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Matthew Eyles
President & Chief Executive Officer

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) —AHIP Comments

Dear Secretaries Mnuchin, Scalia, and Azar:

On behalf of America's Health Insurance Plans (AHIP),[1] we thank you for the opportunity to comment on the proposed rule on "Transparency in Coverage," (Transparency Rule) as published in the Federal Register on November 27, 2019 (84 FR 65464). Below we summarize AHIP's major comments and recommendations on the proposed rule. Our detailed comments and other supporting materials are included in the attachments.

Every American should be able to get the health care information they need, when they need it, in a way that's customized and personal to their own circumstances in order to make informed health care decisions for themselves and their families. This information should empower patients and consumers to seek and receive care from health providers based on accurate, personally relevant information about cost and quality. When implemented appropriately, price and quality transparency should simultaneously enhance consumers' health care experience and, on average, push prices and costs down—not up—for consumers (and payers like employers). AHIP and our member health insurance providers know that consumer-focused transparency strategies and tools are essential to our ability to deliver on these commitments, and we know the Departments share these goals and commitments.

Proposed Rule Fails to Advance Key Consumer Goals and Oversteps Statutory Authority
As currently structured and written, the proposed Transparency Rule fails to advance key consumer goals and oversteps the government's statutory authority in two significant ways.

1. **Forced disclosure of privately and competitively negotiated rates, as proposed in this rule, will not provide information that is actionable by, or helpful to, consumers and exceeds the Departments' statutory authority**. It will undermine competitive negotiations and push health care prices higher—not lower—for patients, consumers, and taxpayers. Such disclosures would

[1] AHIP is a national association representing members that provide health care coverage for millions of Americans across the country. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, quality, access, and well-being for consumers.

fail to deliver on what consumers need to make informed health care decisions, raise significant privacy concerns, distort health care markets by driving prices and premiums up for consumers and employers. In short, the proposed rule is contrary to statute, effects a taking of health insurance providers' trade secrets, unconstitutionally compels speech, and is arbitrary and capricious. That is why AHIP strongly urges the Departments to withdraw the proposal to implement new machine-readable files.

2. **The proposed rule is overly broad and prescriptive and would ultimately not enable consumers to make better-informed health care decisions**. By requiring price disclosure of every conceivable health care item and service rather than a core set of well-defined shoppable services, individuals would not be provided with consumer-friendly, personalized and actionable information. Moreover, the Transparency Rule represents a massive expansion beyond existing transparency tools with proposed implementation timelines that are based on unrealistic, infeasible, and inaccurate assumptions. We recommend a more consumer-friendly and workable approach to achieve this goal so that all enrollees covered by the proposed rule will have access to comprehensive price transparency tools within two (2) years.

Public Release of Health Plan Negotiated Rates Will Not Provide Meaningful Transparency
Governmental agencies like the Federal Trade Commission (FTC), Department of Justice (DOJ) and the Congressional Budget Office (CBO) have expressed concern over the public disclosure of trade secrets and competitively sensitive, proprietary information like payer-negotiated rates that could reduce competition and raise prices for consumers. The FTC, for example, expressed concern about a similar open data state law, suggesting it could result in unlawful collusion, have a chilling effect on competition, and lessen selective provider contracting by issuers, which is a critical tool in controlling health care costs and improving the value of care in that state.[2]

The machine-readable component of this rule, in addition to, and in combination with, several other transparency and interoperability rules proposed by the Department of Health and Human Services (HHS), raise significant privacy concerns. These proposals appear more targeted at providing data to third party application (app) developers than ensuring consumers have access to meaningful, personalized data. In so doing, the federal government would require issuers to share both their trade secrets and their enrollees' sensitive personally-identifiable information with app developers that are not bound by the same heightened level or privacy and security rules that apply to health insurance providers under federal privacy laws like the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The federal government would drive consumers to obtain from third-party apps what is largely available in issuer apps, but leave consumers vulnerable to the business interests of third-party app developers seeking to profit from selling consumers' individually identifiable data without HIPAA protections. For this reason alone, the Departments should focus on increasing the availability and utility of issuer apps, not risk putting Americans' health information and privacy at risk.

AHIP's Price Transparency Tool Survey, as well as a separate analysis conducted by Bates White, analyzed of the estimated cost and time to implement the machine-readable requirements of the rule, if

[2] FTC Letter to MN State Reps Hoppe and Hortman, June 29, 2015, Available at: https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf . *Footnotes omitted.*

finalized.[3] While these analyses found the cost and time to implement would greatly exceed those estimated by the Departments, they also did not address the broader premium and economic impacts of the proposed that we anticipate would result from public disclosure of negotiated rates.

Requiring health insurance providers to release all in-network negotiated rates and information on out-of-network payments in machine-readable formats would not result in consumers being provided with the type of actionable, personalized information they need to make more informed decisions about their costs.

We urge the Departments to withdraw the machine-readable file provisions of the proposed rule because they would: 1) not meet consumer needs; 2) distort health care markets, risking higher prices for consumers and raising privacy concerns; 3) exceed statutory authority, constitute arbitrary and capricious rulemaking, and raise Constitutional concerns; and 4) be extremely costly to implement.

A Better, More Workable Approach for Consumer Price Transparency Tools

We agree with the Departments that every American must have access to meaningful health care cost and quality information before they seek care. AHIP recently conducted a survey of our member health insurance providers on the availability and functionality of current price transparency tools. More than three-quarters of commercial health insurance providers that responded to AHIP's Price Transparency Tool Survey already make online tools available to their combined 120 million commercial enrollees—helping consumers get information on the cost and quality of services before they seek care.[4] These offerings are the result of intensive, iterative efforts over many years, respond to consumers' and employers' needs and demands based on market research and ongoing consumer testing, and demonstrate our members' commitment to price transparency.

The Departments propose an ambitious goal of ensuring consumers enrolled in commercial products have access to price transparency tools that will enable consumers to make better-informed health care decisions. We share the Departments' vision. We know that consumers want to shop for health care. A recent poll of Americans' use of price transparency tools when making decisions about their health care found that American adults value the ability to research their estimated of out-of-pocket cost-sharing liability from trusted sources, want information that is personalized, accurate, and easy-to-understand, and highly value privacy protections for their health care information.[5] Three in four respondents said they would be likely to research their out-of-pocket cost-sharing liability if they needed a medical procedure or service that is covered by insurance.

AHIP and our members wholeheartedly support the goals of informing consumers in advance about the cost and quality of health care services, enabling consumer choice, and encouraging cost-conscious decisions to lower overall healthcare costs. Federal regulations should enable innovation in the delivery of price transparency tools and focus only on high-level functional requirements. Internet-based self-service tools should be:

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[3] Sharma, Arun, Richard Manning, Zachary Mozenter. Estimating the Burden of the Proposed Transparency in Coverage Rule. January 27, 2020. https://www.bateswhite.com/newsroom-insight-246.html

[4] AHIP Survey of member health insurance plans fielded December 5, 2019 to January 10, 2020. Additional survey results to be published on ahip.org at a later date.

[5] Morning Consult poll conducted on behalf of AHIP, 2200 adults, December 14-16, 2019, MoE +/- 2 percent. Additional information about the poll and full results are available at: https://www.ahip.org/new-study-majority-of-americans-value-privacy-and-affordability-over-transparency/

1. **Transparent.** Including descriptions of items, services and/or bundle.
2. **Easy to Use.** Enrollees can easily find, access, and navigate cost and quality information.
3. **Easy to Understand.** Information is clear and easy to understand, using plain language when possible but describing complex and varying medical services when needed to provide an accurate description of the service and estimated costs.
4. **Personalized.** Estimates the enrollee's out-of-pocket cost-sharing liability based on the enrollee's specific plan, benefits, and accumulators.
5. **Current.** Bases estimates on current accumulator information in combination with either current negotiated rates or historical claims experience.
6. **Accurate.** Is based on a methodology and scope of services that supports estimates that are accurate and notifies enrollees of the limitations.
7. **Actionable.** Reflects the population served by the issuer and provides meaningful cost and quality information together to help enrollees identify value.

The excessively ambitious requirements of the proposed rule represent a major expansion beyond existing offerings, requiring massive information technology and resource investments by all commercial health insurance providers to develop, build or modify, test, and implement tools that meet the new standards. Federal regulations should strike a careful balance between ensuring consumers have access to clear, consistent, and concise information and not imposing outsize burden or costs on issuers that could stifle innovation.

While we agree with the Departments' overarching objectives related to price transparency tools, we are concerned certain aspects are overly prescriptive and unnecessarily broad, which could undermine these goals. Specifically, we are concerned the proposed requirements to include *all* items and services in automated consumer price transparency tools offered by health insurance providers, as well as the requirement that issuers develop cost estimates based only on current negotiated rates, are counterproductive to these goals.

Our real-world experience with existing issuer consumer transparency tools shows people primarily use these tools today for a limited set of shoppable services. For some particularly complex conditions, information cannot be accurately conveyed through an automated tool—it requires personal, individualized communication to provide an accurate and understandable estimate. Further, current price transparency tools include reliable cost estimates using a range of methodologies not limited to negotiated rates. Our members continue to refine these methodologies to improve cost estimates and should not be limited to one narrow approach.

Finally, it is essential to *convert consumer access to transparency tools into utilization of those tools*. To that end, we recommend the Departments commit to federal leadership of and funding for a coordinated outreach and education campaign to encourage use of price transparency tools—and our industry stands ready to assist in those efforts**.** Respondents to AHIP's survey reported less than half of enrollees have log-in credentials to access the online member portal, website, or mobile app where the price transparency tool can be accessed. Of those enrollees with log-in credentials, issuers estimate that, as of the most recently available quarter of data, on average, only 9.9 percent of enrollees have accessed the price transparency tool. We can and must do better to ensure patients and consumers use the transparency tools are available to them.

Overview of Detailed Comments on Consumer Price Transparency Tools
In our detailed comments on consumer price transparency tools, we recommend that the Departments:

- **Focus on Shoppable Services.** Adopt a more workable solution for price transparency tools that provide personalized information on estimated out-of-pocket costs based on the enrollee's benefits information for 421 shoppable services as a first phase. The Centers for Medicare & Medicaid Services' (CMS') recent definition of a "shoppable service" ("a service that can be scheduled by a healthcare consumer in advance") serves as a useful framework for this proposed rule.[6] This will ensure the usability of the information presented to consumers, reduce the burden associated with developing and maintaining such tools, and mitigate implementation delays.

- **Allow Additional Time to Implement.** Make any new requirements effective for plan years (or in the individual market, policy years) beginning on or after 2 years after finalization of the rule, to ensure a smooth implementation.

- **Focus on a Core Set of Functionality.** Identify a core set of functional requirements that must be included in all price transparency tools. This should ensure all people enrolled in commercial products have access to the same baseline functionality, while providing enough flexibility for issuers to develop, and iterate on, innovative consumer tools.

- **Establish a Technical Expert Panel.** Establish a technical expert panel to establish a framework for selecting and removing services from the required core set of shoppable services through future rulemaking after this initial implementation phase.

- **Modify Several Tool Features**. Regarding the specific features for price transparency tools, we recommend several additional revisions:

    - *Accumulator amounts.* We agree that a cost-sharing estimate for a particular item or service should reflect progress toward the deductible or out-of-pocket maximum and that consumers should be able to review their accumulator information within a price transparency tool. We recommend the Departments consider daily accumulator updates as meeting this requirement rather than requiring real-time updates. We further recommend information on accumulators for benefits with cumulative treatment limits (e.g., limit on number of items, days, units, visits, or hours covered) be optional.

    - *Negotiated rates.* We recommend the final rule provide issuers flexibility to apply a reasonable methodology for estimating reliable out-of-pocket costs for a specific network provider. Such a methodology may include, but should not be limited to, using current year negotiated rates, historic negotiated rates, historic claims, or a combination of these data points.

    - *Inclusion of out-of-network allowed amounts.* When consumers seek care from an out-of-network provider, the provider should be responsible for providing information on estimated balance billing amounts. The Departments should not finalize the requirement that issuers include information on out-of-network allowed amounts in price transparency tools. We support the Departments' efforts to increase consumers' access to useful data that is customized and personal to their own circumstances. Including out-of-network allowed amounts and cost-sharing estimates

[6] 84 Fed. Reg. 65524, 45 CFR §180.20

would not achieve this goal, could result in misleading information for consumers, and exceeds the Departments' statutory authority.

- **Extended Implementation Timeframe.** Provide issuers with enrollment under 100,000 members an extended implementation timeframe. Issuers with smaller enrollment volumes face a disproportionate burden to undertake an IT project of this size. We recommend small plans with members under 100,000 have an additional 3 to 5 years to implement the proposed requirements.

Price Transparency Tool Cost and Burden Analysis
AHIP's Price Transparency Tool Survey found the Departments steeply underestimate the costs associated with implementing and maintaining internet-based self-service price transparency tools. The Departments estimate a one-time cost of $221,029 for an issuer to implement a new price transparency tool (i.e., for an issuer that does not currently have an online tool) and $55,257 for an issuer with an existing tool to make necessary changes to meet requirements in the rule. Issuers estimated an average cost of $6.2 million to build, develop or modify, implement, test, and launch a price transparency tool. This is 28 times greater than the Departments' estimate for an issuer that needs to build a new tool and 112 times greater than the Departments' estimate for an issuer that has an existing tool. These cost estimates alone would justify an approach that allows issuers to leverage their existing tools.

The Departments estimate ongoing annual costs to maintain an online self-service price transparency tool would be $13,141 per issuer. AHIP survey respondents estimated average annual maintenance costs of $1.4 million per issuer—over 100 times greater than those anticipated by the Departments.

Conclusion
AHIP and our member companies believe that all consumers deserve access to health care information that is customized, personalized, and empowers them with timely and accurate information about cost and quality to make informed health care decisions for themselves and their families. We are committed to working with the Departments and other stakeholders to advance access to, and utilization of, personalized information on costs through issuer price transparency tools.

However, the machine-readable provisions of this proposed rule to require public posting of payer-specific negotiated rates and out-of-network payments would not advance these goals. Instead, the proposed rule would result in: consumers lacking the information they need to make informed health care decisions; higher prices and premiums for consumers and employers by distorting health care markets; the agency exceeding its statutory authority; and significant broader economic impacts. For all of these reasons, we urge the Departments to withdraw these provisions of the proposed rule and work collaboratively with health insurance providers and other stakeholders to find better solutions.

Sincerely,

Matthew Eyles

Matthew Eyles
President & Chief Executive Officer

Attachments

ATTACHMENT A:

AHIP Detailed Comments on the Transparency in Coverage Proposed Rule (CMS–9915–P)

Our detailed comments are organized into the following sections:

I. Framework for Reviewing Proposed Requirements: Principles to Achieve Meaningful Consumer Price Transparency

II. Consumer Price Transparency Tools

III. Public Disclosure of Negotiated Rates

IV. Public Disclosure of Out-of-Network Allowed Amounts

V. RFI: Disclosure of Pricing Information through a Standards Based API

VI. RFI: Provider Quality Measurement and Reporting in the Private Health Insurance Market

VII. Applicability and Exceptions

VIII. Medical Loss Ratio Proposed Changes

I. FRAMEWORK FOR REVIEWING PROPOSED REQUIREMENTS: PRINCIPLES TO ACHIEVE MEANINGFUL CONSUMER PRICE TRANSPARENCY

Every American should have access to meaningful health care cost and quality information before they seek care. More than three quarters of issuers (77 percent) who responded to AHIP's recent Price Transparency Tool Survey already make online tools available to their combined 120 million commercial enrollees to help consumers get information on cost and quality of health care services.[7] These offerings are the result of intensive, iterative efforts to respond to consumers' and employers' needs and demonstrate our member's commitment to price transparency.

The Departments outline an ambitious goal of requiring all *group health plans, including self-insured, and issuers in the individual and group markets ("issuers") to make available a self-service internet tool so consumers can obtain an estimate of their personal cost-sharing liability for an item or service provided by a specific provider before they receive care. The Departments aim to* provide consumers price and benefit information that would enable them to evaluate health care options and to make cost-conscious decisions; to reduce surprises in relation to consumers' out-of-pocket costs; to create a competitive dynamic that will begin to narrow price differences for the same services; to foster innovation by providing industry the information necessary to support informed, price-conscious consumers in the health care market; and to potentially lower overall health care costs over time. We share the Departments' overarching vision. However, new regulations must strike a careful balance between

[7] AHIP Survey of member health insurance plans fielded December 5, 2019 to January 10, 2020. Additional survey results to be published on https://www.ahip.org/ at a later date.

providing clear, consistent, and concise information to enrollees, and imposing outsize costs and burden on issuers that could stifle innovation.

