measures, and looks forward to sharing more information with HHS soon. HHS's engagement with these efforts will be essential to maximizing the impact and minimizing the unnecessary burden of quality measurement.

Lastly, the AHA urges caution in "pairing" cost and quality data because their construction and goals are quite different. Quality data are meant to help patients understand how well a health care provider does, on average, in providing safe, high-quality care. Depending on how the measure is constructed, this average can reflect care for all patients the provider treats, or a subset of those patients. This average can be a reasonable predictor of what quality and outcomes a given patient may receive. But, at the end of the day, it is still an average, and it is not tailored to a patient's particular clinical severity and co-morbidities. As the departments considers how to combine cost and quality data, they should acknowledge the limits of each kind of data, and know that a pairing of granular, out-of-pocket cost data and average quality data likely is not necessarily useful to patients.

REQUEST FOR INFORMATION: DISCLOSURE OF PRICING INFORMATION THROUGH A STANDARDS-BASED APPLICATION PROGRAMING INTERFACE (API)

The departments are considering whether to require, in future rulemaking, that health plans make available through a standards-based API the cost-sharing information that would be disclosed through the proposed internet-based self-service tool as well as the in-network negotiated rates and out-of-network allowed amounts proposed to be publically disclosed through machine-readable files. The request for information seeks feedback on a number of potential future proposals that would align API requirements with those proposed in the Office of the National Coordinator for Health Information Technology (ONC) information blocking and CMS interoperability proposed rules released March 2019.

The AHA supports alignment of technical standards across government agencies and healthcare entities. However, as stated in our comments to both [ONC](#) and [CMS](#), we remain concerned about the privacy and security of a patient's information when entered into a third-party application. While patients should have

access to information to make informed decisions and engage more fully in their care, it is unclear whether patients understand the ramifications of sharing their personal data with third-party vendors. Once shared outside of a HIPAA-protected environment, a patient's data are vulnerable to misuse for marketing and other commercial gain. They also are at risk for being further exposed, as third-party vendors are not required to encrypt patient's data, leaving the data susceptible to hacking.

APIs, while holding great promise to unlock data and put them in the hands of patients and consumers, remain vulnerable to security threats. This was evidenced by the recent breach of patient information through CMS's own Blue Button 2.0 API. It is critical that the privacy and security of patient data be a top consideration in any future proposal that would put sensitive patient information in the hands of third-party actors.

MEDICAL LOSS RATIO (MLR) PROPOSAL

Finally, HHS seeks comment on a proposed change to the MLR calculation. The MLR measures how much of the premium dollars goes toward health care services and quality improvement activities. Current rules require that, if the MLR is less than 80% in the individual and small group markets or 85% in the large group market, the health plan must rebate to its enrollees the difference. Under this proposal, health plans would be able to take credit for shared savings payments to enrollees that use "lower-cost, higher-value providers" by counting those payments in the MLR numerator. **The AHA believes that the MLR standard is an important tool to hold health plans accountable for how premium dollars are spent, and we do not support this proposal as it would diminish the MLR standard.**

In addition, the AHA is concerned that this proposal could steer patients away from the providers best equipped to handle their health care solely based on financial reasons. Not only does the department fail to define "lower-cost, higher-value provider," but it also fails to acknowledge that the value of a provider may vary from patient to patient based on a patient's specific needs, the patient's prior relationships with a provider and the provider's referral partners. By promoting a one-size-fits-all definition of "higher-value," this proposal could lead to more ineffective, lower quality care – the antithesis of its purported objective.

Finally, the AHA does not believe that HHS has the statutory authority to amend the MLR calculation in this way. As HHS notes in the proposal, the standardized methodology for calculating the MLR numerator reflects expenses for: (1) reimbursement for clinical services and (2) activities that improve health care quality. While section 2718(c) of the PHSA does give HHS broad authority to adjust MLR methodologies to account for "special circumstances" and "different types of plans," such methodologies must be "methodologies for calculating measures of [reported activities]." With respect to the MLR numerator, such activities are reimbursement for clinical services and activities that improve health care quality. This proposal does not concern reimbursement for clinical services, so the agency must be assuming that the

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shared savings would improve health care quality. This assumption is incorrect. The AHA does not believe steering patients to lower-cost providers will improve health care quality; in fact, it could have the opposite effect. Therefore, such an amendment to the calculation of the MLR numerator is fundamentally flawed and should not be finalized.

We appreciate the opportunity to comment on the departments' "Transparency in Coverage" proposed rule. The AHA is committed to helping patients gain better access to timely, accurate and personalized cost-sharing information and looks forward to working with the departments on this objective. Please contact me if you have questions, or feel free to have a member of your team contact Ariel Levin, senior associate director of policy, at (202) 626-2335 or alevin@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President