Society of Professional Benefit Administrators

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1694-P

June 25, 2018

Dear Ladies and Gentlemen,

These comments on CMS-1694-P are submitted on behalf of the Society of Professional Benefit Administrators ("SPBA").

SPBA is the leading national trade association of Third Party Administration (TPA) firms hired by employers and employee benefit plans to provide contract-based management of their employee benefit plans. It is estimated that 55% of US workers and their dependents in non-federal health coverage are in plans administered by an SPBA member TPA. SPBA member TPA firms operate much like independent CPA or law firms, providing professional claims and benefit plan administration for several client employers and benefit plans.

A unique perspective of SPBA is that clients of TPA firms include every size and form of employment, including large and small employers, non-federal governmental plans, union, non-union, collectively bargained multiemployer plans (Taft-Hartley), as well as plans representing religious entities. The majority of these clients are ERISA self-funded plans and sponsors; some of our TPA members also provide services to other types of plans, including fully-insured plans and HMOs.

SPBA works closely with the relevant federal agencies to understand the constant flow of regulations and interpretations. This knowledge is used to give perspective and education to plan sponsors, including trustees. The agencies have appreciated our insights and have shared with us that this interaction helps the agencies in understanding issues and developing implementing regulations.

SPBA has been dialoging with HHS on the issue of price transparency for many years now and we submitted a policy brief in the Fall of 2011 on Section 2718(e) of the Public Health Service Act, Standard Hospital Charges, and then submitted an updated policy brief in the Spring of 2012 and another brief in the summer of 2014.

We are encouraged by the recent request of HHS for further comments on Section 2718(e). We believe that the current flexibility afforded hospitals for compliance with this Section is not serving the public effectively and changes are needed. We welcome this opportunity to share our perspective.

"Standard Charges" Definition

In the commercial market, hospital charges have little meaning to the consumer in the health care transaction. The hospital charge does not reflect what the hospital generally accepts as payment in full, often

with the hospital charging different amounts to different payers for the same procedure. Commercial contracted discounts with providers can range anywhere from 5% to 75% off billed charges (depending on the provider, service and geographical region), rendering the charge virtually meaningless. If the hospital "standard charge" for a procedure is $1,000, the hospital is often accepting payment anywhere from $950 to $250. The consumer has no way of knowing what the hospital will accept as payment in full and in most cases lacks the sophistication to know that discounts are available. The consumer is unaware of the complicated discount arrangements that hospitals offer to certain purchasers and not to others.

The current system hurts the most vulnerable health care consumer the most: the uninsured. Those without coverage lack the support system to navigate a system that is shrouded in secret preferred treatment arrangements for certain consumers and not others. Those with coverage are also prevented from shopping effectively based on price and quality.

Offering the consumer the billed charge does little to educate the public of the true price of care and can even do harm in the effort to encourage consumers to use price information as a basis for economic decision-making. The chargemaster is not an accurate measure of a hospital's "standard charges" since it does not reflect the true price the hospital is willing to accept for payment.

The prices a hospital will accept depend upon many factors. For example, the prices change based upon whether the consumer is insured or not, who the insurance payer is or if the consumer is paying in cash. The price differs depending upon who is making the payment, which results in price discrimination against the consumer. This creates further unfair cost shifting against consumers. A higher price should not be charged based on the fact that certain consumers will pay all of the billed amount. Regardless of whether they have coverage or not, consumers and their representatives deserve to have a platform for uniform and consistent comparative evaluation of an episode of care at a facility. Without transparency of the full and total pricing picture, this cannot be accomplished.

SPBA believes the consumer will be best served if "standard charges" are defined to mean the amount the hospital will accept as payment in full for items and services (without complications) by non-governmental payers and individuals. This information would be most beneficial to patients.

This straightforward definition of "standard charges" will resolve many issues.

>> This approach will reduce significantly the administrative cost of hospitals. There will no longer be hundreds of payer discount contracts to manage. Some estimate that this approach would reduce administrative costs by as much as 25%.

>> This approach allows third party payers and insurance companies to compete on their abilities to help educate the patient, inform them of their options, assist with decision making, and focus on staying or getting healthy.