We know that consumers want to shop for health care. Morning Consult, on behalf of AHIP, recently conducted a poll of Americans' use of price transparency tools when making decisions about their health care.[8] The poll found that American adults value the ability to research their estimated of out-of-pocket cost-sharing liability from trusted sources, want information that is personalized, accurate, and easy-to-understand, and highly value privacy protections for their health care information. Three in four respondents said they would be likely to research their out-of-pocket cost-sharing liability if they needed a medical procedure or service that is covered by insurance. When asked how they would use this information, two thirds said they would consider making an appointment with a specialist other than the one recommended by their doctor if they knew they would receive the same quality of care at a lower cost. The same number said they would be likely to choose a lower cost doctor, facility, or hospital for a medical procedure than the one recommended by their doctor if their issuer offered a financial incentive to do so.

However, consistent with the Departments' observations in the preamble and issuers' experiences, the survey found actual utilization of price transparency tools is lagging. Only a quarter of adults have personally used a mobile app or online resource to look up the cost of a medical procedure or service covered by insurance before seeking care. Of those, 42 percent used a mobile app or online resource provided by their health insurance company to look up the cost of a covered medical procedure or service. They said making information easier to find and easier to understand would make their experience better the next time they search for information on costs of covered services. However, three in four respondents would not support a federal regulation that made it easier to find the cost of medical procedures but raised the cost of health insurance premiums.

Based on the results of AHIP's survey and our members' experiences, internet-based self-service price transparency tools should be:

1. **Transparent.** Including descriptions of items, services and/or bundle.
2. **Easy to Use.** Enrollees can easily find, access, and navigate cost and quality information.
3. **Easy to Understand.** Information is clear and easy to understand, using plain language when possible but describing complex and varying medical services when needed to provide an accurate description of the service and estimated costs.
4. **Personalized.** Estimates the enrollee's out-of-pocket cost-sharing liability based on the enrollee's specific plan, benefits, and accumulators.
5. **Current.** Bases estimates on current accumulator information in combination with either current negotiated rates or historical claims experience.
6. **Accurate.** Is based on a methodology and scope of services that supports estimates that are accurate and notifies enrollees of the limitations.
7. **Actionable.** Reflects the population served by the issuer and provides meaningful cost and quality information together to help enrollees identify value.

[8] Morning Consult poll conducted on behalf of AHIP, 2200 adults, December 14-16, 2019, MoE +/- 2 percent. Additional information about the poll and full results are available at: https://www.ahip.org/new-study-majority-of-americans-value-privacy-and-affordability-over-transparency/

Recommendation:

- **We recommend the Departments use these principles to determine whether the proposed polices for price transparency meet the overarching goal of informing consumer decision-making before adopting these requirements in a final rule.**

II. CONSUMER PRICE TRANSPARENCY TOOLS

A. Ensure Policies Do Not Stifle Existing Issuer Innovation

While more than three quarters of commercial issuers currently offer price transparency tools, the ambitious requirements of the proposed rule represent a major expansion beyond existing offerings, requiring massive information technology and resource investments by all issuers to develop, build or modify, test, and implement tools that meet the new standards.

Federal requirements should enable—not impede—private sector innovation to develop tools that meet consumer and employer needs. Unfortunately, the requirements as proposed would not achieve this goal. The proposed rule is overly prescriptive and unnecessarily broad—without adding value—in defining specific requirements for price transparency tools that will undermine the ability of issuers to develop and iterate on innovative consumer tools. We have serious concerns that requirements outlined in the proposed rule will result in tools that are cumbersome and not consumer-friendly. Overly prescriptive and unnecessarily broad regulatory requirements would undermine ongoing efforts by issuers to develop meaningful, consumer-focused tools and could stifle ongoing innovation. Many issuers with existing tools would need to shift focus from the tools they have developed based on extensive research and consumer feedback to build a separate tool and implement new compliance work streams to meet the proposed requirements.

As an alternative, we recommend a more workable solution for price transparency tools that provide personalized information on estimated out-of-pocket costs based on the enrollee's real time benefits information for "shoppable services". We strongly urge the Departments to finalize regulations that specify high-level functional requirements and a narrower set of common shoppable services as a base while providing issuers the flexibility to develop and iteratively improve price transparency tools.

Federal regulations should focus on a vision for price transparency tools that can be successfully implemented and deliver a meaningful experience to consumers within two years, not attempt to solve for every rare use case or services that are not truly shoppable at this time. The Departments should continue to collaborate with industry to advance this vision to continually improve and expand scope and functionality while still providing issuers flexibility to deliver innovative tools that meet the needs of their enrolled populations.

AHIP's Price Transparency Tool Survey found about a quarter of survey respondents (10 issuers) indicated they do not currently offer internet-based self-service price transparency tools for commercial products. These issuers cover 3.6 million consumers enrolled in commercial products and tend to be smaller, regional plans. Their median total enrollment—including commercial and other lines of business—is 145,426. Some of these issuers have a cost estimation process that is not automated or internet-based (e.g., the enrollee contacts customer service, which initiates a process to coordinate with the provider to estimate cost) or provide more general (not member-specific) information on costs. One issuer commented that they previously had a cost estimate tool but discontinued it due to low utilization.

Several commented that the cost of implementing such a tool was prohibitive for a plan of their size or would result in significant increases in premiums.

B. Definition and Scope of "Items and Services" (§§54.9815-2715A(a)(2)(viii), 2590715-2715A(a)(2)(viii), and 147.210(a)(2)(viii))

The Departments propose issuers offer price transparency tools that estimate cost-sharing liability for a covered item or service. The proposed rule defines "items or services" as all encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees including facility fees.

Including every item and service will not provide meaningful information to consumers and will impede the ability of issuers to deliver innovative, easy-to-use price transparency tools. Consumers seeking price and quality information from an automated tool before receiving care need information on shoppable services—procedures, tests or imaging, or episodes of care—that are truly shoppable. We discuss our detailed concerns and provide specific recommendations for identifying a narrower set of shoppable services below:

1. Including *All* Items and Services does not Provide Consumer Value

The proposed policy to include *all* items and services in automated consumer price transparency tools is counterproductive to the Departments' goals of providing consumers with price information that would enable them to evaluate health care options and to make cost-conscious decisions in advance of seeking care.

When we consider the principles for consumer choice outlined above, consumers need tools that show what information is included, are easy to access and use, are personalized to the services they seek and their benefit structure, are based on timely information, are reasonably accurate, and provide comprehensive enough information for consumers to drive decisions. By forcing *all* items and services into automated tools rather than allowing issuers to employ multiple methods of furnishing information, many of these consumer principles will be diminished or violated. To provide examples of an overly expansive scope: the inclusion of rare or low-volume services will compromise the accuracy of estimates; the magnitude of services will make it harder for consumers to find the item or service for which they seek information (e.g., more results in searches, more services in drop down menus) and will diminish the ease of use; the lack of quality measures to pair with *all* items and services will risk driving decisions based on an incomplete, and possibly misleading, picture; and an overly ambitious policy will delay implementation, and thus access to these tools for many consumers. We believe including *all* items and services will greatly diminish the utility of these tools for consumers.

According to a recent study by the Health Care Cost Institute (HCCI), approximately 36 percent of 2017 total spending (including prescription drug spending) and 43 percent of out-of-pocket spending was attributed to shoppable services.[9] Moreover, real-world experience with existing issuer consumer transparency tools indicates that of those services that could be shoppable only a subset are actually used by consumers when searching on their plan website. When looking at the Axis® database that supports the Blue Cross Blue Shield Association National Consumer Cost Tool, the top 50 service categories represent 80 percent of all searches and is reasonably consistent with the CMS definition of shoppable. Beyond the top 10 service categories, consumer interest across the universe of search terms drops off

[9] Health Care Cost Institute #HealthyBytes Blog. January 16, 2020. Available at: https://www.healthcostinstitute.org/blog/entry/cms-specified-shoppable-services-made-up-12-of-2017-health-care-spending-among-people-with-employer-sponsored-insurance-1?highlight=WyJ0cmFuc3BhcmVuY3kiXQ==

significantly, with the vast majority of treatment categories failing to register even 1 percent of all searches. Thus, the rule's requirement that *all* items and services be included in a pre-built calculator (as opposed to allowing many to be handled in alternative, more efficient and effective ways, such as those described below) is arbitrary and capricious; resulting in significantly increased costs to issuers, and ultimately higher premiums for consumers, with minimal to no consumer benefit.

In addition, forcing *all* items and services into an automated tool could crowd out potentially more accurate and convenient consumer access channels. Some conditions are especially complex and require human intervention to provide an accurate and understandable estimate, rather than fully automated estimates. Moreover, according to the Morning Consult poll, Americans are split on how they would most prefer to obtain information about the cost of a health care service. Thirty percent would prefer to call their insurance company, 30 percent would prefer to look up the information on their company's website or mobile app, and 28 percent would prefer to look up information on their insurance company's website or mobile app with their doctor. Only 11 percent would prefer to obtain information on their health care costs from a third party's website or mobile app. The Departments should be careful not to divert resources from existing consumer-friendly options whether on a website, an app, on the phone, or with their doctor.

Recommendation:

- **The Departments should not require the inclusion of *all* items and services in the automated price transparency tools, which could diminish the utility of such tools for consumers.** Just because a service is not included in the automated tool does not mean that consumers do not have ready access to pricing estimates. In some cases, the most consumer-friendly and accurate approach may be via phone with a concierge or customer service agent to help navigate complex care estimates. In other cases, the issuer may need to interact with the provider to have a full understanding of expected services. The focus on automated tools should not diminish alternatives that may in fact be more consumer friendly.

2. Narrow the Scope Based on the Notion of Shoppable Services

The Centers for Medicare and Medicaid Services (CMS) recently finalized a formal definition of shoppable services for the consumer-facing tool as "a service that can be scheduled by a healthcare consumer in advance" as part of new hospital rules.[10] CMS describes shoppable services in the preamble as those items and services that are routinely provided in nonurgent situations that do not require immediate action or attention to the patient, thus allowing patients to price shop and schedule a service at a time that is convenient for them. Examples of shoppable services that meet such a definition include certain imaging and laboratory services, medical and surgical procedures, and outpatient clinic visits.

CMS notes that it proposed, and later finalized, this definition because it is consistent with definitions used by policy experts and researchers. Researchers White and Eguchi, identify a service as shoppable if a patient is able to determine where and when they will receive services and can compare charges for multiple providers.[11] The research CMS cites indicates "using an inclusive definition, all shoppable services accounted for about one third of total spending if both inpatient and ambulatory services are

[10] 84 Fed. Reg. 65524, 45 CFR §180.20

[11] White C, and Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. National Institute for Health Care Reform Research Brief Number 18 (2014). Available at https://www.nihcr.org/wp-content/uploads/2016/07/Research_Brief_No._18.pdf.

included."[12] Moreover, it aligns with various State price transparency efforts and is consistent with stakeholder feedback. Based on this, CMS finalized a requirement for hospitals to display a total 300 items or services for consumer use—70 specified service codes and 230 items and services to be determined by hospitals based on the population they serve.

In the final hospital rule, CMS recognized that not all items and services would be appropriate for a consumer tool, the burden on providers would increase the more items and services were included, and that the varying needs of the population warrant variability in the items and services included. Yet, in this proposed rule, the Departments would require all items and services covered by an issuer to be included in the consumer-facing tools and do not account for the considerations that led CMS to narrow the scope to shoppable services in the hospital rule. The notion of what consumers deem "shoppable," and therefore useful in price transparency tools, should be comparable across hospitals and issuers.

AHIP compared CMS' list of 70 shoppable services that hospitals are required to display to the lists of items and services (including CPT codes) that are included in a subset of issuers' price transparency tools. The detailed analysis is included in Attachment B. We found moderate to strong consistency across 63 does. This left 11 items and services for which there was little overlap. Some of the difference may be because our members generally provided CPT codes while CMS also includes DRGs and HCPCS. We believe some of this variation stems from the fact that issuers tailor their price transparency tools to the subset of the population they cover—sometimes by product or employer group—whereas the CMS hospital list is meant to be inclusive of all payer types. For example, cataract removal and prostate surgery skew to a more elderly population and thus may not be as high of a priority for the younger enrollees on average who are enrolled in commercial plans. Thus, the nature of the commercial population would need to be factored in as the Departments consider the CMS list to narrow the required items and services.

According to the HCCI study cited above, the 70 service codes identified by CMS represented about 12 percent of total healthcare spending, and 16 percent of out-of-pocket spending, using commercial data from 2017. HCCI also updated an analysis, that identified 429 codes as shoppable services.[13] This work was largely based on the work of White and Eguchi that was cited by CMS in defining shoppable services. [14] Recognizing that the 70 CMS service codes are a subset of what might be considered shoppable, and the subset of 63 service codes we identified in member tools as appropriate for commercial populations even smaller, we undertook a second analysis to identify additional items and services that could be appropriate for commercial price transparency tools.

AHIP's Price Transparency Tool Survey found a median of 526 services are included in existing price transparency tools available to consumers enrolled in commercial coverage. Based on a subset of respondents who provided specific codes currently included in their tools, we sought to identify commonalities. We found that at least half of the respondents included a set of 421 codes in their tools that can be found in Attachment C. Not surprisingly, the items and services included, among other things, imaging, scheduled procedures, lab tests, and office visits, consistent with the CMS definition.

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[12]Coluni B. White Paper: Save $36 Billion in U.S. Healthcare Spending Through Price Transparency. Truven Health Analytics, 2012. Available at: http://www.akleg.gov/basis/get_documents.asp?session=30&docid=14495

[13] Health Care Cost Institute #HealthyBytes Blog. January 16, 2020. Available at: https://www.healthcostinstitute.org/blog/entry/cms-specified-shoppable-services-made-up-12-of-2017-health-care-spending-among-people-with-employer-sponsored-insurance-1?highlight=WyJ0cmFuc3BhcmVuY3kiXQ==

[14] White C, and Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. National Institute for Health Care Reform Research Brief Number 18 (2014). Available at https://www.nihcr.org/wp-content/uploads/2016/07/Research_Brief_No._18.pdf.

These 421 items and services would provide a sound list for issuers to standardize the information made available to consumers with the least disruption of existing tools.

Issuers conduct extensive research to determine which items and services to include in their tools and continually review and adjust the items and services in their tools. The AHIP Price Transparency Tool survey found that the majority of issuers use member feedback and claims frequency to determine which services to include in their price transparency tools. Other considerations include operational feasibility, state mandates or regulations, and services their vendor can support. In addition, members consider variability in costs for the services as well as search frequencies by members. These factors all come to bear in decisions made by issuers about what items and services, along with what other features, are most important to and actionable for enrollees in price transparency tools and at the same time feasible. Given the 421 codes are in use by at least a subset of issuers, we have confidence that these are shoppable services.

We note, however, that only one service was common across all respondents in our comparison of member responses, and only 19 items and services were common across all but one issuer. Thus, there is significant variability in the content of the tools. The information deemed important to consumers can vary not just by plan but even by product. For example, as part of Administrative Services Only contracts, the included information can be customized to the employer sponsoring the coverage focusing on the specific employee population and where there is variability in out-of-pocket costs based on the unique benefit structure. At the same time as including *all* items and services is not the right approach to serve consumers, dictating a large prescriptive subset of items and services and inhibiting customization and innovation is not either. While there may be a core common set of items and services that are ubiquitous, issuers need the flexibility to best serve their own enrollees based on their own research, interactions and analyses. We believe there is merit in CMS' approach of establishing an overall number of required items and services, but then bifurcating that into a smaller required core set and variable set based on issuer choice.[15]

Recommendations:

- **The Departments should narrow the scope of items and services initially required to the 421 shoppable services recommended by AHIP.** This will protect the utility of the information provided to consumers, reduce the burden associated with developing and maintain such tools, and prevent implementation delays. This number is also greater than the initial expectation of hospitals and consistent with research identifying the scope of shoppable services.

- **Any expansion of required services should come only after the issuers that do not currently have tools have successfully implemented tools with the first 421 recommended items and services, and those issuers that have tools are able to conform their tools to the new requirements.** Lessons learned from this first phase of implementation should be gathered and incorporated into a future round of rulemaking before an expansion of the required items and services.

