COMMENTS FOR CMS-1694-P

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We write today to express our strong support for your efforts to increase transparency in health care. The status quo harms those with chronic conditions trying to afford care, raises premiums, and creates barriers to entry for health care innovators.

The Foundation for Government Accountability (FGA) exists to strengthen communities and improve the lives of individuals and families by equipping policymakers with principled strategies to reform health care and welfare programs nationwide.

FGA brings a unique perspective to this conversation given our wide-reaching work in over a dozen states to actively increase transparency in health care. We have learned many valuable lessons from being part of the same debate repeatedly in red, blue, and purple states alike, and have been privileged to be part of formal transparency discussions and related proposed and successful legislation in AK, AZ, CO, FL, IL, IA, KS, KY, ME, MA, MO, MT, NE, NH, NC, OH, OK, SC, TN, VA, and WV.

Pertaining to the questions posed, we suggest that the best definition of "standard charge" should be the average paid after discounts off the chargemaster across all payers. The definition of standard charge should be both for the release of average paid after discounts prices under fee for service payments, but also for bundled pricing- the goal should be apples to apples comparisons for consumer in both forms. There is little value in disclosing simple chargemaster rates, as that is often not even the price a cash paying patient would pay.

Providers can help inform patients by providing the possible price if the patient were to pay cash as well as basic procedure codes or service information to aid the patient in obtaining more estimates from their insurer. We suggest exploring many avenues that are available to authorize providers and insurers alike that participate in the exchanges, Medicaid and Medicare to empower patients with more information by addressing gag clauses, QHP transparency options, and most favored nation clauses.

Our research and direct experience has taught us that not all transparency is created equal. Here is what we have learned in our transparency work:

1. **Patients in the small and nongroup (individual) health insurance markets need the most help.** Unlike self-insured companies that can access their claims, the "small guys" have no access to their past claims or cost estimates ahead of time. We also believe there are opportunities to lower health care costs in Medicare, Medicaid, and exchange plans with more transparency and shared savings incentives that are worth considering in your effort.

2. **Patients need to see what *their* health plan pays**, so they can compare options. This must include not only out-of-pocket estimates, but what a patient's plan will pay. Patients also need to know the average rates (or some kind of pricing anchor) so they can compare rates and decide if they are getting a "good deal" or not.

3. **Patients need to see a direct positive result to shopping**. Transparency alone is not enough. Patients should be paid a shared saving if they shop to find a better deal. According to transparency companies with transparency tools, shared savings have been shown to increase patient engagement by 11 times.

4. **Patients need access to high-value (i.e. high-quality, lower-cost) providers <u>regardless of network status</u>.** Independent lower-cost options are becoming more and more rare. In many markets they are being pushed out of insurer networks. Significant provider consolidation has taken place, and many insurers have narrowed their networks. Better-priced options often exist out-of-network, but patients are effectively penalized for seeking those options as they pay 100 percent of the costs and that out-of-pocket spending does not count against their deductible and out-of-pocket limit. This must change if we want to protect patients and prevent "too-big-to-fail" health systems that charge very high rates with uneven quality care being delivered—the worst of all outcomes.

What you can learn from the states on meaningful transparency?

We worked with a local lawmaker in Maine to help pass an innovative law called Right to Shop that reflects many of the principles highlighted above and passed with ***unanimous bipartisan*** support.

Our extensive state level work has taught us that insurers must play the central role in price disclosure. They are closest to the right information for patients and should be expected to provide any information to the enrollee that is requested. That is why transparency must not stop at the hospital or facility level.

While many states have required provider-level transparency on charge rates, the information required is often not actionable for patients, and providers are often not best positioned to provide this information quickly given unique insurer plan designs. Providers and potential providers play an important role in giving procedure or service information, but their role on price disclosure is secondary and should be more focused on facility-fee related costs. In any final rule, breaking out facility-fee costs as part of standard cost could be helpful to patients.

While most insurance companies claim to offer cost information or transparency tools, many of the tools are hard to find, rarely publicized, not user friendly, very limited in nature, and don't display enough information for patients to make fully informed decisions. In fact, the best ones often only disclose estimated out-of-pocket costs for a handful of services or procedures, which is not sufficient.

Estimated out-of-pocket cost estimates are not enough information, as there are numerous situations where patients have little or no incentive to shop for better value options, which results in wasted money being spent on higher-cost care, and consequently higher insurance premiums the next year. Contracted rates in-network can vary by up to 1,000 percent with no correlation to quality. Patients empowered with this information and incentives to shop can dramatically reduce health care spending without sacrificing quality of the care they receive.

Patients also need to be engaged every time they interact with the health system. For example, with ACA-preventative services where there is no cost-sharing for the patient, or once a patient has exceeded their deductible, out-of-pocket estimates don't help a patient find their way to a procedure or service that may cost 10 times less for high-quality services. That is why positive incentives matter so much with transparency. The lack of widespread positive incentives highlights an area where current insurer designs have fallen short.

Lastly, transparency of cash-pay prices is important, but it is important to acknowledge that these prices are often not the same as charge amounts, a fact that is often overlooked in transparency efforts. Patient need to know more than the undiscounted charge rates.

Finally, we want to mention three transparency companies* that are well worth speaking with to learn more about their processes to use incentives and transparency to lower health care costs. All three companies have instructive track records of how to engage patients and lower health care costs.

- Healthcare Bluebook
- MyMedicalShopper
- Vitals Smartshopper

We would be happy to answer any questions you may have and look forward to additional future conversations about this topic.

**FGA does not have any financial relationship with any of these companies and would recommend you cast a wide net to learn from companies already in the transparency space and learn from their years of experience, as well.*