The current health care system is filled with services that compete using this approach. One only has to look in any newspaper to see ads for cosmetic procedures not typically paid for by insurance to see how effective this approach can be. Lasik surgery prices have plummeted over the last 15 years and quality has improved. It is remarkable and simple.

Bundled Payments

SPBA recognizes and applauds the efforts at CMS to develop bundled payments for Medicare. We believe the knowledge developed in this area could be leveraged to assist hospitals in educating consumers on bundled episodes of care.

Out-of-Network Physicians

In the private insurance market, it is common for hospital-based providers such as emergency room physicians, radiologists, anesthesiologists and pathologists who have privileges in a network facility to charge

significantly higher fees because they consider themselves out-of-network providers. Even though hospitals know their facility participates in the network, they allow and encourage non-network providers to service and bill the in-network patients. The patient has little or no knowledge of the use of these providers and yet, they are routinely balance-billed for their services. Some legal analysts have submitted arguments that such practices are a deceptive trade practice and that the public should be protected from such runaway and undisclosed charges.

Since the hospital provides the utility of the facility to privileged physicians, disclosure of the services provided during a medical event should include those hospital-based and non-network professional services. This is especially true since the number one negative listed on consumer credit reports is due to medical charges, including such balance billed items.

Price Information is Disparate and Inconsistent so Consumers are Unable to Comparatively Shop

A TPA member of SPBA provided the below factual illustration of how patient knowledge of underlying cost would have saved the consumer a significant amount of money. The TPA processed both of the claims in this illustration.

Illustration 1

The patient in this case was told by his physician that he should have both knees replaced. The patient was cleared for surgery and had his first knee replaced in the Spring of 2016. The second was replaced in the Fall of 2016. The patient remained in good health throughout and there were no complications or changes in underlying health conditions. In addition, the same surgeon performed both surgeries. The difference, as you can see below, comes in the facility charges. Despite the facilities being located within 30 minutes of each other and the procedures and outcomes identical, the outpatient surgical center charges are *230%* of the charges billed by the hospital for the same services.

Facility	**Spring 2016 (Billed Charges)**	**Fall 2016 (Billed Charges)**
• In-Patient Hospital	**$45,275**	
• Outpatient Surgical Center		**$106,905**

State Transparency Efforts

Altarum's Center for Payment Innovation (formerly the Health Care Incentives Improvement Institute) and Catalyst for Payment Reform publish a combined price transparency and quality report card that assesses states' success in these areas. The Price Transparency & Physician Quality Report Card 2017 ("Report Card 2017") gives states transparency and quality scores ("A" to "F"). States with high price transparency grades supply price information on a wide range of procedures and services that is presented in a publicly available website.

According to the Report Card 2017, states can either compel providers and/or health plans to report prices, or mandate an all payer claims database (APCD). APCDs gather data from multiple sources, including private health insurers, Medicaid, children's health insurance, state employee health benefit programs, prescription drug plans, dental insurers, self-insured employer plans, and Medicare. APCDs include paid amounts, not charged amounts, which often are significantly lower due to contracted or negotiated rates between payers and providers. "When there is no APCD, providers typically only turn over data on charged amounts to states or consumers, making the price information significantly less useful for comparisons."

Most states fail to provide effective price transparency and physician quality resources. The Report Card 2017 gives 43 states an "F" grade for transparency and 42 states an "F" grade for quality.

Researchers found no evidence of improvement in hospitals' ability to provide price estimates from 2012 to 2016 in an article published May 29, 2018 in the Journal of the American Medical Association (JAMA) Internal Medicine Online, “Changes in Ability of Hospitals to Provide Pricing for Total Hip Arthroplasty from 2012 to 2016.”

Billing Databases are Helpful But Do Not Provide Information on What the Hospital Will Accept Currently

Transparency in healthcare pricing and quality metrics can serve as a powerful tool, not only as a method to curb cost inflation, but to promote higher quality outcomes for patients. A TPA member provided the following example of how transparency initiatives can facilitate cost containment for both the patient AND the Plan Sponsor, as well as promote higher quality outcomes for those seeking care.