- **For any expansion, the Departments should continue to follow the framework of a core set of required services in addition to variable services chosen by the issuers based on the unique needs of the populations they serve.** This is consistent the approach CMS applied the

[15] While we express support for the approach CMS uses to define and determine shoppable services for use in the consumer price transparency tool, our opposition to the release negotiated rates within that policy remains.

hospitals and would allow issuers to continue to ensure their tools reflect the needs of their specific populations. The core set should be focused on common services that are routinely searched and stable over time allowing issuers to innovate based on their population for the remainder of the services. This avoids diverting resources to information that may not be of value to an issuer's enrollees and employer sponsors of coverage.

3. Establish Technical Expert Panels for Service Selection and Quality

We are proposing a list of items and services to include based on what commonalties exist across a subset of existing member price transparency tools. For future phases, a Technical Expert Panel (TEP) is needed to review data and input from stakeholders, advise on what research the Departments should undertake, and determine which items and services are suitable for future expansions. We anticipate that the core set of services will need to evolve over time to recognize changes in healthcare delivery (e.g., standard of care changes, new technologies become available, etc.) and healthcare operations (e.g., changes in codes, advanced consumer analytics, etc.). Thus, the TEP could play an important role in maintaining and expanding the core set of required services.

The White and Eguchi research states "In general, a shoppable health care service must typically be scheduled in advance, there must be more than one provider in a market that can perform the service, and there has to be price data available for the different providers. Ideally, the patient also would have some information on each provider's quality of care, or at least some reasonable assurance that quality does not vary much."[16] Based on research such as this, our consumer-framework, and member feedback, we developed criteria for identifying shoppable items and services that could serve as a starting point for a TEP in developing a framework for assessing possible additions to or removals from the required list.

- Covered, routine items/services
- Non-emergent/urgent and can be scheduled
- There is variation in out-of-pocket costs
- There is a choice in providers
- The provider is in network
- There is a specific item or service to be purchased (e.g., not exploratory surgery, staged surgery, or other ill-defined services)
- Can be adequately described (e.g., not so medically complex a layperson would not be able to identify the correct service)
- Electronic data sources on which to base an estimate are available
- Sufficient volume of the service is provided to ensure reasonable accuracy
- Meets a minimum cost threshold
- Not a significant variation in costs (e.g., inter-quartile range, coefficient of variance, etc.)
- Not a propensity for significant outliers (e.g., complication rates, follow-on care, change in DRG, etc.)
- Stability of consumer searches over time.

While some of the above criteria cannot be applied on a national basis for a TEP selecting shoppable services for a required set, such as the "provider is in network" criterion, this also could be applied at the

[16] White C, and Eguchi M. Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle. National Institute for Health Care Reform Research Brief Number 18 (2014). Available at https://www.nihcr.org/wp-content/uploads/2016/07/Research_Brief_No._18.pdf.

plan level to customize the list of items and services available in their tool if choice is permitted. In addition, such criteria could be used to determine if an issuer would be permitted to exclude a particular item or service based on low consumer utility.

Furthermore, we believe that, ultimately, price information should ideally be posted in tandem with quality indicators to give consumers a more complete perspective on value. Higher prices may not be correlated with higher-quality providers and vice-versa, yet we know consumers tend to make this assumption. However, that integral component of quality is only in the request for information stage. Thus, while cost and quality information should ideally be presented together, we realize it would be unrealistic to require quality information for many, if not most, items and services at this stage. As quality measure standards continue to be developed, we recommend the Departments work closely with industry—specifically that the Departments work with the multi-stakeholder Core Quality Measures Collaborative (CQMC) co-led by AHIP and CMS—to develop a framework for required quality information in price transparency tools through future rulemaking. The CQMC, however, does not develop measures and other stakeholder groups will need to be engaged to fill gaps. Nor, does it address how the core measures are displayed in issuer tools, so the Departments should work closely with industry to determine appropriate parameters for such displays.

Recommendations:

- **The Departments should establish a Service Selection technical expert panel (TEP) to advise on changes to the list of required items and services, including removing items or adding new ones.** The Service Selection TEP should include representatives from issuers, consumer groups, employers, providers and other relevant stakeholders.

- **The TEP should establish a data- and consumer-driven framework for identifying additional shoppable services in the future and the total number of additional services that an issuer should elect to include beyond the required list of common items and services.** This should include the creation of a criteria for selecting shoppable items and services as well for removals. The framework should also account for ongoing changes in healthcare delivery and healthcare operations. The framework, selection and removal criteria, and resulting core set of services should be included in subsequent rulemaking for stakeholder comment before implementation.

- **The TEP should develop a framework for items and services on the required core set that issuers can exclude based on their particular population served or benefit structure.** This would be similar to the exception in the CMS hospital rule that allows hospitals that do not offer a particular service to choose another service to meet the required threshold of services. There will be items and services that are included on the national core set but are of little value to the consumers in a particular product. The Departments should not stifle innovation by too strictly adhering to a one-size fits all approach.

- **A second TEP should be established to address the pairing of quality and patient experience data with pricing information to ensure consumers are fully informed when making decisions about their care.** This Quality TEP should work closely with the Service Selection TEP so that the availability and adequacy of quality information is consider in the selection of services. This TEP should develop basic functional requirements as well as assess the gaps in measurement associated with the initial core set of required services to promote development in

these areas. However, the TEP should defer to the CQMC and other stakeholders on which measures should be used and how the information should be displayed.

- **The Departments should consult with the Federal Trade Commission (FTC) and the Department of Justice (DOJ) on the best ways to ensure that pro-consumer efforts to streamline quality measure collection, reporting, benchmarking and display are not inappropriately chilled by antitrust concerns.** Streamlining certain aspects of quality reporting has the potential to significantly benefit to consumers by allowing for common user experiences across issuers and across providers. Furthermore, it has the system to make the system more efficient, by reducing the burden on providers associated with quality measurement—especially if more measures are needed to fill gap areas in transparency tools.

C. Information Required to be Disclosed to Participants, Beneficiaries, or Enrollees

The Departments identify seven content elements that a plan must disclose when a consumer requests cost-sharing information. We agree with including many of these content elements, and the results of AHIP's Price Transparency Tool Survey show that issuers that currently have consumer tools which already include these elements. We have concerns about including certain content elements, or including some of them immediately, and provide recommendations below for the Departments to consider while finalizing these standards as part of an initial set of shoppable services.

1. Definitions (§§54.9815-2715A(a)(2), 2590715-2715A(a)(2), and 147.210(a)(2))

The proposed rule would require disclosure of cost-sharing information to participants, beneficiaries, or enrollees. Participant and beneficiary are defined as in sections 3(7) and 3(8) of ERISA, respectfully. These definitions expand beyond individuals currently enrolled in the group health plan (e.g., former employees or employees who *may* become eligible for benefits).

Recommendation:

- **The Departments should clarify that issuers are only required to make information on estimated out-of-pocket cost-sharing available to individuals (and their beneficiaries or an authorized representative) currently enrolled in coverage.** The rule envisions providing personalized feedback based on the specific product, benefits, and cost-sharing accumulators. It would not be possible to provide such information to an individual not currently enrolled in coverage. It does not appear the Departments envision providing this information to individuals not enrolled in coverage. Thus, we recommend a clarification that price transparency tools are only intended for individuals, and their dependents, who are currently enrolled in coverage. Throughout this comment letter, we refer only to "enrollees."

2. Estimate of Cost-Sharing Liability (§§54.9815-2715A(b)(1)(i), 2590715-2715A(b)(1)(i), and 147.210(b)(1)(i))

The central proposed content element is cost-sharing liability for a requested covered item or service furnished by a provider, which must reflect any cost-sharing reductions the enrollee would receive that is calculated based the enrollee's accumulated amounts, negotiated rate, and out-of-network allowed amount.

All issuers with price transparency tools provide estimates of out-of-pocket costs for medical services. Over 83 percent of issuers responded that they allow members to obtain advance out-of-pocket cost estimates on elective outpatient surgery/procedures, inpatient surgical services (e.g., scheduled surgical services), inpatient non-surgical services, physician services, outpatient laboratory services, radiology

services, services for select chronic conditions (e.g., HbA1c testing for diabetes), and prenatal care, delivery and postpartum care. Less than half of respondents currently provide information on telemedicine, fees (including facility fees), durable medical equipment (DME), or supplies. Respondents noted some supplies and some facility fees are included in costs for other services but not independently searchable. As we discuss below, price transparency tools use the enrollee's specific plan, benefits, and accumulators to provide reasonably reliable and personalized cost information.

Recommendation:

- **We recommend the estimate of cost-sharing liability only be required for a narrower set of shoppable services in the initial phase.** We discuss our significant concerns with the scope of "all items and services" above in section II.B. of our comments.

3. Accumulated Amounts (§§54.9815-2715A(b)(1)(ii), 2590715-2715A(b)(1)(ii), and 147.210(b)(1)(ii))

The second proposed content element is accumulated amounts, or the amount of financial responsibility the enrollee has incurred at the time of the request with respect to a deductible or out-of-pocket maximum. Issuers would also be required to include accumulated amounts toward a cumulative treatment limit if applicable.

Accumulated amounts are commonly included in consumer price transparency tools. Ninety percent of issuers that currently offer a price transparency tool to commercial enrollees provide estimated enrollee cost-sharing liability for a specific item or service, including deductibles, coinsurance, and copayments. Nearly all provide accumulated amounts to date (86 percent) and individual and family deductibles for family or other-than-self-only coverage (83 percent). Information on accumulators is updated in real time (57 percent) or daily (30 percent), thus it may not be possible for all cost-calculator tools to be updated "at the time of the request" and additional flexibility is needed.

Recommendations:

- **We agree that a cost-sharing estimate for a particular item or service should reflect progress toward the deductible or out-of-pocket maximum and that consumers should be able to review their accumulator information within a price transparency tool.** We recommend the Departments consider daily accumulator updates as meeting this requirement rather than requiring real-time updates.

- **We recommend information on accumulators for benefits with cumulative treatment limits (e.g., limit on number of items, days, units, visits, or hours covered) is considered optional at this time.** Only 21 percent of issuers with price transparency tools provide information on accumulated amounts for cumulative treatment limits. Information on treatment limits may be maintained in separate benefit systems and is more challenging for issuers to integrate with real-time cost information. We recommend this functionality not be required to be fully integrated with an online price transparency tool until a later implementation phase. This will give issuers flexibility to include cumulative treatment limit information if available. For issuers that are unable to immediately integrate this in a price transparency tool, it will maintain the focus on ensuring the accuracy of core information that will directly impact a cost estimate. Enrollees would still be able to obtain information on treatment limits by contacting their issuer by phone.

4. Negotiated Rate (§§54.9815-2715A(b)(1)(iii), 2590715-2715A(b)(1)(iii), and 147.210(b)(1)(iii))
The third required content element is information on cost-sharing liability that is based on the negotiated rate for an in-network provider, expressed as a dollar amount. Disclosure of the negotiated rate would not be required if it is not relevant for calculating cost-sharing (e.g., copayment is a flat dollar amount, the deductible has been satisfied, or the deductible does not apply).

Issuers are split in the underlying provider reimbursement information used to estimate cost-sharing liability. Currently, over eighty percent of price transparency tools use data other than current negotiated rates to develop reliable estimates of enrollee out-of-pocket costs—43 percent use historical negotiated rate information while 40 percent use other data. Issuers who reported using other data primarily use a data analytics approach that leverages historical claims data only or in combination with negotiated rates or other data. Still more reported using other data like a market average. Only 17 percent provide cost-sharing estimates based only on negotiated rates in current-year contracts.

Developing a reliable out-of-pocket estimate is not as simple as producing the information included in an explanation of benefits (EOB) prior to the health care service, which is what the Departments envision by proposing cost estimates based on current negotiated rates. Whereas an EOB is produced after a service is rendered and reflects the exact billing codes submitted by the provider for the exact service(s) performed at the point of care, an "advance EOB" may not be able to account for provider practice patterns or decisions at the point of care. While issuers work to provide the most accurate estimates possible, actual out-of-pocket costs may vary due to an individual's medical profile, risk factors, unanticipated changes at the point of service, and a provider's decisions at the point of care. Issuers that use a data analytics approach using historic claims information emphasized the importance of accounting for provider practices.

Recommendations:

- **We recommend the final rule provide issuers flexibility to apply a reasonable methodology for estimating reliable out-of-pocket costs for a specific network provider. Such a methodology may include but should not be limited to using current year negotiated rates, historic negotiated rates, historic claims, or a combination of these data points.** By allowing issuers to determine a reasonable methodology, the final rule would also preserve flexibility for issuers to continually evolve this approach to improve the accuracy of cost estimates as available clinical data, technology, and data analytics evolve.

- **We disagree that not using current negotiated rates will result in less accurate information for consumers**. In the preamble, the Departments cite stakeholder concerns from 2018 listening sessions that "use [of] historical claims data, which results in broad, sometimes regional estimates, rather than accurate and individual prices."[17] On the contrary, price transparency tools based on claims data can be both accurate and individualized. One issuer that uses historic claims reported that estimates for its highest volume procedures (representing over a third of claims) are very accurate—specifically, the average difference between actual and estimated is cost was 5.8 percent; 55 percent of estimates were an exact estimate for the actual claim; and 84 percent of estimates varied from the final claim by less than 10 percent. Using claims information to develop a cost estimate accounts for variation in how different providers may perform and bill a service. Alternatively, negotiated rate information alone may not always provide the most accurate estimate of an enrollee's out-of-pocket costs for a particular provider. For example, issuers may

[17] 84 FR 65467

use a combination of current negotiated rate and historic claims information or rely primarily on historic claims information. Issuers noted that a data analytics model, which attempts to predict out-of-pocket costs based on a provider's historic practice and billing patterns, may be a more accurate prediction of out-of-pocket costs for that provider. Estimates that rely only on negotiated rates, as envisioned in the proposed rule, may not provide cost estimates that reflect a specific provider's tendency to provide care or bill in a particular manner.

- **We recommend cost transparency requirements for capitated services be limited to amounts that are not service dependent (e.g., flat copayments), as well as accumulator information about deductibles and out-of-pocket maximums.** The Departments seek comment on whether there are certain reimbursement or payment models that should be partially or fully exempt from these requirements or should otherwise be treated differently. Issuers do not always have access to the negotiated rates or internal payment methodologies utilized by capitated medical groups or other providers and would not be able to reliably provide cost transparency based on a negotiated rate at the service level. Thus, we support narrower scope for capitated arrangements.

5. Prescription Drugs (84 FR 65472)

The Departments acknowledge there are several variables when considering a prescription drug's price and seek comment on which rates should be displayed to consumers for prescription drugs. Addressing high drug prices is a top priority for issuers and we appreciate the department's thoughtful consideration of this issue.[18] The comments in this section address drugs covered under a consumer's prescription drug benefits. Our comments about medical services throughout this letter would apply to drugs covered under a consumer's medical benefits.

For the purposes of this proposed rule, we recommend the Departments define requirements related to prescription drugs in a manner that supports consumer access to personalized, relevant, actionable information about drug costs. We also recommend the Departments permit issuers to leverage existing prescription drug price tools, minimizing new regulatory burdens and costs.

As the Departments acknowledge in the proposed rule, there are several rates that can be considered when analyzing drug prices, for example average wholesale price or specific negotiated rates. Which rate should be considered for a specific purpose should be determined based on an understanding of the reason a consumer is considering the drug price.

When consumers are considering treatments and alternatives or planning financially for their health care costs, their primary question is "what will I spend out-of-pocket on this drug?" To answer this question, patients need to know: what is my cost-sharing for this drug on my plan, accounting for any relevant spending towards a deductible at that point; and what would this drug cost me if I don't use my insurance? Providing pricing information that isn't relevant to these two questions will likely confuse consumers and could lead to patients not filling needed prescriptions because of a misconception about the sticker price of the drug. Regulations should not require the display of negotiated drug prices, rebates or other discounts or fees that are not relevant to what the consumer will owe.

[18] More information on AHIP's positions on policy issues related to drug prices can be found at https://www.ahip.org/issues/high-cost-drugs/.

To the primary consumer question, "what will I spend out-of-pocket on this drug?" issuers already provide formulary documents and tools that include information on which specific drugs are covered, cost-sharing for specific drugs and any applicable pre-authorization that applies. In many cases these tools are provided in partnership with the pharmacy benefits manager (PBM) that administers the prescription drug coverage. Any new regulations related to providing this information should be flexible enough to: (1) treat current tools that are working for consumers as meeting those requirements; and (2) allow tools and services related to prescription drug costs to evolve as technology changes and consumer preferences evolve.

