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Association of
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January 29, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9915-P
P.O. Box 8010
Baltimore, MD 21244-8010

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

Dear Administrator Verma:

The Association of American Medical Colleges (the AAMC or Association) welcomes this opportunity to comment on the proposed rule entitled “Transparency in Coverage,” 84 *Fed. Reg.* 65464 (November 27, 2019), issued by the Centers for Medicare & Medicaid Services (CMS or the Agency), the Internal Revenue Service, and the Departments of Treasury and Labor.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC supports the Administration’s goal to provide patients with timely, up-to-date cost-sharing information. We appreciate that parts of this proposed rule would help further this objective and look forward to working with the departments on this shared goal. However, we strongly disagree with the additional proposal requiring health plans to publicly release their in-network negotiated rates and out-of-network allowed amounts. **Instead of helping patients, AAMC believes this requirement could lead to widespread confusion and even more consolidation in the commercial health insurance industry and should not be finalized.**

PATIENT SPECIFIC COST-SHARING INFORMATION

The proposed rule would require group health plans and issuers to disclose patient-specific cost-sharing information for a covered item or service upon request from the patients. This information would need to be made available either via an online tool or in paper form. We agree that patients should have access to up-to-date cost-sharing information and insurers are able to inform patients of specific information such as whether the patient’s deductible has been met; the amount of the co-pay, if any; and other requirements such as prior authorization, step therapy, or limits on benefits. As described below, the optimal solution is for CMS to work with patients, providers, and insurers to provide assistance that will allow for the development of tools

that will be widely available for patients to help them understand their out-of-pocket costs for many items and services.

Expand Current Efforts to Ensure Access to Patient-Specific Information

Working over many years, and in collaboration with electronic health records (EHR) vendors and insurers, some AAMC members have developed tools to assist patients to better understand their cost-sharing responsibilities. An example of this model is the current patient calculator that the University of Colorado is using to help patients determine their coverage and out of pocket expenses. In addition, it is better for the patient to understand the potential out of pocket expenses for a plan of care rather than a single proposed service. Patient education for a plan of care is key. CMS and the departments should continue to work with stakeholders as it moves forward to expand price disclosure proposals to ensure that patients understand their cost-sharing obligation.

It is imperative that when informing patients about their cost-sharing responsibilities the information be paired with consumer education. For example, a surgeon may think that a patient needs a certain procedure and an estimate of the out-of-pocket costs based on that information is provided. However, the patient should be informed that the estimate could change based on circumstances. For example, once a surgery begins the surgeon discovers that another procedure is preferable for a better outcome, but it results in the patient's actual cost to be than what had been estimated. Patients must understand that medically necessary changes in care may alter their out-of-pocket costs. **Therefore, we appreciate the acknowledgement in the proposed rule that the estimates may not reflect the amount ultimately charged to the patient and support the inclusion of this key point in the proposed model disclosure.** Additionally, since patients often discuss insurance coverage details with providers at the time a procedure is contemplated or scheduled, insurers should also be encouraged to enable providers' to be able to access patients' specific benefit information via a secure website in order to better inform both patients and providers.

PUBLICLY POSTING NEGOTIATED RATES

The proposed rule would require health insurance issuers to post negotiated rates and out-of-network allowed amounts for all items and services covered under an insurance plan. As we have stated in past comments regarding a similar requirement for hospitals, posting third-party negotiated charges would not provide patients with the information that is of most importance or usefulness to them – their financial obligation based on *their* insurance coverage, including *their* plan-specific cost-sharing requirements such as their deductible and applicable co-pay amounts, if any. **Requiring health insurers to post negotiated rates for in-network providers and allowed rates for out-of-network providers would lead to widespread confusion as the negotiated rates do not represent what patients will pay. We urge CMS not to finalize the requirement for insurers to publicly disclose provider-specific negotiated rates.**

Additionally, the AAMC has concerns regarding the departments' authority to require issuers to post negotiated charges, and concerns that the proposed requirements are outside the scope of the departments' regulatory authority. Further, CMS and the other departments lack the legal authority to compel the public disclosure of such highly sensitive and confidential pricing information. The American Hospital Association has provided more detailed comments on these matters with which the AAMC agrees.

REQUEST FOR INFORMATION: PROVIDER QUALITY MEASUREMENT

The proposed rule includes a request for information on how “public and private sector quality measures can be used to compliment cost-sharing information for plans and issuers in the private health insurance market.” (p.65488). We appreciate the department’s acknowledgement that in addition to price, “quality is essential for making value-based purchasing decisions.” (p. 65487). The AAMC supports efforts to better inform patients of quality outcomes and patient experience as part of broader transparency efforts to assist patients and their families with decision making. However, to allow for valid comparisons among hospitals, outcomes need to be risk-adjusted, as well as adjusted for social determinants of health. It also is important to understand the type of quality information that patients would find useful.

Engage Stakeholders on How Best to Incorporate Quality Information into Price Transparency Programs and Must Prioritize Patient-Centered Engagement on Cost and Quality of Care

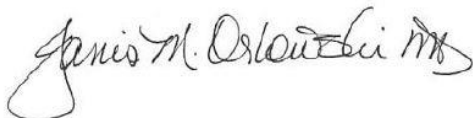
Consensus among policymakers has been building that current quality measures and programs must be revamped to better measure what matters to patients and families and to evaluate providers fairly. CMS’s Meaningful Measures framework development and a recent report which recommended that CMS commit resources to overhaul the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience survey are examples of the important work that is being done to push our healthcare system to the next generation of measuring the quality and value of care.¹

This broad area of work towards patient-centeredness will be critical to the development of quality and cost information that is most meaningful for patients. **We urge CMS to take the necessary time to work with stakeholders, including patients, providers, insurers, and consumer groups, to evaluate and integrate these broader patient-centeredness efforts into any future initiatives to build and test a valid and reliable framework for incorporating quality information with price transparency.** The AAMC pledges are continued work in this area. Providers serve a critical role in assisting patients and their families make medical decisions. As this work is nascent, the AAMC recommends that CMS develop the framework for tools and resources to facilitate these conversations.

CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at 202.909.2084 or mmullaney@aamc.org.

Sincerely,



Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer

¹ “Modernizing the HCAHPS Survey: Recommendations from Patient Experience Leaders,” (Jul. 2019). Retrieved at: https://www.fah.org/fah-cc2-uploads/website/documents/Modernizing_HCAHPS_-_Recommendations_from_PELs.pdf.