KAISER PERMANENTE®

November 15, 2021

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

*Submitted electronically via: www.reginfo.gov*

RE: Transparency in Coverage Information Collection Request, CMS-10715
(OMB Control Number 0938-1372)

To Whom It May Concern:

Kaiser Permanente appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) Transparency in Coverage (TiC) Information Collection request for comment.[1] The Kaiser Permanente Medical Care Program[2] is the largest private integrated health care delivery system in the United States, delivering health care to more than 12.5 million members in eight states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Consistent with our mission, Kaiser Permanente believes that health care should be affordable for all and that consumers should be able to access and understand the costs of their care. It is for these reasons that over the last several years we developed and implemented personalized cost estimate tools, allowing our members to obtain an estimate of their expected out-of-pocket costs for common clinical services as well as expected costs for their prescription drugs.

While we strongly support the goals of the TiC final rule[3]—to enable consumers to make informed choices about health care services, increase competition, and lower prices—we continue to have serious concerns about the methods the Administration has adopted toward achieving these goals. With respect to the subject of this Information Collection, we support the comments and recommendations submitted by America's Health Insurance Plans (AHIP) and wish to emphasize several important points.

Consistent with our comments on the TiC proposed rule,[4] we remain concerned that the public disclosure of negotiated rates, historical allowed amounts and current and historical prescription drug prices via machine-readable files (MRFs) will cause consumer confusion, lead to higher

[1] 86 Fed. Reg. 57,151 (Oct. 14, 2021).
[2] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and more than 700 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.
[3] 85 Fed. Reg. 72,158 (Nov. 12, 2020).
[4] 84 Fed. Reg. 65,464 (Nov. 27, 2019).

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prices and reduced competition, and further cement into place the fee-for-service (FFS) model of provider payment.

First, we are concerned that the MRF requirements will not result in meaningful or actionable information for most consumers. Rather, we expect consumers will be confused and overwhelmed by the large amount of non-personalized pricing information that will be made available. Furthermore, without quality and outcomes information for each hospital/provider, a consumer's choices will not be fully informed—the choice will be based only on price and not on the *value* of care. Adding complexity is the expectation that third-party app developers will attempt to use the published pricing data to provide personalized information for individuals. Such apps, without specific plan information and cost-sharing accumulators for the individual, will likely provide inaccurate guidance, all while not being subject to the same state and federal health care privacy laws intended to protect sensitive patient information.

We also remain concerned that the disclosure of negotiated rates and historical allowed amounts could lead to problematic market-pricing and competitive dynamics, raising costs throughout the health care system. If actual negotiated rates between providers and payers—which to this point have been confidential and proprietary—are made public, a possible outcome is that providers could choose not to negotiate with payers and simply set prices (e.g., no discounts for payer volume), driving prices higher. While most care provided to Kaiser Permanente members is provided within our integrated system, we also contract with outside hospitals and facilities, as well as with specialists. We are very concerned that our plans could face increased challenges in securing reasonable contract rates, resulting in a combination of increased costs and/or more limited networks and provider choices for members.

Finally, we remain very concerned that the MRF requirements will have the effect of further cementing into place the FFS model of provider payment. The recent progress toward paying for value instead of volume through alternative payment models would be undermined through the provisions of the TiC final rule, as there is no way for a consumer to directly compare prices for individual services that are part of a capitated, global, episodic, or outcomes-based arrangement between a provider and a payer.

For these reasons, we urge CMS to reconsider and/or further defer implementation of the MRF requirements and to focus on implementation of the enrollee disclosure tool to ensure that health plan enrollees can obtain accurate cost estimates to guide their health care decision-making. We appreciate CMS' recognition that the prescription drug MRF duplicates other federal reporting requirements (Section 204 of the No Surprises Act and qualified health plan (QHP) transparency reporting) and the agency's deferring enforcement pending future rulemaking to determine whether the prescription drug MRF is still appropriate. Kaiser Permanente recommends that CMS withdraw the prescription drug MRF requirements given the similar pharmacy reporting requirements included in the No Surprises Act.

Finally, while we appreciate CMS delaying the compliance date for the in-network and out-of-network allowed amount MRFs to July 2022, CMS recently announced that the final technical specifications (schema) will not be finalized until March 2022. This leaves plans insufficient time to finalize, test and produce the highly complex files by the enforcement date. There are also significant expenses associated with condensing the implementation timeline. In order to ensure

plans can meet CMS' expectations for these files, we recommend an enforcement deadline that is no sooner than six months after the schema is finalized.

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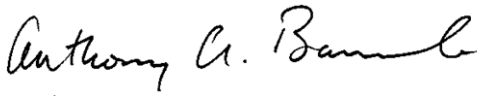
Kaiser Permanente appreciates CMS' consideration of these comments. We would be pleased to provide additional information or answer any questions. Please contact me at anthony.barrueta@kp.org or Simon Vismantas at simon.p.vismantas@kp.org.

Sincerely,



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