To the secondary consumer question, "what would this drug cost me if I don't use my insurance?" pharmacies change what prices they charge day-to-day and issuers do not have this information for every pharmacy at any given time. Retail pharmacies are best positioned to provide this information and requiring issuers to provide an amount that might be incorrect is not in the best interest of the consumer.

In existing tools, when a total cost number is displayed, issuers have made choices about which rate to display based on the benefits design and what information is available. Any new requirements should continue to allow issuers to determine and display the most consumer-relevant and accurate total cost number available. Sixty two percent of issuers that offer a price transparency tool include capabilities to estimate out-of-pocket costs for prescription drugs. Some issuers noted that their medical price transparency tool does not integrate prescription drug cost information, but makes this information available through a separate pharmacy tool (often provided by the PBM).

Recommendations:

- **Focus any new transparency requirements for issuers related to prescription drugs on providing the amount the consumer can expect to pay under the terms of their plan.** This is the most relevant information to the consumer and the information plans have and can provide accurately. The Departments should not require display of negotiated drug prices, rebates, or other discounts or fees.

- **Confirm that issuers may meet drug cost transparency requirements by providing links to prescription drug cost tools provided by partners or vendors.** Prescription drug benefits are designed and administered differently than medical benefits because there are fundamental differences in: the way patients obtain and pay for prescription drugs and the procurement process for insurers to negotiate prices on drug for their enrollees. Stand-alone drug cost-comparison tools will provide the best consumer experience for consumers in most cases.

6. Out-of-Network Allowed Amounts (§§54.9815-2715A(b)(1)(iv), 2590715-2715A(b)(1)(iv), and 147.210(b)(1)(iv))

The Departments propose to define "out-of-network allowed amount" as the maximum amount a plan or issuer would pay for a covered item or service furnished by an out-of-network provider. Issuers would be required to disclose the out-of-network allowed amount and any cost-sharing liability the enrollee would be responsible for paying.

a. The Inclusion of Out-of-Network Amounts is Flawed as an Operational and Policy Matter

One of the ways issuers provide value to enrolled consumers is by developing a curated provider network to meet the needs of its enrollees. In-network providers have agreed to accept a discounted rate for covered services provided to consumers enrolled in the health plan offering that network. Steering enrollees toward network providers is a key lever in controlling health care costs for everyone. Issuers

also ensure that network providers meet certain quality standards, another tool for promoting high-value providers. Providing cost information on out-of-network providers would undermine a core tenant of provider networks.

When consumers seek care from an out-of-network provider, the provider should be responsible for providing information on estimated balance billing amounts. Issuers should not be responsible for attempting to estimate cost-sharing liability for covered items and services furnished by an out-of-network provider. The Departments propose that issuers provide the out-of-network allowed amount and any cost-sharing liability. In most instances, this would provide an incomplete picture of the enrollee's potential out-of-pocket costs and could result in consumers making a decision about their health care based on incomplete or inaccurate information. Consumers who seek services from an out-of-network provider may be subject to balance billing, which could result in substantial costs above and beyond the cost-sharing liability provided by the issuer. In these situations, it would be impossible for an issuer to estimate the enrollee's out-of-pocket costs.

Providing information on out-of-network providers would not be helpful to consumers enrolled in products with no or limited out-of-network benefits. While such products may cover out-of-network emergency services, consumers cannot shop for emergency services. Consumers can view their out-of-network benefits, if applicable, in the Summary of Benefits and Coverage, by reviewing their policy details, or contacting their health insurance company.

We strongly recommend the Departments not require issuers to provide allowed amount and cost-sharing information for covered services furnished by an out-of-network provider. Operationally, it is not possible for issuers to include allowed amounts for out-of-network providers because, without a provider contract, issuers do not have the necessary information, including provider names, National Provider Identifier (NPI), address, specialty, or other demographic information to include these providers in a price transparency tool. Thus, issuers would not be able to identify and include out-of-network providers in price transparency tools. Identifying out-of-network providers (by definition, every provider, facility, or hospital in the country not included in the issuer's network) and the necessary specialty, NPI, and demographic information on an ongoing basis to include up-to-date information in price transparency tools would be a costly and resource-intensive exercise which would result in inaccurate information that would be misleading for consumers. Instead, issuers should focus on ensuring accuracy of information for network providers so consumers can make an informed decision when seeking covered services in-network.

b. The Inclusion of Out-of-Network Amounts Lacks Legal Authority

Congress carefully articulated the parameters of the individualized information that issuers must provide: the "amount of cost-sharing" for a service "by a participating provider," i.e., in-network providers. 42 U.S.C. § 18031(e)(3)(C). The requirement to provide advance individualized estimates of out-of-network cost-sharing exceeds this authority because out-of-network providers are not "participating provider[s]." It is also irrational because, as the Departments acknowledge in the proposed rule, issuers generally do not have the information needed to estimate an enrollee's out-of-pocket costs for specific out-of-network care ex ante (84 FR 65475). The inability to make meaningful individualized estimates of out-of-network cost-sharing explains why Congress addressed out-of-network cost-sharing under the more general disclosure requirements of section 1311(e)(3)(A) of the Affordable Care Act (ACA), which requires disclosure of general policies on "cost-sharing and payments for any out-of-network coverage," 42 U.S.C.

§ 18031(e)(3)(A)(vii), not individualized estimates.[19] Moreover, even if the more general disclosure authorities in section 1311(e)(3)(A) could be read to require individualized estimates—which they cannot, as discussed below in the legal analysis of the negotiated rates proposal—the Departments could not circumvent Congress's careful and well-reasoned choices within the specific statute governing individualized disclosures by invoking its catch-all authority.[20]

Recommendation:

- **The Departments should not finalize the requirement that issuers include information on out-of-network allowed amounts in enrollee price transparency tools available to enrollees.** We support the Departments' efforts to increase consumers' access to useful data that is customized and personal to their own circumstances. Including out-of-network allowed amounts and cost-sharing estimates would not achieve this goal, could result in misleading information for consumers, and exceeds the Departments' statutory authority.

7. Items and Services Content List (§§54.9815-2715A(b)(1)(v), 2590715-2715A(b)(1)(v), and 147.210(b)(1)(v))

The fifth proposed content element is a list of covered items and services included in a bundled payment if an item or service is subject to a bundled payment arrangement. Only 14 percent of our survey respondents provide a list of all items or services included in the bundled payment arrangement for items or services subject to bundled payments. Issuers noted they provide an aggregated dollar amount for the episode and include language explaining the amount reflects professional, facility, and diagnostic charges included in the episode.

Recommendation:

- **We support requiring that issuers include a description of items and services included in a bundle or episode of care.** We believe price transparency tools should include descriptions of items and services included in a bundle as well as any code used by the issuer for payment purposes. Including a general description of what is included in a bundle should help consumers compare options, but requiring every billed item and services would not advance the objectives of value-based care and should not be required. For example, a consumer comparing costs for a knee replacement should be able to assess whether a cost estimate includes pre- and post-surgery items and services like imaging and physical therapy. This description should be in plain language where possible, but due to the complexity of various medical procedures, plain language may not be able to accurately describe a procedure or service.

8. Notice of Prerequisites of Coverage (§§54.9815-2715A(b)(1)(vi), 2590715-2715A(b)(1)(vi), and 147.210(b)(1)(vi))

The sixth required element is notice of prerequisites of coverage, if applicable, including prior authorization, concurrent review, step therapy or fail-first protocols. Only 20 percent of issuers with price

[19] See, e.g., QHP Issuer Application Instructions 2020, Appendix C: Transparency in Coverage Template, at C-4 (May 2019) ("QHP Disclosure Guidance"), https://tinyurl.com/vqqjp8f (implementing section 1311(e)(3)(A)(vii) by requiring issuers to disclose "[i]nformation regarding whether an enrollee may have financial liability for out-of-network services" and "[a]ny exceptions to out-of-network liability," but specifying that "[i]ssuers do not need to include specific dollar amounts for out-of-network liability").

[20] See Halverson v. Slater, 129 F.3d 180 (D.C. Cir. 1997) (holding that statute conferring general delegation authority could not be invoked to avoid limitations in more specific delegation statute).

transparency tools currently include a notice when other considerations (i.e., concurrent review, prior authorization, step therapy, or first-fail protocols) apply.

Recommendation:

- **We recommend price transparency tools indicate when other medical management considerations apply to a specific item or service.** We agree it would increase transparency and advance a consumer's understanding of their benefits to provide a notification when considerations like medical or utilization management apply to a specific item or service. However, we note that it may be impossible to include specific information regarding medical or utilization management for each item or service as these may vary. For example, this information may be delegated to multiple medical groups or other entities and individual groups or entities may develop their own prerequisites. Issuers may not be able to establish processes to compile that information to present it on a medical group, service, or provider-specific level for implementation within two years. Thus, we recommend price transparency tools be required to indicate whether other considerations apply for a particular item or service (e.g., through an indicator, note, or pop-up) and provide information on how the consumer can learn more specific information for that item or service.

9. Disclosure Notices (§§54.9815-2715A(b)(1)(vii), 2590715-2715A(b)(1)(vii), and 147.210(b)(1)(vii))

The proposed rules would require several disclosure notices, including statements that: (1) enrollees may be balance billed by out-of-network providers and that these estimates do not account for those potential additional amounts; (2) actual charges may be different than those in the cost-sharing estimate depending on actual items and services provided at the point of care; (3) the cost-sharing estimate is not a guarantee that coverage will be provided for those items or services; and (4) other necessary disclaimers, such as when the estimate expires or whether rebates, discounts, or dispensing fees may impact prescription drug cost estimates as long as they don't conflict with the required disclosures.

The Departments seek feedback on model notice language, issued through a separate Paperwork Reduction Act (PRA) request for comment, on the proposed notice disclaimers as well as whether additional disclaimers are needed (e.g., length of the validity of estimate, expiration date of the cost-estimate, and whether additional prescription drug disclaimers should be added regarding rebates, discounts, and dispensing fees).

These sorts of disclaimers are common in issuers' price transparency tools today. Survey respondents reported they currently include notices that actual charges may differ from the cost sharing estimate (87 percent), that the cost-sharing estimate is not a guarantee that coverage will be provided (67 percent), that the estimate is based on accumulators at the time of request but could change by the time services are rendered (63 percent), and that out-of-network providers may balance bill (27 percent). Some issuers also noted other disclosures, including a required disclaimer that enrollees must Accept/Decline; cost-sharing information does not constitute medical advice or substitute for medical treatment by a medical provider; that consumers should not avoid getting health care nor make health care decisions based on the estimates for services; that estimates are not legally binding; that consumers should consider an estimate as a guide but only your health care provider will know what service is right for you; and other state and federally required disclosures.

Recommendations:

- **We agree with the proposed notice requirements, which are already commonly included in most price transparency tools today.** We appreciate the model notice language included in the PRA (CMS-10715) and do not offer specific comments on this model notice language. We agree that this model notice be optional. Issuers should have the flexibility to develop their own notice language, including the proposed disclosure topics, consistent with their own consumer testing and any applicable state requirements.

- **Regarding the Departments' request for comments on whether plans and issuers should be required to add to the notice a date on which the estimate will expire, we do not support additional inquiry-specific requirements.** Such a requirement would substantially increase the burden of the notice, primarily because it adds individual-specific information to the disclaimers, rather than a uniform disclaimer. Further, this additional burden does not seem necessary as it is most likely that participants and beneficiaries will be looking up cost-sharing information in relatively close timing to any planned procedure or receipt of health services. We strongly recommend against a requirement that issuers provide personalized disclosure notices, including a requirement that issuers include an expiration date on all estimates.

D. Required Methods for Disclosing Information

1. Internet-Based Tool (§§54.9815-2715A(b)(2)(i), 2590715-2715A(b)(2)(i), and 147.210(b)(2)(i))
The proposed rules would require issuers to make available a self-service tool on an internet website for enrollees to search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers. The tool would be required to allow users to search for cost-sharing information by either a billing code or a descriptive term and allow users to input the name of a specific in-network provider in conjunction with a billing code or descriptive term. The tool must have the ability to sort and filter search results by geographic proximity and amount of estimated cost-sharing liability.

Of the 30 commercial issuers who reported offering a price transparency tool, 28 (93 percent) offer an online tool to enrolled consumers. Online price transparency tools are available to enrolled members only, i.e., in a member portal or behind a password-protected member website. They are not the general public. Nearly all (97 percent) price transparency tools offered by survey respondents allow enrollees to look up costs for specific items or services by searching a descriptive term. Consumers can also search by symptoms, health topics, specialty, provider by name, provider by specialty, provider attributes, location, or certain accreditation measures or quality designations. Tools may also allow enrollees to browse an A-Z list of services, chronic conditions, inpatient or outpatient, diagnostic tests and x-rays, office visits, vaccines and immunizations, or lab tests.

Recommendation:

- **We generally agree with the requirements and guidelines for a self-service internet-based tool but recommend the Departments not finalize overly prescriptive requirements in regulations, which could create a risk that federal requirements will lag behind ever-evolving technology.** Federal requirements should create flexibility and build upon private sector solutions, rather than creating an overly rigid set of IT requirements. Issuers should have the flexibility to create and update price transparency tools that evolve with the needs of consumers. As the Departments acknowledge in the preamble, this may include soliciting consumer feedback or conducting consumer testing but may also include testing and deploying

new functionality or features to align with emerging consumer technology trends. We believe overly prescriptive requirements in federal regulations would restrict issuers' ability to continually improve and evolve their tools.

2. Mobile Apps (84 FR 65475)

Section 1311(e)(3)(C) of the ACA requires a self-service tool made available through an internet website, however the Departments acknowledge technology has evolved and other methods like mobile apps are available now and may provide additional benefits beyond internet websites. The Departments seek comment on whether the final rules should permit the proposed disclosure requirements to be satisfied with a self-service tool made available through a mobile app, or whether multiple means, such as websites and mobile apps, should be required. Nearly two thirds (63 percent of issuers) offer a price transparency tool via mobile app. Several issuers that offer an internet-based tool noted they do not have a mobile app but have a mobile-responsive website.

Recommendation:

- **We recommend the Departments permit issuers to meet the proposed cost-sharing disclosure requirements by offering a self-service tool through either a mobile app or an internet website. Mobile apps should not be required at this time.** Broadly speaking, it is critical that consumer-facing tools, and their underlying requirements, continue to evolve to align with the information consumers want and their preferred method of accessing it. We agree that price transparency tools available via mobile app provide unique opportunities for consumers to review cost-sharing information in various settings, including while discussing options with their provider at the point of care. Today, issuers determine what technology to use and what features to include in a price transparency tool through continuous feedback from consumers (e.g., consumer focus groups, real-time feedback) as well as emerging consumer technology trends. At the same time, developing a mobile app could create a disproportionate burden for smaller plans with fewer IT resources. We recommend mobile apps remain optional at this time so that issuers have the flexibility to develop consumer tools that they believe best meet the needs of consumers.

3. Requests in Paper Form (§§54.9815-2715A(b)(2)(ii), 2590715-2715A(b)(2)(ii), and 147.210(b)(2)(ii))

The proposed rule would require issuers to provide cost-estimate information in paper form upon request and without a fee by mail within two business days of request. In the preamble (82 FR 65501), the agencies note plans or issuers may, upon request, provide the required information through other methods, such as over the phone, through face-to face encounters, by facsimile, or by email.

Less than half (43 percent) of issuers currently provide personalized cost sharing information via paper**.** Nearly all issuers (80 percent) provide estimates through other customer service resources like a call center or concierge. Several issuers who have the ability for consumers to request personalized cost-sharing information through a call center or concierge noted that they may be able to provide the out-of-pocket estimate on paper in the mail, but it is more common to call the consumer back, provide through secure email, or communicate through a secure member portal. Providing an estimate by paper can be slow and result in information being outdated by the time it is delivered.

Recommendations:

- **Issuers should not be required to provide cost estimates in paper form**. **Issuers should have flexibility in how cost estimates are provided for enrollees without regular internet access.** When consumers request a cost estimate via customer service channels (e.g., issuer's call center),

issuers should be permitted to provide a response through secure email or portal message or call the enrollee to provide the estimate—options that may be more secure and timely than providing a paper response via mail.

- **If the paper form remains in the final rule, we recommend the timeframe to respond is expanded to five business days to allow additional time for processing and issuers have flexibility to include a manageable number of providers (e.g., no more than 20) in the paper results**. Further, issuers should have flexibility in disclaimer language for cost information sent via paper, for example, to indicate the estimate is "as of" a certain date, that the estimate may not reflect the most recent services rendered or claims processed, or encourage enrollees to call customer service or use the online tool for more up-to-date information, etc.

