BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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January 29, 2020

The Honorable Steven Mnuchin
Secretary of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Alex Azar
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Eugene Scalia
Secretary of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Submitted via the Federal Rulemaking Web Portal: http://www.regulations.gov

RE: Transparency in Coverage Proposed Rule (CMS–9915–P)

Dear Secretaries Mnuchin, Azar and Scalia:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Proposed Rule on "Transparency in Coverage," as published in the Federal Register on November 27, 2019 (84 FR 65464).

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide healthcare coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

We support the Administration's goal of greater access to information to empower consumers to make the best choices for their care and to evaluate the quality of their providers. BCBS companies have a long-standing commitment to improving the interoperability and transparency of healthcare information and believe the secure and seamless flow of meaningful data among patients, doctors, hospitals and insurance companies is essential to improving decisions and outcomes in the healthcare market.

We support transparency done the right way – by providing consumers with secure, meaningful and actionable data that is relevant to their healthcare decision-making. BCBS Plans in all 50 states provide consumer-focused tools to help members estimate the range of costs for specific "shoppable" procedures across providers in their communities. Shoppable services are non-emergent and typically offered by multiple providers in a region so consumers have an opportunity to consider several providers and delivery settings prior to receiving care. All Plans are also continuously working to innovate and improve their consumer tools, incorporating ongoing requests, feedback and insight from our members. Our experience tells us consumers most want clear information about their out-of-pocket (OOP) costs, the quality of care provided and whether providers are in-network.

While we support the goals of the Proposed Rule, we are concerned that certain requirements would not support effective consumer decision making, while imposing costly, unworkable and unnecessary burdens on stakeholders and diverting resources from efforts already under way to develop more sophisticated consumer transparency solutions. As detailed below, we also have concerns regarding the proposed requirements related to machine-readable files, which would expose massive amounts of commercially sensitive data and put consumer health information at risk.

In our comments, we provide recommendations for a more effective, less burdensome and more secure approach for achieving the Administration's goals for empowering consumers. Specifically, we provide recommendations on standards that could be finalized in the near-term (e.g., functional requirements for tools to compare out-of-pocket costs across in-network providers for a set of shoppable services), those which should be delayed to ensure adequate time to build and properly test to ensure success (e.g., a process for expanding transparency tool capabilities beyond an initial core set of shoppable services), and those which we believe should not be finalized at this time as set out in the Proposed Rule in light of the legal, privacy, and burden concerns discussed herein (e.g. release of negotiated rates and historical allowed amounts).

Our high-level comments on the major provisions of this rule are as follows:

- **Information for Consumers on Cost-Sharing:** We enthusiastically support providing robust tools allowing consumers to obtain information on the cost and quality of shoppable services across providers tailored to the members' own coverage and benefits, including information on co-pays and progress towards meeting deductibles.

  We believe consumer transparency should focus on the shoppable services to serve what healthcare consumers seek, reducing the noise of additional complicated health services delivered in tandem with these shoppable services. Our real-world experience with existing health plan consumer transparency tools indicates more than 80 percent of consumer searches are for 50 services, a small subset of the more than 1,600 shoppable services that are available today. As examples, shoppable services include office visits, knee surgeries, MRIs and preventative care where consumers have advanced knowledge of the care they

need and can research the costs in advance. Non-shoppable services might include emergency room visits, rare treatments only offered by a very limited number of providers or subcomponents of care delivered within a care visit, like the cost for a specific anesthesiologist.

As written, the Proposed Rule would require health plans to provide information on all covered items and services. No existing transparency technology solution we are aware of supports this level of information – nor would they want to, since much of the required information could confuse and mislead consumers and the costs to implement would be enormous. Based on an economic analysis prepared by Bates White Economic Consulting, the average of the total set-up and maintenance costs for carriers to comply with the Proposed Rule is estimated to be $13.63 million – **26 times** what the Departments estimated. Some Plans have indicated they would be forced to run two sets of tools – one designed to meet member shopping needs and another implemented only to meet the requirements of the Proposed Rule, which would provide little value to the consumer and few members would use. The Proposed Rule also sets forth a timeframe for implementing new requirements health plans could not possibly meet and would impose enormous burdens on stakeholders.

As discussed in our detailed comments, we believe there are less burdensome solutions the industry could implement within a reasonable timeframe to ensure the availability of effective consumer tools. We suggest the Departments focus on these alternative solutions rather than certain other aspects of the Proposed Rule as drafted, which are either unworkable or have no clear value to consumers based on our years of experience with consumer tools.