Our clinical teams are actively engaged as a concierge service for patients – endeavoring to educate them about their diagnosis and prognosis, help them understand their expected course of care, make sure that the proposed treatment is appropriate according to established clinical guidelines, and that the care is being provided by a provider that is qualified to perform the proposed treatment. Their objective is to educate the patient, protect them from overtreatment and over-testing, and guide them to the high-quality physicians and facilities that are most capable and likely to deliver them the best outcome for a reasonable cost for both the patient and the Plan. (It should be noted that this level of engagement, guidance and service is not common and frequently lacking due, in part, to PPO network contract requirements.)

A healthcare provider contacted the clinical team responsible for pre-certification of outpatient procedures for one of our self-funded clients, requesting certification for a total knee replacement. The procedure was certified as clinically appropriate treatment based upon the patient’s symptoms and history. However, the clinical team identified that the physician and the facility at which the procedure was to be performed had demonstrated a lower quality score than other options within the same community. (TPAs can purchase quality and cost data, which utilizes billing databases to identify average billed charges in conjunction with publicly available quality metrics self-reported to CMS by healthcare facilities). The clinical team notified the TPA and Plan Sponsor that they intended to certify the procedure and educate the patient about alternatives that existed within the community that had a better track record for quality and that perform more total knee replacements than the proposed physician and facility. As is most often the case in the healthcare market, these higher quality options also charged LESS, on average, than the proposed facility. In addition, the healthcare Plan has made available to their employees and eligible dependents the opportunity to reduce their out of pocket costs if they have schedulable procedures performed at facilities that have published a bundled rate that is less than their network’s contracted rates. The nurse(s) of the clinical team advised the patient of their options:

1. Continue with their original doctor and facility, with information regarding the number of total knee replacements performed and their self-reported quality information. Average billed amount: $54,500. Expected final allowed amount after network terms (based on prior paid claims for this procedure at this facility): $27,500 – of which the patient responsibility (deductible and co-insurance according to the Plan) would be $6,000
2. Re-direct to facility A, with information regarding quality, frequency of procedure and expected costs. Average billed amount: $45,630. Expected final allowed: $25,500 Expected patient responsibility: $6,000
3. Re-direct to facility B, with information regarding quality, frequency of procedure and expected costs. Average billed amount: $44,500. Expected final allowed: $24,000. Expected patient responsibility: $6,000
4. Re-direct to bundled price facility, that has been vetted for quality outcomes and that has an established reputation in the community. Final, all in price: $17,800. Patient responsibility reduced to $500.

Facility	Average Amt Billed	Expected Allowed Amt	Patient Responsibility (Est)	Plan Responsibility (Est)
Original Facility	$54,500	$27,500	$6,000	$21,500
Fee for Service Facility A	$45,630	$25,500	$6,000	$19,500
Fee for Service Facility B	$44,500	$24,000	$6,000	$18,000
Bundled price (Transparent Facility)	N/A	N/A	$500	$17,300

The Plan sponsor agreed to provide paid time off for the patient to visit and interview alternatives. All options were in the same metropolitan area and were within 15 minutes driving distance of each other. It should be noted that the average billed costs for total knee replacements in this geographic region are generally lower than regional and national averages, leading to the conclusion that savings can be even greater in high cost regions.

Healthcare inflation represents a problem of enormous proportions to private healthcare plans as well as Medicare and Medicaid. Therefore, the obvious benefit of transparency in this circumstance is cost reduction. As illustrated, a well designed and integrated Plan that rewards the patient for diligence and engagement can save money for both. But there are other less obvious benefits to remember:

1. Patients are more educated about their condition, what to expect in their course of treatment, warning signs to observe, and how to succeed post procedure – resulting in better outcomes and avoiding prolonged recovery.
2. Patients are informed about quality, and where they can find qualified healthcare providers. This information is nearly impossible for most patients to find – and if they do find their way to a source of information, what they find is often tied to notoriously fickle on-line patient reviews, lacking relevant detail, and/or difficult for a lay person to interpret. High quality providers have fewer expensive, painful, debilitating outcomes.
3. Providers offering bundled pricing as illustrated dramatically simplify their accounting operations, receive payment from Plans more quickly, and (assuming patients are incentivized with reduced cost sharing as illustrated) have a lower burden of collection from patients.