E. Special Rules (§147.210(c)(4))

1. Rules to Prevent Unnecessary Duplication

The Departments propose several rules to reduce duplication and allow for aggregation in reporting. We agree that these rules are necessary given how different information will be held by different parties when meeting the proposed requirements. However, given we do not support the inclusion of allowed amounts both in the consumer price transparency tool requirements and the machine-readable file requirements, we recommend this special rule is removed from the final rule.

Recommendation:

- **The Departments should not finalize the special rule related to permitted aggregation for out-of-network allowed amounts.**

2. Good Faith Safe Harbor (§§54.9815-2715A(d)(4), and 147.210(d)(4))

The proposed rules include a good faith safe harbor if a plan or issuer acts in good faith and with reasonable diligence, makes an error or omission in a disclosure, provided that the plan or issuer corrects the information as soon as practicable.

Recommendation:

- **We support the proposed rule's inclusion of a good faith safe harbor in the regulatory text.** Such a safe harbor will be necessary given the complexity of implementation.

3. Interaction with State Laws

The proposed rules note that nothing alters or otherwise affects a group health plan's or health insurance issuer's duty to comply with requirements under other applicable state or federal laws. Some existing state laws require plans to provide the ability for enrollees to look up their out-of-pocket costs for several hundred procedures online and by phone. To reduce burden on issuer implementation any federal requirements should recognize compliance with existing state requirements to avoid duplication of effort.

Recommendation:

- **We recommend that the issuers who comply with existing state laws requiring certain cost-calculator functionality be deemed in compliance with any related federal requirements.**

F. Implementation Cost & Timing

1. Findings from AHIP Survey on Costs to Implement Price Transparency Tools

In the economic analysis of the proposed rule, the Departments estimate the one-time cost of $221,029 for an issuer to implement a new price transparency tool (i.e., for an issuer that does not currently have an online tool) and $55,257 for an issuer with an existing tool to make necessary changes to meet requirements in the rule. The Departments estimate ongoing annual costs to maintain an online self-service price transparency tool would be $13,141 per issuer.

AHIP's survey found the costs to implement a price transparency tool if the rule is finalized as proposed would greatly exceed the initial implementation costs estimated by the Department. Thirty-four issuers offering commercial coverage estimated the average cost to build, develop or modify, implement, test, and launch a price transparency tool would be $6.2 million, or about $10.41 per enrollee. This greatly exceeds the implementation costs anticipated by the Departments. Issuers anticipate average one-time implementation costs that are 28 times greater than the Departments' estimates for issuers that do not currently have a price transparency tool and 112 times greater for issuers that have an existing price transparency tool. AHIP survey respondents estimated average annual maintenance costs of $1.4 million per issuer—over 100 times greater than those anticipated by the Departments—or about $1.31 per enrollee. The high implementation costs alone support an alternative approach that would allow plans to leverage their existing tools.

2. Implementation Timing (§§54.9815-2715A(d), 2590.715-2715A(d), and 147.210(d))

The Departments propose that requirements related to consumer price transparency tools would become effective for plan years (or in the individual market, policy years) beginning on or after 1 year after the finalization of this rule.

The estimated time to implement all necessary changes to build a new price transparency tool or modify an existing tool to comply with the rule if finalized as proposed would greatly exceed the proposed implementation timeframe. Nearly two thirds (62 percent) of issuers said it would take two years or more to build, develop or modify, implement, test, and launch a compliant price transparency tool. An additional 17 percent estimated it would take at least 18 months. Many issuers indicated this timeline would be impacted by various factors, including requirements in the final rule. Issuers who currently use a vendor to provide a price transparency tool, or who would consider using a vendor to meet the requirements of the final rule, noted that there is not a wide universe of vendors who provide these services and vendor availability and bandwidth would largely determine implementation timing. Additional time would also be needed to develop, test, implement and incorporate new or existing quality measures associated with items and services in the tool.

It is our goal to work with the Departments toward successfully improving the availability of cost-sharing information for enrollees in commercial products. However, the proposed timeline is over-ambitious and would undermine our shared goal of providing meaningful, personalized, accurate information in an easy-to-use consumer experience. Consumers will factor this information into decisions about what health care will best meet their health and financial needs. It is vital that issuers have enough time to ensure that price transparency tools provide accurate information in a smooth consumer experience and not be rushed to deploy tools on an artificially accelerated timeline.

Prior private sector and public sector efforts have underscored the importance of taking adequate time to plan, develop, test, and implement consumer-facing IT projects of this magnitude. Further, we have seen

the adverse consequences of rushing implementation of such projects and the harmful effects it can have on consumers. In October 2013, healthcare.gov was launched and immediately failed. Most users experienced crashes, delays, errors and slow performance in the initial days and weeks after launch. More recently, an issue with the Blue Button 2.0 API impacted the privacy of up to 10,000 Medicare beneficiaries' data. Issuers do not—and we believe the Departments do not—want to risk similar incidents that would adversely impact consumers when implementing price transparency tools.

As shown in our survey results, developing, building or modifying, implementing, testing, and launching a consumer price transparency tool will require much more time and far greater costs than suggested by the Departments. These provisions will require reworking of existing tools, creating new tools, reexamining multiple legal relationships, massive IT development, consumer testing, and other efforts that relate to every relationship an issuer has with physicians, hospitals, drug manufacturers, device manufacturers, external health plan networks and numerous entities. Accomplishing this will take at least two years.

Recommendation:

- **To ensure a smooth implementation of consumer price transparency tools, we recommend the requirements be effective for plan years (or in the individual market, policy years) beginning on or after 2 years after finalization of the rule.** We share the Departments' goal of providing consumers meaningful, personalized information about out-of-pocket costs to help consumers make informed decisions about their health care. As demonstrated by AHIP's survey, most commercial issuers already provide this information to their enrollees and work to continually improve their price transparency tools and consumer experience. Implementing the proposed requirements would be a massive undertaking for issuers. Issuers that do not currently have a price transparency tool in place will have to undertake a significant IT and operations effort to deploy a new tool. Issuers that currently have price transparency tools indicated that they too would have to make significant changes to their tools or build new tools to meet the proposed requirements.

3. Recommendation to Promote Successful Implementation and Use of Price Transparency Tools

While issuers are best positioned to develop a consumer experience that will best meet the needs of their enrollees, we recognize the challenges of providing meaningful price transparency information that consumers use and take into consideration when making decisions about their health care. In a recent Morning Consult poll for AHIP, Americans reported that they would consider seeing a different doctor or having a service performed at a different hospital or facility if they knew they would receive quality care but at a lower price. However, as the Departments recognize in the preamble, actual utilization of existing price transparency tools is lagging.

AHIP survey respondents reported less than half of enrollees (43 percent) have created log-in credentials to access the online member portal, website, or mobile app where the price transparency tool can be accessed. Of those enrollees with log-in credentials, issuers estimate that—as of the most recently available quarter of data—on average, only 9.9 percent of enrollees have accessed the price transparency tool available to them. Issuers direct enrollees to the price transparency tool by outreach through employers, messaging on a member portal, email, postal mail, inbound and outbound phone outreach by customer service, and other less frequently used methods like nurse care manager outreach, social media, provider outreach, text message, welcome kits and other member materials, and employer and agent/broker updates. Survey respondents cited various challenges in enrollee uptake of price transparency tools, including lack of member awareness, user frustration

because costs are an estimate, not a guarantee of actual member liability, translating price data into consumer-friendly information, complying with state or federal regulatory requirements, and lack of reliable or complete data.

A small subset of issuers (13 percent) offer incentives to use the price transparency tool. Respondents described incentive programs that include: incentives for choosing a lower cost provider after using the tool; cash incentives if the enrollee shops for a procedure and files a claim with a lower cost provider; opt-in rewards program for choosing high-quality, lower-cost providers for specific services that provides incentives after services have been rendered; cash incentives provided directly to the enrollee for choosing a lower cost provider or lower cost site of care. Twenty seven percent of issuers who reported they do not currently offer incentives for using their price transparency tool said they plan to offer incentives in the future.

Recommendations:

- **We recommend the Departments commit to federal leadership of and funding for a coordinated outreach and education campaign to encourage use of price transparency tools.** It is evident that increasing access to consumer price transparency tools is only the first step in engaging and empowering consumers to take a more proactive role in evaluating health care and options and making informed, cost-conscious decisions. As demonstrated by the Morning Consult poll, consumers want access to information about their health care costs and believe they would elect lower cost options, but AHIP survey respondents confirm that despite widespread availability of price transparency tools, consumer uptake is still low. Increasing utilization of price transparency tools, and converting utilization into consumers making cost-conscious decisions about their health care, will require a substantial, coordinated effort by issuers, providers, and the federal government. A coordinated outreach and education campaign should: (1) increase consumer awareness of the availability of price transparency tools; (2) educate consumers on how to interpret cost and quality information when evaluating health care options; (3) encourage and enable consumers and providers to engage in discussions about cost and quality when discussing health care options; and (4) conduct ongoing analysis of consumer utilization and understanding of cost and quality information.

- **We recommend the Departments work in partnership with issuers, specifically through a workgroup of issuer technical experts, to promote a smooth implementation and launch an effective outreach and education campaign.** The Departments envision broad implementation of price transparency tools as a paradigm shift for consumers and the health care industry. We agree that the proposed rule, if finalized, will have significant effects for both issuers and consumers. We recommend the Departments establish a working group with a cross-section of issuers (i.e., large and small, national and regional, those that already have a tool and those that don't) to work through implementation issues between finalization of the rule, implementation, and beyond. As discussed above, we strongly recommend the final requirements are not overly prescriptive and preserve flexibility for issuers to design innovative tools that met the needs of their enrolled populations. However, based on prior experience, a public-private partnership that serves as a forum for working through consumer-facing and implementation issues could be hugely beneficial for the entire industry as we work toward the common goal of increasing access to and utilization of price transparency tools.

III. PUBLIC DISCLOSURE OF NEGOTIATED RATES (§§54.9815-2715A(c), 2590715-2715A(c), and 147.210(c))

The Departments propose to require that issuers make publicly available in machine-readable format a Negotiated Rate File that includes the name and Employer Identification Number or Health Insurance Oversight System identifier for each plan or coverage offered by a health insurance issuer or group health plan; a billing code or other code used to identify covered items and services and plain language description for each billing code; and confidentially negotiated rates for each covered item or service under the plan furnished by an in-network provider. The Negotiated Rate File must be published on a monthly basis.

A. Lack of Value for Consumers

AHIP and its members are committed to the common goal of increasing the availability of meaningful consumer information to promote choice in health care. The vast majority of issuers have developed online tools to allow enrollees to actively shop for care and bring greater value to consumers. Large group plans and health insurance issuers have taken significant steps toward increasing the availability of meaningful price and quality information for health care services and to promote its use in consumer decision-making.

Unfortunately, the proposal to require public disclosure of negotiated rates via machine-readable file to drive innovation in industries outside of health insurance will not meaningfully inform patient decision-making and allow consumers to compare prices and quality to effectively ascertain the full value of care. Requiring the publication of the dollar amount negotiated rates for a covered item or service has no utility to a patient seeking information on their expected out-of-pocket costs, whether they are insured or not, and will not provide consumers any actionable information. The dollar amount negotiated rates are not translatable into price information meaningful to the patient's decision-making related to their own out-of-pocket costs. In fact, CMS notes that their stakeholder engagement and research show that "consumers of health care services simply want to know where they can get a needed health service and what it will cost them out-of-pocket."[21]

Requiring a public list of negotiated rates separate from the required price transparency tool is unnecessary to the patient's needs, and the potential negative market impacts this would create far outweigh the inadequate arguments supporting requiring plans to release negotiated rates. The proposed rule assumes that uninsured individuals would use negotiated rates to shop for lower cost health care providers and to inform their negotiated rates with providers.[22] But it also acknowledges that "a provider's negotiated rates with group health plans and health insurance issuers do not necessarily reflect the prices providers charge to uninsured patients."[23] These kinds of inconsistent justifications are insufficient to justify agency action."[24] We believe this proposal is similarly inconsistent and inadequately justified.

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[21] Proposed Rule CY 2020 Outpatient Prospective Payment System.
[22] 84 Fed. Reg. at 65,477.
[23] Id.
[24] *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015) ("We have often declined to affirm an agency decision if there are unexplained inconsistencies in the final rule."); *General Chem. Corp. v. United States*, 817 F.2d 844, 846 (D.C. Cir. 1987) (holding agency action was arbitrary and capricious where agency's "analysis was "internally inconsistent and inadequately explained").

Furthermore, the proposed rule fails to deliver meaningful data to consumers at the same time that it risks reducing market competition, leading to *higher* negotiated rates and thus higher premiums. Given the complexity and individuality of health insurance plan design features, furnishing large-scale static negotiated rates to third parties will not eliminate the need for issuers to provide timely and accurate cost-sharing information based on coverage policies, co-insurance structures, deductible accounting, and other critical plan features. Finally, posting pricing information devoid of quality metrics will send an incomplete and potentially misleading signal of value to consumers. The mismatch between the rule's high risks and low rewards is another indicator that the rule fails to meet the requirements of reasoned decision-making.[25]

Moreover, the preponderance of consumers do not want to obtain information about costs from a third-party. According to the Morning Consult poll, 30 percent would prefer to call their issuer, 30 percent would prefer to look up the information on their company's website or mobile app, and 28 percent would prefer to look up information on their issuer's website or mobile app with their doctor. Only 11 percent would prefer to obtain information on their health care costs from a third party's website or mobile app. Americans may be split between physicians and issuers in terms of who they consider to be a trusted source of information, but few put their trust in third-party developers. A majority of adults would most trust their issuer (66 percent) or doctor (58 percent) to provide them information on the cost of a medical procedure in advance. Only 4 percent said they would trust a technology company to provide information on their out-of-pocket costs for a medical procedure or service before it was performed.

Recommendation:

- **The proposed requirement for public disclosure of a list of confidentially negotiated rates should be withdrawn as it would not provide consumers with actionable information, while at the same time putting them at risk for even higher health insurance premiums.**

B. Could Increase Health Care Costs

The proposed rule hardly acknowledges that the public disclosure of negotiated rates will have anticompetitive effects, nor have the Departments offered an adequate rationale to justify such a disruption to the healthcare marketplace in this way. Meaningful and actionable information comes from individualized information from a plan and will not be provided pursuant to this proposal.

For every premium dollar spent today in the United States, 16 cents goes to hospital stays, 20 cents toward office and clinic visits and 22 cents towards doctor services.[26] Thus it is critical that policies help reduce health care spending, not increase it. Numerous organizations including the FTC, DOJ and the Congressional Budget Office (CBO) have raised concerns about the unintended consequences of releasing competitively-sensitive, proprietary information, including the negotiated rates of group health plans and issuers.

The CBO, in reviewing the budgetary impacts of health care transparency proposals that are not as far-reaching as this rule, indicated that federal spending could increase "if providers became less willing to negotiate discounts once they had more information about their competitors' negotiated rates, particularly if the market is highly concentrated among a small number of providers." We are concerned that

[25] *See Business Roundtable v. SEC*, 647 F.3d 1144, 1148-49 (D.C. Cir. 2011) (invalidating rule where the agency "inconsistently and opportunistically framed the cost and benefits of the rule").
[26] AHIP, Where Does Your Health Care Dollar Go?, May 22, 2018. https://www.ahip.org/health-care-dollar/

providers would use this information (as the CBO noted) to "exert their market power during negotiations," thus raising the floor on contracted pricing.[27]

Along with the CBO, both the FTC and the DOJ have expressed concerns about other similar transparency proposals, especially in more consolidated provider markets. Our members have raised the possibility that consultants aiding providers in seeking higher reimbursements from issuers will use the data included in the machine-readable files to increase their leverage (and in turn, their prices) in future price negotiations once these data are widely-available and easy to manipulate.

When small providers with less brand recognition can see what larger, higher brand providers are being paid, they demand higher prices. We are also concerned that hospitals who originally agreed to accept substantially lower contracted rates than others in the market, would request higher prices as a result of more transparency. Below are two examples of how providers could use the new information disclosed:

- When the most expensive hospital in the network sees that an issuer allowed it to join the network even though the hospital has the highest contracted rates, this hospital will not lower its rates. The hospital can infer that if the issuer could have found a similar quality hospital that was less expensive, the issuer would have already contracted with the alternative hospital. Therefore, the most expensive hospital is standing in a place of strength in contracting and will not lower its rates.

- When lower cost hospitals see that other hospitals in the same network are getting more money from an issuer, they will go to the issuer and ask why they are not getting the same reimbursements for providing the same services for the same members. These hospitals will demand an increase in their contract rate.