These recommendations include:

- Establishing a reasonable set of functional requirements for OOP cost estimator tools focused on a set of shoppable services and standards for inclusion, which health plans could meet by 2022 (as detailed in the body of our comment letter).

- Developing a multi-stakeholder process (i.e., technical expert panel) to develop recommendations to expand that set of services and functional requirements over time (beyond 2022) in a manner that leverages consumer research and industry insights to create the best consumer experience and encourage greater utilization of transparency tools.

- Working with the industry to develop functional requirements for payers to create a separate capability that can allow any provider or facility to request an estimate of the costs for a broader set of items and services in the future, so that providers have greater ability to estimate member liability for services they will perform on a member's behalf by submitting a mock claim for that service.

There should also be reasonable understanding by the Departments that the complex and evolving healthcare marketplace will result in an ongoing evolution of services that are and are not included in the proposed tools as new capabilities in health care are developed and older capabilities are sunset. These tools will always be in some form of development. We stand ready to work with the Departments to develop a roadmap for successful implementation of effective tools that will provide consumers with reliable and accurate information to make important healthcare decisions.

- **Public Disclosure of Negotiated Rates and Historical Allowed Amount Data:** The Proposed Rule would require health plans to publish machine-readable files with specific payment amounts for every single item or service (including drugs and medical devices) that are provided by in-network and out-of-network providers, for every single provider and facility, for every individual and employer plan.

  We fully support the disclosure of out-of-pocket costs through consumer tools. However, in light of the concerns discussed herein, we ask the Departments not to finalize the proposed requirements for health plans to make available machine-readable files on negotiated rates and historical allowed amounts as set out in the Proposed Rule.

  Public disclosure of negotiated rates will likely lead to consumer confusion rather than empowerment, since consumers will not be able to determine their own out-of-pocket costs from this information. Moreover, the Proposed Rule would require health plans to manufacture dollar figures for value-based contracts with providers, complex reimbursement formulas, and allowed amounts for out-of-network care which would be misleading or inaccurate for an individual consumer. A Proposed Rule grounded in traditional fee-for-service provider reimbursement models runs counter to the Administration's priority to shift the industry to value-based contracting and away from encounter-based reimbursement.

  The sheer volume of data health plans would be obligated to disclose is staggering. There are more than 94,000 codes that exist currently—77,559 ICD-10-PCS and 16,448 HCPCS (includes CPT)—covering institutional inpatient, outpatient and professional claims. Within the BCBS system alone, there are more than 2 million unique practitioners, groups of practitioners or facilities. When considering the number of provider locations and networks offered by Plans, there are **more than 50 million unique combinations** of provider network locations. As a significant portion of pharmacy and medical device provider networks are carved out, these unique combinations of provider network locations do not reflect all of these provider types. As a result, the potential universe of prices would increase even more to include all of those services. The resulting potential universe of prices health plans would be required to disclose in the machine-readable files could be in the hundreds of billions, the near entirety of which would not be shoppable or meaningful to a consumer.

  If finalized, these requirements would expose billions of health-related financial data points for BCBS companies that may have serious unintended consequences. For instance, the secondary users of information will seek to commercialize it by offering searchable online or

mobile platforms that will track and capture consumers' health-related concerns, questions and searched treatments, as well as providers they search for, see and/or review. As a result, enormous amounts of consumers' personal data will be tracked, stored and resold for marketing and other purposes (potentially without consumers' knowledge of how their personal health data is being used). Given the enormity of the data and the current technological capabilities to reverse engineer de-identified information and/or to track and predict consumer behaviors using algorithms, the potential for privacy and security to be compromised under the Proposed Rule could be unprecedented. The risks are even greater because these secondary users are not subject to existing health plan privacy laws and Congress has not yet acted to create applicable federal privacy standards for such users.

Compelling the release of the prices negotiated between two private parties also raises First Amendment concerns. The Departments state they "are aware that price transparency could have negative unintended consequences … potentially resulting in higher prices." As this statement makes clear, compelling disclosure of negotiated rates may not lead to the Administration's intended objective of lowering healthcare costs. For these reasons, the Departments should also consider whether the rule is likely to be viewed as arbitrary and capricious and thus prohibited by the Administrative Procedure Act (APA). Similarly, we encourage the Departments to consider whether the slim "catchall" provision of § 1311(e)(3) of the Patient Protection and Affordable Care Act (and cross-referenced in § 2715A) provides the Departments with the necessary authority to promulgate the rule as drafted.