Patient-Friendly Interfaces

The preamble to the proposed rule requests ideas on how CMS can help third parties create patient-friendly interfaces with transparency data. The states with "A" scores in the Report Card 2017 offer websites that CMS could use for ideas on presenting data. While SPBA does not believe that the data used in these websites is the most beneficial to patients, the interfaces are worthy of consideration.

Out-of-Pocket Costs

SPBA does not think health care providers should be required to inform patients how much their out-of-pocket costs for a service will be before those patients are furnished that service. Health care providers do not have this information and asking them to obtain it would be far too burdensome, forcing them to misallocate precious resources.

Consumers covered by private sector employee benefit plans are given documents, required under the Employee Retirement Income Security Act (ERISA), explaining out-of-pocket costs. The primary role for

providers to play in helping to inform patients covered under private sector employee benefit plans of their out-of-pocket costs would be to remind patients to review the plan information or call the plan's Third Party Administrator.

Alternative Approach

The policy briefs SPBA submitted in the past included a hospital pricing disclosure chart. SPBA offers this chart again for consideration in the event HHS declines to embrace our proposed definition of "standard charges."

Hospital Pricing Disclosure Chart

All Utilized MS-DRGs & APCs on a Rolling 12 Month Cycle

[MS-DRG Description] or [APC Description]	Medicare Patients	Medicaid Patients	In-Network Commercial Patients	All Others
Number of Procedures				
Total Amt. Billed Charges	$	$	$	$
Total Amt. Received/Paid	$	$	$	$
Median Billed Charge	$	$	$	$
Median Amt. Received/Paid	$	$	$	$
Median Contracted Allowable Amt.	n/a	n/a	$	n/a
Total Contracted Allowable Amt.	n/a	n/a	$	n/a

Since Medicare represents a significant percentage of health care spending in the United States, it is considered the standard measuring stick by which other prices or charges are compared. Specifically in Section 2718(e), the law says the charges must include those for diagnosis-related groups as established through the Social Security Act, which is expressed through Medicare. Therefore, reference to the Medicare standards in the listing of any "charge" is important since it is the only price that has consistency, consumer awareness and structure.

Access to the full pricing spectrum would complete the initial picture of information a consumer or consumer representative would need to fairly assess the value of the prospective services. Therefore, for the public to better understand the term "charges" and to address the dilemma of relevant and inconsistent pricing in the hospital markets, Section 2718(e) should include basic, but meaningful, amounts for the public to make their own determination of relevance. In order to reflect both inpatient and outpatient services, these amounts should include the following components for each MS-DRG and APC (ambulatory payment classification) as it relates to Medicare patients, Medicaid patients, In-network commercial patients and All Other patients:

> “Number of Procedures”

> “Total Amount of Billed Charges”

> “Total Amount Received/Paid"

> “Median Billed Charge”

> “Median Amount Received/Paid”

> “Median Contracted Allowable Amount” (in-network commercial patients only)

> “Total Contracted Allowable Amount” (in-network commercial patients only)

Hospital services that need price disclosure are not just limited to inpatient stays. A significant portion of health services for facilities are now provided in an outpatient setting, often scheduled in a fashion that would allow for the consumer to seek quality and pricing alternatives, if such information was available. Thus, the disclosure of pricing information needs to be made in advance of the services rendered for both inpatient and outpatient hospital settings so that the consumer can derive a true benefit.

In order to be current and relevant, pricing information should be provided quarterly on a rolling twelve-month period for all utilized inpatient and outpatient services provided by a specific facility.

Conclusion

The simplest, most effective and efficient approach is for hospitals to publish yearly and update quarterly the amount the hospital will accept as payment in full for items and services (without complications) by non-governmental payers and individuals. With this information, consumers could compare prices and make informed health care purchasing decisions for themselves and their families.

Respectfully Submitted,
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SPBA