The net impact of the above examples will be to force the lower-cost issuers in a market to raise their average contract rates and increase premium rates for consumers. Thus, those consumers in the market will find transparency as proposed causes them to pay more for insurance. Many stakeholders have provided feedback that support these concerns. In 2015, the FTC submitted comments to Minnesota state legislators in response for their request for comment on the possible competitive effects of a recently enacted law to have the contract terms of Minnesota issuers subject to public disclosure. The FTC warned such release:

> "may chill competition by facilitating or increasing the likelihood of unlawful collusion and may also undermine the effectiveness of selective contracting by health plans, which serve to reduce health care costs and improve overall value in the delivery of health care services in Minnesota. This risk of such harm is especially great if this information is accessible to competing health care providers, and in highly concentrated markets where competition among providers is already limited."[28]

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[27] Congressional Budget Act Cost Estimate of S. 1895 as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on June 26, 2019. Available at: https://www.cbo.gov/system/files/2019-07/s1895_0.pdf

[28] FTC Letter to MN State Reps Hoppe and Hortman, June 29, 2015, Available at: https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf. *Footnotes omitted.*

The FTC expressed concern about scenarios "when information exchanges or disclosures promote the sharing of sensitive information among competitors." It further noted that "this may facilitate their ability to coordinate or collude to fix prices, allocate markets, or engage in other conduct that harms competition."[29] Economists at the University of Minnesota came to the same conclusion stating:

"classifying plan-provider contracts as public data would offer little benefit but could pose substantial risk of reducing competition in health care markets."[30] We have the same concerns with this proposed rule.

Certain state activities have also led to hospitals seeking higher pricing during contract negotiations. In New Hampshire, Maine and Massachusetts, state organizations use claims data submitted by issuers to produce health plan specific price estimates. For example, on the New Hampshire NH HealthCost™ website, consumers can search cost by hospital or medical procedure, by issuers and by product type (i.e., individual market vs. group) for each service. Quality information is also available.[31] Several factors differentiate the information presented on these websites from what the Departments are proposing. Information posted must meet a threshold for a minimum number of claims, the information is only posted after the fact (generally several years old) and it is not physician specific (only facilities). In addition, separate prices are not presented for individual plans but rather these numbers are averaged and combined across issuers different product offerings. Even with these factors that mitigate the potential impact of the rate exposure, data from these sites has been used in contract negotiations

Providing tools for competitors to easily know the range of contracted rates will impede the ability of issuers to contract with providers and will negatively impact their efforts to negotiate lower rates. This is not a hypothesis. Our members have seen this play out in some states that have posted specific negotiated prices calculated from issuers' claim submissions to state all-payer claims databases. When small providers with less brand recognition can see what larger, higher brand providers are being paid, they demand higher prices. We are also concerned that hospitals that originally agreed to accept substantially lower contracted rates than others in the market, would request higher prices as a result of more transparency.

In our view, based on our members' experiences, prices will converge around the high-point, not around a low- or mid-point. Alternatively, providers will choose to stay out of health plan networks offered by smaller issuers in the market with fewer enrollees compared to other market players, risking the viability of these products and reducing the competitiveness of the insurance market.

Costs may also rise given potential impact to federal spending on Advanced Payments of Premium Tax Credits (APTCs), which are determined based on a consumer's Federal Poverty Level and the second lowest-cost silver (SLCS) premium rate in their county of residence. Most counties have the SLCS offered by the lowest-cost issuer. Since the lowest-cost issuer's contract rates are at risk of increasing due to negotiated rate transparency, the federal government could find that APTCs will also increase. Given that the federal government paid approximately $53 billion in APTCs in 2018, even a marginal increase in APTCs could result in a substantial increase in the federal deficit over a ten-year period.

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[29] ibid
[30] Minnesota Department of Human Services Health Care Administration, Health Care Contracting and the Minnesota Government Data Practices Act, January 30, 2015. Available at: https://mn.gov/dhs/assets/Health_Plan_Data_Report_tcm1053-166426.pdf
[31] https://nhhealthcost.nh.gov/

Recommendation:

- **The proposed requirement for public disclosure of confidentially negotiated rates should be withdrawn as it runs contrary to the goal of lowering consumer prices and may increase federal expenditures related to APTCs.**

C. Privacy Concerns

As noted above, a preponderance of issuers have automated consumer price transparency tools and are actively enhancing them based on consumer feedback and advancing technology. While we support increasing access to such tools and continuing to improve upon existing tools, we have concerns about pushing comparable information out through publicly available files that will be combined with other information to entice consumers to share sensitive personal information. Issuers are subject to the Health Insurance Portability and Accountability Act (HIPAA), among other federal and state laws and regulations. Even data obtained that are not subject to these rules are often voluntarily held to the same high standard anyway.

The machine-readable component of this rule, in addition to and in combination with several other transparency and interoperability rules recently released by HHS, are intended to fuel the 'app economy'. In so doing the federal government would require issuers to share both their trade secrets and sensitive personally identifiable consumer information with third-party application (app) developers that are not bound by the same heightened level or privacy and security rules. The federal government would drive consumers to obtain from third-party apps information that is largely available in issuer apps but leave consumers vulnerable to the business interests of third-party app developers seeking to profit from selling consumers' individually identifiable data. Even if the information in the machine-readable files is not combined with information obtained through one of the other related proposed rules—like clinical and claims data—by simply creating third-party apps that estimate out-of-pocket costs, the federal government is encouraging consumers to divulge their medical conditions through their searches in a venue where the information gleaned can be sold by third-party app developers to anyone for almost any purpose as long as the possibility is noted in the terms and conditions of the app.

The Morning Consult poll found that respondents highly value privacy when it comes to their personal health information. These respondents said privacy protections outweigh ease of access to health information. When thinking about their personal health information, 62 percent value stronger privacy protections for their health information over having easier access to their health information. Respondents also raised concerns about expanding the availability of personal health information to private technology companies. Ninety percent responded that private technology companies should be required to meet the same privacy requirements to protect patients' health information that doctors, hospitals, and insurance companies are required to meet.

At the same time, releasing these static large-scale datasets is likely to lead to the communication of inaccurate and misleading information to consumers. This data would not consider the patient's coverage under their benefit plan, where they are in their deductible, how much cost sharing (e.g., co-pays or co-insurance) would be required, and other critical benefit features that would inform the patient's out-of-pocket costs. Moreover, the timelines for both this rule and the other related rules are very short, possibly short-changing adequate build and testing timelines (whether it be the issuer tools or the machine-readable files). As CMS itself recently experienced, insufficient review and testing can lead to unintended consequences for consumers.

Recommendations:

- **The Departments should consider this proposed rule in the context of the other rules proposed and finalized by HHS related to the transparency and interoperability of data, and delay the implementation of these rules until adequate consumer privacy protections can be developed for third-party apps dealing in sensitive health care data that are outside of HIPAA.** Otherwise, we risk eroding the public trust and derailing technological advancements by pushing enormous amounts of potentially erroneous data out into a gap in the national privacy framework.

- **If the regulations are finalized without additional privacy protections, the Departments along with the FTC should undertake an educational campaign to ensure consumers understand the pitfalls of using third-party apps that estimate prices for enrollees.**

D. The Proposal Lacks the Necessary Legal Authority

The provision of the proposed rule requiring issuers to disclose to the general public confidential provider-specific negotiated rates is contrary to statute, effects a taking of issuers' trade secrets, unconstitutionally compels speech, and is arbitrary and capricious. **For these reasons, the general public disclosure provision of the proposed rule should be withdrawn.**

1. Statutory Basis

The proposed rule's requirement that issuers disclose to the general public confidential negotiated rates exceeds the Secretary's statutory authority. The Secretary cannot point to any specific congressional authorization for its market-transforming disclosure rule, instead resting on a generic catch-all clause. But it is "a familiar canon of statutory construction that [catchall] clauses are to be read as bringing within a statute categories similar in type to those specifically enumerated."[32] The provider-specific negotiated rates that the Departments propose to require issuers to compile and make public are nothing like the items included by Congress in the list, in two ways.

First, as the title of the section reflects, all of the disclosures under section 1311(e)(3) must relate to "[t]ransparency in coverage."[33] The enumerated items all relate to coverage—claims payment policies, claims denied, enrollment in coverage, etc.[34] Disclosure of negotiated rates, on the other hand, does not relate to coverage but to prices, as the proposed rule makes clear by mentioning "price transparency" 76 times. As discussed further below, the tenuous connections the proposed rule attempts to draw between prices and coverage are at best irrational and at worst pretextual given that the disclosure of negotiated rates will confuse consumers, rather than helping them make informed choices about their health care coverage.

Second, the disclosures listed in the statute consist of aggregate data, such as the number of claims denied, and information on a health plan's policies and practices.[35] The implementing guidance confirms that the statutorily-mandated disclosures require only a handful of aggregate numbers and a website location where specified policies and practices are posted.[36] None of the delineated statutorily-required

[32] Paroline v. United States, 134 S. Ct. 1710, 1721 (2014) (internal quotation marks omitted; alteration in original).
[33] 42 U.S.C. § 18031(e)(3); *see* Almendarez-Torres v. United States, 523 U.S. 224, 234 (1998) ("[T]he title of a statute and the heading of a section are tools available for the resolution of a doubt about the meaning of a statute.").
[34] *Id*. § 18031(e)(3)(A)(i)-(viii).
[35] *See id.* § 18031(e)(3)(A)(i)-(viii).
[36] *See* QHP Issuer Application Instructions 2020, Appendix C: Transparency in Coverage Template (May 2019).

disclosures demands a technologically-intensive and hugely burdensome data collection effort, results in tens if not hundreds of thousands of detailed entries, or threatens the release of issuers' trade secrets. Simply put, disclosure of negotiated rates is materially different in kind and magnitude from the listed disclosures, and therefore is not a permissible use of the catch-all clause.[37]

Surrounding textual provisions confirm that Congress did not, via a generic catch-all clause, authorize the Departments to require issuers to make their most commercially-sensitive information public. Within section 1311, Congress authorized granular disclosures of service-specific cost-sharing information only to individual enrollees, 42 U.S.C. § 18031(e)(3)(C), in contrast to the public-facing more general disclosures required by section 1311(e)(3)(A). Elsewhere in Affordable Care Act, moreover, where Congress specifically required pricing-related disclosures, it expressly protected commercially-sensitive negotiated rates from disclosure. For drug benefits, Congress authorized the agency to collect only aggregate data and expressly provided that information collected "is confidential" and could not be disclosed in a form that reveals the prices charged for drugs.[38] And for hospitals, Congress limited the disclosure of price information to a single list of standard charges, excluding negotiated rates from release.[39]

Beyond the ACA, there is an unbroken line of statutory enactments and regulatory promises protecting issuers' confidential information from disclosure. Congress has enacted several statutes protecting trade secrets from disclosure.[40] And the Departments have long recognized that information like negotiated rates falls within the protection of these statutes.[41] Given the extensive regime protecting this information as trade secrets, Congress would have to speak clearly to authorize the Departments to bypass these protections and require all issuers in the individual and group markets—not only those insurance providers seeking to participate on the exchanges—to disclose negotiated payment rates.

Reading the catch-all clause to upend these protections and permit the Departments to require public disclosure of negotiated rates is in irreconcilable conflict with these earlier and more specific statutes, which transgresses the canons against implied repeal and dictating that more specific statutes control over general ones.[42]

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[37] *See* Edison Elec. Inst. v. Occupational Safety & Health Admin., 411 F.3d 272 (D.C. Cir. 2005) (Under "the established interpretive canon of ejusdem generis," the "'other means' sanctioned by the [regulations at issue] include procedures similar to the examples offered …, but do not include procedures that are fundamentally different.").

[38] 42 U.S.C. § 1320b-23(c) (ACA § 6005).

[39] 42 U.S.C. § 300gg-18(e).

[40] *See, e.g.*, Defend Trade Secrets Act of 2016, 18 U.S.C. § 1836 et seq.; 5 U.S.C. § 552(b)(4) (Freedom of Information Act exemption for "trade secrets and commercial or financial information obtained from a person [that is] privileged or confidential").

[41] *See, e.g.*, 42 C.F.R. § 422.310(f)(2)(iv) (limiting disclosure of Medicare part C risk adjustment data to aggregate forms to protect proprietary information); 84 Fed. Reg. 17,454, 17,487-88 (Apr. 25, 2019) (same for QHP risk adjustment data); 73 Fed. Reg. 48,434, 48,654 (Aug. 19, 2008) (acknowledging that any proprietary Medicare Advantage encounter data "would be protected from disclosure under the Trade Secrets Act"); 73 Fed. Reg. 30,664, 30,675 (May 28, 2008) (noting pricing data within Medicare part D claims data would be covered by FOIA Exemption 4).

[42] *See* Nat'l Ass'n of Home Builders v. Defenders of Wildlife, 551 U.S. 644, 666 (2007) (canon against implied repeal); Crawford Fitting Co. v. J.T. Gibbons, Inc., 482 U.S. 437, 445 (1987) ("Where there is no clear intention otherwise, a specific statute will not be controlled or nullified by a general one.").

Most fundamentally, forced publication of issuers' trade secrets raises grave constitutional doubts under the Takings Clause and the First Amendment—if not violating those provisions outright. If Congress wishes to authorize the Departments to trench upon insurance providers' property and speech rights in this manner, it must express its intent far more plainly than a general catch-all clause in a list of wholly dissimilar disclosure requirements.[43] Nothing in the statute's plain terms can justify the proposed rule's upheaval of the long-established practice of maintaining confidentiality for negotiated rates, which will have far-reaching negative consequences in health care markets with no meaningful consumer benefit.[44]

Recommendation:

- **The general public disclosure provision of the proposed rule should be withdrawn as it exceeds statutory authority.**

2. Takings Clause

The proposed rule exceeds the Department's power under the Constitution as well as the statute. Trade secrets are private property protected by the Takings Clause, and the forced disclosure of such trade secrets under a statute, even if for private benefit, is a public use.[45] Because the proposed rule provides no "just compensation" to issuers compelled to relinquish their trade secrets for public use, it is an unconstitutional taking.

Forced disclosure of a trade secret eviscerates the right to exclude that defines the property right.[46] For that reason, the proposed rule's disclosure requirement effects a per se taking.[47] In addition, the proposed rule effects a regulatory taking because it upends issuers' reasonable investment-backed expectations that negotiated rates are trade secrets that the government is bound to protect from disclosure.

The network of federal statutes protecting commercially-sensitive information like negotiated rates from disclosure, including the Freedom of Information Act and the Defend Trade Secrets Act, supports issuers' reasonable expectations that such rates are trade secrets not subject to involuntary disclosure. So, too, does the routine protection of such information from disclosure in litigation, given the demonstrated value of the information, the measures plans take to protect it, and the competitive harm likely to ensue if it is disclosed.[48] To the extent that CMS has collected commercially-sensitive information in the past, it has promised to protect it, and has authorized its release only in a form that will not jeopardize that property interest.[49] Moreover, the state initiatives described in the proposal only reinforce issuers' reasonable expectations that this proprietary information would remain confidential. State departments of insurance

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[43] Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps of Eng'rs (SWANCC), 531 U.S. 159, 172-73 (2001).
[44] *See* Utility Air Regulatory Group v. EPA, 572 U.S. 302, 324 (2014) ("We expect Congress to speak clearly if it wishes to assign to an agency decisions of vast economic and political significance.").
[45] *See* Ruckelshaus v. Monsanto, 467 U.S. 986, 1003, 1014-16 (1984).
[46] Monsanto, 467 U.S. at 1011 ("With respect to a trade secret, the right to exclude others is central to the very definition of the property interest.").
[47] *See* Lucas v. S.C. Coastal Council, 505 U.S. 1003, 1015 (1992); Philip Morris, Inc. v. Reilly, 312 F.3d 24, 35 & n.65 (1st Cir. 2002) (en banc).
[48] *See, e.g.*, Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc., 784 F.2d 1325, 1345–46 (7th Cir. 1986); Med. Ctr. at Elizabeth Place, LLC v. Premier Health Partners, 294 F.R.D. 87, 95 (S.D. Ohio 2013); *New Mexico Oncology and Hematology Consultants, Ltd. v. Presbyterian Healthcare Services*, No. CV 12-526 MV/GBW, 2015 WL 13650055, at *2 (D.N.M. Nov. 23, 2015); BlueCross BlueShield of Tennessee, Inc. v. Lee et al, Case No. 3:19-cv-01116, Document 9 (Dec. 13, 2019), *available at* http://tcog.info/files/2019/12/BCBS-TRO-granted.pdf.
[49] *See, e.g.*, 42 C.F.R. § 422.310(f)(2)(iv) (promising that release of risk adjustment data will be "subject to the aggregation of dollar amounts reported for the associated encounter to protect commercially sensitive data").

routinely protect this information as trade secrets. State all-payer claims databases generally publicly release information, if at all, only in aggregate form, for example by reporting median prices. Many of them, moreover, expressly protect the raw data collected from disclosure as proprietary or trade secret information.