Finally, we believe the Proposed Rule vastly underestimates the burden of this requirement on the industry and fails to consider other less burdensome and useful alternatives.

For these reasons, we recommend the Departments not finalize this portion of the Proposed Rule as drafted, at this time. As outlined above, we look forward to working with the Departments on more effective ways to achieve the end result of greater transparency that will be more useful to consumers.

- **Disclosure of Pricing Information through Third Party Applications:** We have serious concerns that there are not adequate privacy and security standards to properly and thoroughly safeguard sensitive member data that will be accessed by third parties' applications not covered under HIPAA privacy laws. Under this proposal, once consumers give their consent to download an app, the third party direct-to-consumer applications could be empowered to access, store and use the data without limitation. Consumers likely will not appreciate what third party application makers can and will do with these data. Since these third party applications are not health plan-issued applications, they are not subject to the more stringent HIPAA privacy and security laws. The lack of standardization due to inconsistent laws across privacy and security requirements of third party applications accessing and using consumer health data creates serious privacy and security concerns for the consumer. We ask the agencies not move forward with rulemaking on this provision until Congress has developed a legislative solution to address this issue.

- **MLR:** We support the provision in the Proposed Rule allowing issuers who use financial incentives to encourage consumers to use lower-cost, higher-value providers to account for these incentives in their MLR calculation, and also recommend that the Departments allow a portion of the implementation and ongoing costs to be included in the MLR calculation. Health plans are increasingly using rewards programs that generate "shared savings" to encourage the use of lower-cost, higher-value providers in order to help slow the increase in health care costs. The proposed changes to 45 CFR 158.221 which would allow shared savings payments to be included in the MLR numerator will remove the existing barrier facilitating the use of innovative benefit designs that increase consumer engagement in health care purchasing decisions.

- **Quality Information:** We support efforts to integrate quality and cost information so consumers can make truly informed decisions and recommend CMS consider opportunities to centralize certain relevant quality information, including Merit-based Incentive Payment System (MIPS) scores and Quality Payment Program (QPP) status, accreditation, certification status, education, professional achievements and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Our experience demonstrates that including quality information can help mitigate the potential that consumers will incorrectly assume that higher prices correlate with higher quality. Thus, health plans have worked as a top priority to present quality information wherever possible. However, the current state of quality measurement across all provider types, items and services in the Proposed Rule is nowhere near ready for mandatory reporting. As a first step to better informing consumers, CMS should consider the information that is readily available and can be understood by consumers in their decision-making and encourage health plans to build this information into existing tools. As consumers become more comfortable with using price transparency tools and shopping for healthcare services, efforts should be made to expand the available quality information to more outcomes and clinically focused measures, which provide a greater level of detail on the quality of those providing certain services.

- **Economic Impact Analysis:** In this Proposed Rule and the accompanying Paperwork Reduction Act (PRA) Notices, we believe the Departments grossly underestimated the burden of implementation on health plans and issuers. In an independent economic analysis conducted by Bates White Economic Consulting, carriers who were interviewed estimated the cost of implementing the Proposed Rule to be substantially larger than the Departments' estimate. The total estimated cost (including set-up and annual maintenance) to carriers was *more than 26 times the estimate produced by the Departments*. The average cost estimate provided by carriers was approximately $13.632 million, while the Departments' estimate was only $510,000.

  Using the Departments' estimate of the number of affected insurers and Third Party Administrators (TPAs), and relying on findings in the Bates White report, we estimate the first year total private sector cost of implementation could be nearly $27 billion. That amount completely negates the $11.4 billion in regulatory savings OMB estimated for the

Department of Health and Human Services under Executive Order 13771 for fiscal year 2019.[1] In future years, the annual maintenance cost would be about $10 billion (and that number would increase each year with inflation). Importantly, the Bates White report estimates only the operational costs for establishment and maintenance of the tools, not the potentially much more significant economic consequences of the Proposed Rule.

Our detailed comments on the price transparency issue and other provisions in the Proposed Rule follow. We look forward to continuing to work with the Departments to advance our shared goal of providing consumers with meaningful and actionable information so they can make the best decisions for themselves and their families. If you have questions, please contact Anshu Choudhri at 202.626.8606 or Anshuman.Choudhri@bcbsa.com.

Sincerely,

Kris Haltmeyer
Vice President, Legislative and Regulatory Policy

[1] Regulatory Reform Under Executive Order 13771: Final Accounting for Fiscal Year 2019.