To break with these settled practices would disturb insurance providers' reasonable investment-backed expectations. Coupled with the character of the government action, which would eviscerate the value of the property interest; the lack of countervailing consumer benefit; and the severe economic impact in terms of harm to competition and health care markets, the proposed rule is a regulation that "goes too far" and thereby constitutes a taking.[50] In addition, forcing issuers to disclose trade secrets in order to sell health insurance not only on the exchanges, but in any individual or group market, places an unconstitutional condition on the right to sell their products.[51] At a minimum, forcing issuers to disclose up-until-now carefully protected payer-specific negotiated rates raises sufficient questions of constitutional infirmity that it should not be undertaken without clear congressional authorization that is lacking here.[52]

Recommendation:

- **The general public disclosure provision of the proposed rule should be withdrawn as it takes issuers' property without compensation.**

3. First Amendment

In addition to effecting an unconstitutional taking, the proposed rule unconstitutionally compels speech in violation of the First Amendment. Because the disclosures do not "propose a commercial transaction," they are not "commercial speech."[53] To compel issuers to make these disclosures, therefore, the Departments must establish that the proposed rule is narrowly tailored to serve a compelling interest—a showing the Departments have not attempted to make and cannot achieve.[54] Even if the disclosures were deemed commercial speech, the proposed rule would still fail First Amendment scrutiny because it does not "directly advance[]" a substantial interest that cannot be "served as well by a more limited restriction on commercial speech."[55] Where a speech regulation "provides only ineffective or remote support for the government's purpose," it is invalid under the First Amendment.[56] That is precisely the case here, because the mandatory disclosure of negotiated rates will not provide information useful to consumers for evaluating health care options. Nor will it create a competitive dynamic or lead to lower prices. If anything, the contemplated disclosures will reduce competition, lead to higher prices, and cause consumer confusion. Such counterproductive effects cause the proposed rule to fail even the less strict standard applicable to commercial advertising.[57] At a minimum, the serious constitutional questions raised by the proposed rule demand that it be clearly authorized by Congress, which it is not.

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[50] Penn. Coal Co. v. Mahon, 260 U.S. 393, 415 (1922); see Philip Morris, Inc., 312 F.3d at 33-46 (holding that forced disclosure of tobacco products' ingredient lists effected a regulatory taking).
[51] *See* Philip Morris, Inc., 312 F.3d at 46-47.
[52] For similar reasons, the Departments' proposed rule violates Constitutional Due Process requirements.
[53] Spirit Airlines, Inc. v. Dep't of Transp., 687 F.3d 403, 412 (D.C. Cir. 2012).
[54] *See* Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos., 515 U.S. 557, 573 (1995) (noting that the same strict-scrutiny standard applies to compelled statements of fact as to compelled statements of opinion).
[55] Central Hudson Gas & Electric Corp. v. Public Service Commission, 447 U.S. 557, 564 (1980); *see* Nat'l Ass'n of Mfrs. v. SEC, 800 F.3d 518, 522 (D.C. Cir. 2015) (applying Central Hudson to disclosure requirement).
[56] Central Hudson, 447 U.S. at 564.
[57] *See* Nat'l Ass'n of Mfrs., 800 F.3d at 526 (invalidating requirement to make certain disclosures on business websites where it was "speculation or conjecture" that the disclosures would serve the asserted government interest).

Recommendation:

- **The general public disclosure provision of the proposed rule should be withdrawn as it unconstitutionally compels speech.**

4. Arbitrary and Capricious

Even if the proposed rule were within the Departments' authority, the explanation falls far short of what would be necessary to justify such a burdensome and disruptive change. The proposed rule's bare acknowledgement that the disclosure of negotiated rates "might" have anticompetitive effects is woefully inadequate and does not reasonably grapple with the mountain of evidence—and the judgment of the government's competition experts—that this type of disclosure is likely to chill competition and increase health care prices.[58]

Nor have the Departments offered an adequate rationale to justify disruption of the health care marketplace in this way. The disclosure of negotiated rates is not meaningful information to consumers, as the proposed rule implicitly acknowledges.[59] The Departments posit that the disclosures will help uninsured consumers choose among health care providers, but that is not a statutorily cognizable rationale—by definition it does not relate to coverage—and it is irrational given the Departments' acknowledgment that providers' negotiated rates do not necessarily reflect what they would charge uninsured patients.[60] Nor will the disclosures help insured consumers make better decisions about their insurance coverage, because consumers shop for health insurance coverage based on coverage-related information like premiums and cost-sharing, not health care provider prices. The Departments' conclusion otherwise is internally inconsistent and implausible, and therefore arbitrary.[61] The proposed rule separately requires disclosure of the primary information that is useful to consumers—out-of-pocket costs—and that alternative, especially if accompanied by information on provider quality, would better achieve the objectives laid out for the proposed rule with substantially less burden and reduced harm to the market. If any more were needed, it could be achieved with aggregate information about negotiated rates that would not risk the same anticompetitive harm. The failure to meaningfully consider these alternatives also renders the proposed rule arbitrary and capricious.[62]

Recommendation:

- **The general public disclosure provision of the proposed rule should be withdrawn as it is arbitrary and capricious.**

E. Implementation Cost & Timing

The Departments estimate the total burden for an issuer or their third-party administrator (TPA) to make appropriate changes to their IT system and processes to develop and implement the Negotiated Rate File is $107,905. The Departments estimate annual costs of $3,002 for each issuer or TPA to produce a monthly Negotiated Rate File.

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[58] *See* Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983) (agency action is arbitrary and capricious when it "entirely fail[s] to consider an important part of the problem" or "offer[s] an explanation for its decision that runs counter to the evidence before the agency").

[59] 84 Fed. Reg. at 65,478.

[60] Id. at 65,477.

[61] *See* Business Roundtable v. SEC, 647 F.3d 1144, 1148-49 (D.C. Cir. 2011) (invalidating rule where agency subject to statutory cost-benefit mandate "inconsistently and opportunistically framed the costs and benefits of the rule").

[62] Dist. Hosp. Partners 786 F.3d at 59 (Courts do not "uphold agency action if it fails to consider significant and viable and obvious alternatives.").

Commercial issuers estimated an average cost to create the file of $2.1 million per issuer, or about $9.40 per enrollee to create the Negotiated Rate File and Out-of-Network Allowed Amount File. Half of commercial issuers anticipate it would take two years or longer to make all necessary changes to initially develop the Negotiated Rate File and Out-of-Network Allowed Amount File while an additional 13 percent expect it would take at least 18 months. Issuers estimated average annual costs of $600,000 per issuer, or about $1.98 per enrollee, to produce a monthly Negotiated Rate File and Out-of-Network Allowed Amount File.

F. Effective Date

We urge the Departments to withdraw the negotiated rate machine-readable file provision of proposed rule because it: 1) would not meet consumer needs; 2) would distort health care markets risking higher prices for consumers and raises privacy concerns; 3) exceeds statutory authority, constitutes arbitrary and capricious rulemaking, and raises Constitutional concerns; and 4) is operationally unrealistic. **However, if the agency does not withdraw the proposed rule, and the Departments choose to move forward despite these fatal flaws, we strongly recommend a final rule include a delay in implementation until at least 3 years following the effective date of the final rule.**

As documented above, the Departments severely underestimated the time and cost of implementing this rule. Publication of negotiated rates touches on every relationship that an insurer has with physicians, hospitals, drug manufacturers, device manufacturers, and numerous other entities. Legal agreements will need to be examined and revised, data from multiple systems will need to be reviewed, harmonized, and integrated, and processes will need to be established for identifying necessary changes to the files going forward.

Perhaps more importantly, the compelled disclosure of payer-specific negotiated rates will cause immediate, irreparable harm when the rule goes into effect. Once issuers' trade secrets are disclosed, their value is greatly diminished. Because disclosure vitiates the value of a trade secret, courts routinely find that disclosure of such commercially sensitive information would cause irreparable harm.[63,64] Moreover, once the rule goes into effect, the anti-competitive effects are likely to be far-reaching and not susceptible to correction. An extended period of time prior to implementation is thus essential for issuers and other stakeholders to prepare for these disruptive market effects and to determine how, if at all, they can mitigate these harms.

IV. PUBLIC DISCLOSURE OF OUT-OF-NETWORK ALLOWED AMOUNTS (§§54.9815-2715A(c), 2590715-2715A(c), and 147.210(c))

The Departments propose to require that issuers make publicly available in machine-readable format an Out-of-Network Allowed Amount File that includes the name and Employer Identification Number or Health Insurance Oversight System identifier for each plan or coverage offered by a health insurance issuer or group health plan; a billing code or other code used to identify covered items and services and plain language description for each billing code; and unique out-of-network allowed amounts for covered items and services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to publication of the file. The Out-of-Network Allowed Amount File must be published on a monthly basis.

[63]NACM-New England, Inc. v. Nat'l Ass'n of Credit Mgmt., Inc., 927 F.3d 1, 5–6 (1st Cir. 2019) (affirming preliminary injunction enjoining disclosure of trade secrets).
[64] Bimbo Bakeries USA, Inc. v. Botticella, 613 F.3d 102, 118 (3d Cir. 2010) (same).

Recommendations:

- **The proposed requirement for public disclosure of out-of-network allowed amounts would not provide meaningful or actionable cost information for consumers, could create privacy risks, and creates unnecessary operations challenges for issuers. It should, therefore, be removed.**

- **The proposed Out-of-Network Allowed Amount File would not provide meaningful information to consumers seeking covered items or services out-of-network and could result in misleading information with financial consequences for consumers.** As discussed above, providing information on potential costs a consumer could incur when receiving covered services from an out-of-network provider undermines the purpose of curated provider networks and could provide misleading information about costs. Issuers contract with providers at a discounted rate, and ensure providers meet certain quality standards, to develop a curated provider network. If app developers use the Allowed Amount File to incorporate information on potential out-of-network allowed amounts, this could lead consumers toward seeking care at out-of-network providers, resulting in those consumers incurring unexpected costs and raising premiums. Information on historic allowed amounts would provide consumers an incomplete, and likely misleading picture of their potential out-of-pocket costs. Allowed amounts would not provide any information on potential provider balance billing, which could result in surprise cost-sharing liability. This could be especially problematic for consumers enrolled in plans with little or no out-of-network coverage.

- **The proposed Out-of-Network Allowed Amount File could undermine privacy of consumers' health information. If this requirement is finalized, we recommend a minimum threshold of 50 claims to require public disclosure of unique historic allowed amounts for a particular provider.** Disclosing unique out-of-network allowed amounts could pose significant risks for consumer privacy. The Departments propose a threshold minimum of 10 claims to require public disclosure of unique historic allowed amounts for a particular provider. This threshold is far too low to protect consumers' health information. Especially in small employer groups, data could be easily de-identified with a sample size this small. Further, we anticipate this data could be merged with other consumer data and sold, threatening consumer privacy.

- **The proposed Out-of-Network Allowed Amount File creates an unnecessary operations burden for issuers and data can be accessed through other existing sources.** Developing and publishing an allowed amount file on a monthly basis would create an unnecessary operations burden for issuers. As discussed below, the costs are much higher than the Departments anticipate. Especially for issuers with limited or no out-of-network benefits, this would represent an intensive monthly process to produce a file with very little information on out-of-network allowed amounts.

A. Implementation Cost & Timing

The Departments estimate the total burden for an issuer or their TPA to make appropriate changes to their IT system and processes to develop and implement the Out-of-Network Allowed Amount File is $117,757. The Departments estimate annual costs of $1,225 for each issuer or TPA to produce a monthly Negotiated Rate File.

Commercial issuers estimated an average cost to create the file of $2.1 million per issuer, or about $9.40 per enrollee to create the Negotiated Rate File and Out-of-Network Allowed Amount File.

Half of commercial issuers anticipate it would take two years or longer to make all necessary changes to initially develop the Negotiated Rate File and Out-of-Network Allowed Amount File while an additional 13 percent expect it would take at least 18 months. Issuers estimated average annual costs of $600,000 per issuer, or about $1.98 per enrollee, to produce a monthly Negotiated Rate File and Out-of-Network Allowed Amount File.

B. The Proposal Lacks the Necessary Legal Authority

The legal analysis above with respect to statutory authority, the First Amendment, and arbitrary and capricious rulemaking applies to the Allowed Amount File as well. The Departments lack statutory authority to impose this requirement, the requirement would violate the First Amendment, and the rule would be arbitrary and capricious. For a fuller discussion of the legal problems with the proposed rule, see the legal analysis above. **As a result, this portion of the rule should be withdrawn.**

C. Effective Date

We urge the Departments to withdraw the allowed amount machine-readable portion of proposed rule because it: 1) would not meet consumer needs; 2) would distort health care markets in a manner harmful to consumers; 3) exceeds statutory authority, constitutes arbitrary and capricious rulemaking, and raises Constitutional concerns and 4) is operationally unrealistic. **However, if the agency does not withdraw the proposed rule, and the Departments choose to move forward despite these fatal flaws, we strongly recommend a final rule include a delay in implementation until at least 3 years following the effective date of the final rule.**

As documented above, the Departments severely underestimated the time and cost of implementing this rule and of setting up processes for producing the updates required by the rule.

V. RFI: DISCLOSURE OF PRICING INFORMATION THROUGH A STANDARDS BASED API (84 FR 65483)

The Departments seek comment on whether to propose, through future rulemaking, that issuers make available cost-sharing information for the data disclosures in this proposed rule—including the internet-based self-service tool as well as the in-network rate and out-of-network allowed amount machine-readable files—through a standards-based open application programming interface (API). The Departments seek input on whether API technical standards proposed in the Office for the National Coordinator for Health IT (ONC) 21st Century Cures Act Proposed Rule and CMS Interoperability and Patient Access Proposed Rule (based on the Health Level 7 [HL7®] Fast Healthcare Interoperability Resources [FHIR®] standard), should be required in the future across group and individual coverage.

Recommendations:

- **AHIP supports the Departments' efforts to align data sharing requirements across payer types where possible.** Issuers are committed to finding innovative ways to integrate and share data with consumers, doctors and hospitals. Improving access to meaningful information can help all actors in the health care ecosystem to realize the full benefits of health IT and data sharing to achieve better health outcomes, more affordable care, and higher patient satisfaction. We continue to support the interoperability standards proposed in the ONC and CMS proposed rules as a technical mechanism for exchange of information, including the HL7 FHIR standard with associated authentication and authorization protocols (OAuth 2.0 and OpenID Connect Core).

- **We stress the importance of protecting patient privacy in any proposal to make cost information available via APIs, and do not support requiring plans to utilize this technology before appropriate safeguards are in place.** Under HIPAA, patients have the right to access their protected health information (PHI) and direct that it be shared with a third party. This provides the basis for the proposals in the CMS Interoperability and Patient Access proposed rule. As the Departments note, while cost information is not PHI under HIPAA, individuals would typically be seeking information related to their own potential health conditions and needs. Thus, revealing what information has been requested by individual enrollees could reveal sensitive information about their health status.

  For this reason, we recommend that a process be established by the FTC in collaboration with the Departments to vet third-party applications accessing plan and issuer APIs for the adequacy of their consumer disclosures, the privacy and security of the information once it is no longer governed by the HIPAA and secondary uses are permitted, and clinical soundness (for those applications that offer medical advice). The vetting process should be at the application level, not just at the application developer level, and the results of such vetting process should be made public in the form of an application "safe list." Additionally, issuers should be able to refuse to connect to non-vetted applications. The Departments should also make it starkly clear in any potential future regulations via a safe-harbor provision in the regulatory text for covered programs that insurance and health care providers are not responsible for the downstream privacy and security of the PHI shared with patient-selected apps consistent with the recent guidance issued by the HHS Office for Civil Rights (OCR).[65]

- **We recommend that the Departments establish the methods for disclosing information proposed in this Rule as a floor, not a ceiling, and allow plans and issuers the option to <u>voluntarily</u> deploy API technology that leverages the information provided in the self-service internet tool for consumer-directed disclosure of cost information via APIs.** We recognize the significant financial and administrative resources needed to build API technology, as well as the wide variation in adoption of such technology among plans and issuers. We also recognize that API technology provides a much greater opportunity for innovation and flexibility than static, machine-readable files. Issuers taking the initiative to use this technology should be rewarded for doing so, and the Departments should encourage use of APIs. Permitting voluntary use of, not requiring, open API technology would allow issuers innovating in this area to take advantage of new technology while providing avenue for plans and issuers in the early stages of moving toward interoperable systems.

- **We recommend that the Departments allow use of API technology in this manner to satisfy the requirements for creation of the machine-readable file, if finalized.** This would allow for a more accurate, up-to-date delivery of the information, while leveraging efficiencies for plans already innovating in this space. Thus, for example, plans participating in public programs who are required to disclose information via APIs for their Medicare, Medicaid or Exchange products in accordance with the CMS Interoperability and Patient Access proposed rule would be "deemed" as having met the requirements for the machine-readable file if they leverage those same resources to deploy APIs for their commercial products. We also recommend, aligning with the proposals in the CMS rule, that this program require disclosure of information via APIs to be

[65] HHS FAQ, April 18, 2019. Available at: https://www.hhs.gov/hipaa/for-professionals/faq/3009/does-a-hipaa-covered-entity-bear-liability.html

consumer-directed, in that each individual enrollee must grant a third-party application access to the plan or issuer's API for the purposes of collecting their individual data only, and third-party applications will not be granted broad access to a plan's data.

- **We recommend that implementation of voluntary API use be tied to maturation of interoperability standards.** We recommend allowing for voluntary use of APIs after the Implementation Guide (IG) for Patient Cost Transparency is finalized (as in, after October 2023 at the earliest). We do not recommend implementation of the program while the IG is a Standard for Trial Use, as suggested in this RFI. We also recommend the Departments allow plans and issuers the flexibility to use updated standards in the future via the ONC Standards Version Advancement Process with adequate public input and time for implementation.

- **We support the Departments' assertion that it may be appropriate for a plan or issuer to deny or terminate specific applications' connection to its API under certain circumstances in which the application poses an unacceptable risk to the PHI on its systems or otherwise violates the terms of use of the API technology**. We recommend the Departments rely on continuing conversations with stakeholders to establish and maintain additional circumstances in which it may be appropriate for issuers to delay or deny a request by a consumer via a third-party app developer. Additionally, we recommend that CMS develop and regularly update FAQs as we learn more though implementation experience.

VI. RFI: PROVIDER QUALITY MEASUREMENT AND REPORTING IN THE PRIVATE HEALTH INSURANCE MARKET (84 FR 65487)

The Departments seek input on how to leverage public and private sector quality measures to provide quality information alongside cost-sharing information for commercial plans. The Departments seek comment on whether they should impose requirements for the disclosure of quality information for providers of health care items and services, whether this information should be standardized, whether it is feasible to use health care quality information from existing CMS quality reporting programs, and what type of existing quality of health care information would be most beneficial to beneficiaries, participants, and enrollees in the individual and group markets.

Recommendations:

- **AHIP strongly supports the pairing of quality and cost information, where feasible.** We appreciate the Departments' efforts to advance quality measurement and reporting programs that contribute to the availability of consistent and reliable performance information. Issuers already offer transparency tools that give consumers estimates of anticipated costs and allow them to compare services based on aspects of care such as quality, experience and accessibility of care. We believe that any quality information paired with the cost information proposed in this proposed rule should consistent across public and payers (with some flexibility to account for different populations' needs), aligned with existing measures and programs, and relevant to consumers' needs.

- **We strongly urge the Departments to engage in existing public-private partnerships to align quality measures across payers rather than dictating what health care and issuers must provide.** We remain committed to offering consumers actionable information about provider performance to help them make decisions about where to receive their care, and we feel this is best achieved through reducing provider measure reporting burden and aligning measures across

public and private payers. AHIP and CMS together leads the Core Quality Measures Collaborative (CQMC). This partnership includes other insurance providers, medical providers, consumers and purchasers, to promote alignment of quality measures across public programs and the private sector. We recommend the Departments leverage the CQMC to this purpose.

- **We recommend the Departments solicit input from consumers about what quality information would be most useful to them, what quality measures they would want access to in conjunction with cost information, what measures would be most likely to influence their choice of provider, and what measures should be developed in the future**. Just as any price transparency proposals should focus on information that is most valuable to the consumer, so too should complementary quality measurement proposals prioritize information that would be most helpful to consumers choosing a provider. The existing landscape of quality information is vast, and many stakeholders are actively engaged in reducing the burden of measure reporting. Despite the industry's efforts, little information exists on what quality information consumers find most useful. CMS should also lead efforts to educate consumers about the utility of quality metrics more broadly. After gathering this information, CMS should work with the CQMC to develop a recommended process for pairing quality measure results and cost information on websites and mobile applications, including suggested formats for display of quality information and recommended measures or measure sets to be used for this purpose.

- **We strongly believe that cost information should only be paired with quality information that is relevant to the specific item or service the consumer is shopping for.** For example, a consumer looking for information on total hip/knee arthroplasty should view cost-sharing information paired with measures of outcomes (e.g., readmissions, functional status, complications) specific to that procedures, as opposed to a broad, all-cause or all-condition measure. CMS should leverage existing quality measures, such as those found in CQMC Core Measure Sets, measures used in the Quality Payment Program, and measures used in CMS' various Star Ratings programs. However, we note that many of these measures and measures used in existing quality reporting programs are specified for the Medicare population. We urge the Departments to look to measures specified for commercial populations, such as those used in National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information (HEDIS) set. We also urge the Departments to consider innovative measures that incorporate clinical data from electronic sources and work closely with provider organizations to promote interoperability and exchange of this information with group health plans and issuers.

VII. APPLICABILITY & EXCEPTIONS (§§54.9815-2715A(d), 2590.715-2715A(d), and 147.210(d))

The Departments propose the provisions of this rule do not apply to grandfathered health plans, plans not subject to PHSA 2715A (i.e., excepted benefits), and health reimbursement arrangements (HRAs). Regarding Accountable Care Organizations and other capitated payment arrangements, the Departments indicate that pricing information related to items and services that are subject to capitation arrangements under a specific plan or contract could meet transparency standards by disclosing only the consumer's anticipated liability.

Recommendations:

- **We support excluding HRAs & excepted benefits plans not subject to PHSA 2715A from the requirements for price transparency tools and machine-readable files. We recommend**

the Departments also clarify that expatriate plans are exempt from these requirements. The Expatriate Health Coverage Clarification Act of 2014 (EHCCA) exempts expatriate health plans from most of the provisions of the ACA, including sections 1311(e)(3) of the ACA and section 2715A of the PHSA, both of which the Departments cite in asserting statutory authority to propose these transparency requirements. Because the Departments propose requirements to implement legislative mandates that do not apply to expatriate health plans (i.e., sections 1311(e)(3) of the ACA and 2715A of the PHSA), we recommend the Departments update section VI of the preamble to specify expatriate health plans are not subject to the proposed rule.

- **Regarding consumer price transparency tools for accountable care organizations (ACOs) and other capitated payment arrangements, we recommend several modifications.** For these plans, transparency tools should only be required to display amounts that are not service dependent (e.g., flat copayments), as well as accumulator information about deductibles and out-of-pocket maximums. Issuers do not always have access to the negotiated rates or internal payment methodologies utilized by capitated medical groups or other providers and would not be able to reliably provide cost transparency based on a negotiated rate at the service level. Thus, we support narrower scope for capitated arrangements.

- **We recommend the final rule adopt a longer implementation timeframe for issuers with enrollment under 100,000 members to provide an additional 3-5 years for small issuers to implement these requirements.** Issuers with smaller enrollment volumes may face a disproportionate burden to undertake an IT project of this size. Providing additional time to implement would lessen the cost and operations burden for these issuers and may help to mitigate the otherwise outsize impact of such a large IT project for smaller plans.

VIII. MEDICAL LOSS RATION PROGRAM PROPOSED CHANGES (§158.221(b)(9))

HHS proposes an update to 45 CFR 158.221 to allow issuers to include shared savings payments made to enrollees in the numerator of Medical Loss Ratio calculations (MLR) beginning with the 2020 MLR reporting year. **We strongly support this provision.**

Today, some plans make shared savings payments to enrollees who choose to obtain a service at a lower-cost provider. If the enrollee had selected a higher cost provider and not received the shared savings payment, the excess covered charges of the higher-cost provider would be included in the MLR numerator. Providing the option to include the amount of the shared savings payment to the consumer in the MLR numerator will align issuer and consumer incentives to lower the overall cost of providing medical care.

The extraordinary IT system expenditures resulting from this proposal would significantly increase administrative costs for issuers. We urge CMS to specify in the final regulation that costs associated with development, implementation, and ongoing support of the capabilities and requirements described in the proposal will be recognized as quality improvement expenditures for purpose of the MLR calculations and reporting, consistent with regulations at 42 CFR 438.8(e)(3).

Recommendation:

- **We recommend CMS finalize the proposed update to 45 CFR 158.221 as proposed.** While we strongly support the proposed option for MLR calculations, it is our position that issuers are best positioned to decide in which markets and for which products shared-savings programs are

most likely to benefit consumers and have the desired impact on overall costs. We recommend that state and federal regulators continue to provide flexibility to issuers to design shared savings programs as an optional plan feature.

- **Due to the extraordinary costs issuers will incur to implement the provisions of this rule, we recommend the Departments should specify in the final regulation that costs associated with development, implementation, and ongoing support of the proposed requirements will be recognized as quality improvement expenditures for purpose of MLR calculations.**

ATTACHMENT B:

CMS' 70 Shoppable Services List Comparison to AHIP Member Tool Services

*The below table displays the comparison of AHIP member tool services to CMS' 70 shoppable services list (plus 4 item codes). The **44 green** highlighted codes strong consistency with AHIP member plans, while the **19 yellow** highlighted codes represent moderate overlap. The **11 red** highlighted codes display little to no overlap.*

2020 CMS CPT/ HCPCS primary code	Descriptors	2020 CMS CPT/ HCPCS primary code	Descriptors
97110	Physical therapy, therapeutic exercise	99204	New patient office of other outpatient visit, typically 45 min
80048	Basic metabolic panel	99205	New patient office of other outpatient visit, typically 60 min
80053	Blood test, comprehensive group of blood chemicals	99385	Initial new patient preventive medicine evaluation (18-39 years)
80061	Blood test, lipids (cholesterol and triglycerides)	99386	Initial new patient preventive medicine evaluation (40-64 years)
80076	Liver function blood test panel	80055	Obstetric blood test panel
84443	Blood test, thyroid stimulating hormone (TSH)	81000	Manual urinalysis test with examination using microscope
85610	Blood test, clotting time	81002	Automated urinalysis test
70450	CT scan, head or brain, without contrast	84153	PSA (prostate specific antigen)
70553	MRI scan of brain before and after contrast	85025	Complete blood cell count, with differential white blood cells, automated
72110	X-Ray, lower back, minimum four views	85027	Complete blood count, automated
72148	MRI scan of lower spinal canal	72193	CT scan, pelvis, with contrast
73721	MRI scan of leg joint	76805	Abdominal ultrasound of pregnant uterus (greater or equal to 14 weeks 0 days) single or first fetus
74177	CT scan of abdomen and pelvis with contrast	77065	Mammography of one breast
76700	Ultrasound of abdomen	77066	Mammography of both breasts
76830	Ultrasound pelvis through vagina	77067	Mammography, screening, bilateral
29881	Removal of one knee cartilage using an endoscope	19120	Removal of 1 or more breast growth, open procedure
43239	Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope	42820	Removal of tonsils and adenoid glands patient younger than age 12

2020 CMS CPT/ HCPCS primary code	Descriptors	2020 CMS CPT/ HCPCS primary code	Descriptors
45380	Biopsy of large bowel using an endoscope	43235	Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope
95810	Sleep study	47562	Removal of gallbladder using an endoscope
99203	New patient office or other outpatient visit, typically 30 min	49505	Repair of groin hernia patient age 5 years or older
45378	Diagnostic examination of large bowel using an endoscope	66984	Removal of cataract with insertion of lens
45385	Removal of polyps or growths of large bowel using an endoscope	93000	Electrocardiogram, routine, with interpretation and report
90834	Psychotherapy, 45 min	90847	Family psychotherapy, including patient, 50 min
90837	Psychotherapy, 60 min	90853	Group psychotherapy
99243	Patient office consultation, typically 40 min	460	Spinal fusion except cervical without major comorbid conditions or complications (MCC)
99244	Patient office consultation, typically 60 min	473	Cervical spinal fusion without comorbid conditions (CC) or major comorbid conditions or complications (MCC)
80069	Kidney function panel test	62322	Injection of substance into spinal canal of lower back or sacrum using imaging guidance
81001	Manual urinalysis test with examination using microscope	470	Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC)
81003	Automated urinalysis test	59510	Routine obstetric care for cesarean delivery, including pre-and post-delivery care
85730	Coagulation assessment blood test	59610	Routine obstetric care for vaginal delivery after prior cesarean delivery including pre-and post-delivery care
743	Uterine and adnexa procedures for non-malignancy without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	90832	Psychotherapy, 30 min
59400	Routine obstetric care for vaginal delivery, including pre-and post-delivery care	93452	Insertion of catheter into left heart for diagnosis

2020 CMS CPT/ HCPCS primary code	Descriptors	2020 CMS CPT/ HCPCS primary code	Descriptors
66821	Removal of recurring cataract in lens capsule using laser	84154	Prostate specific antigen (PSA)
216	Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	55700	Biopsy of prostate gland
64483	Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance	55866	Surgical removal of prostate and surrounding lymph nodes using an endoscope
29826	Shaving of shoulder bone using an endoscope	62323	Injection of substance into spinal canal of lower back or sacrum using imaging guidance
90846	Family psychotherapy, not including patient, 50 min	45391	Ultrasound examination of lower large bowel using an endoscope

ATTACHMENT C:

Consistency Across AHIP Member Tool Services

*The **142 green** highlighted codes represent items and services that show strong consistency among issuers, while the **279 yellow** highlighted codes indicate moderate consistency. Given these **421 total codes** are present in many current issuer tools, we have reasonable confidence these are shoppable services even though we have not yet been able to evaluate this list against our selection criteria.*

AHIP Codes	Descriptors	AHIP Codes	Descriptors
10022	FNA W/IMAGE	76819	FETAL BIOPHYS PROFIL W/O NST
11401	EXC TR-EXT B9+MARG 0.6-1 CM	76830	TRANSVAGINAL US NON-OB
11422	EXC H-F-NK-SP B9+MARG 1.1-2	76831	ECHO EXAM UTERUS
17110	DESTRUCT B9 LESION 1-14	76856	US EXAM PELVIC COMPLETE
17111	DESTRUCT LESION 15 OR MORE	77065	DX MAMMO INCL CAD UNI
17311	MOHS 1 STAGE H/N/HF/G	77066	DX MAMMO INCL CAD BI
19120	REMOVAL OF BREAST LESION	77067	SCR MAMMO BI INCL CAD
28296	CORRECTION HALLUX VALGUS	78452	HT MUSCLE IMAGE SPECT MULT
29848	WRIST ENDOSCOPY/SURGERY	80048	METABOLIC PANEL TOTAL CA
29880	KNEE ARTHROSCOPY/SURGERY	80050	GENERAL HEALTH PANEL
29881	KNEE ARTHROSCOPY/SURGERY	80053	COMPREHEN METABOLIC PANEL
29888	KNEE ARTHROSCOPY/SURGERY	80055	OBSTETRIC PANEL
30520	REPAIR OF NASAL SEPTUM	80061	LIPID PANEL
36415	ROUTINE VENIPUNCTURE	80076	HEPATIC FUNCTION PANEL
36471	NJX SCLRSNT MLT INCMPTNT VN	81000	URINALYSIS NONAUTO W/SCOPE
36478	ENDOVENOUS LASER 1ST VEIN	81002	URINALYSIS NONAUTO W/O SCOPE
42820	REMOVE TONSILS AND ADENOIDS	81025	URINE PREGNANCY TEST
42826	REMOVAL OF TONSILS	82306	VITAMIN D 25 HYDROXY
42830	REMOVAL OF ADENOIDS	82570	ASSAY OF URINE CREATININE
43235	EGD DIAGNOSTIC BRUSH WASH	82670	ASSAY OF ESTRADIOL
43239	EGD BIOPSY SINGLE/MULTIPLE	83001	ASSAY OF GONADOTROPIN (FSH)
45378	DIAGNOSTIC COLONOSCOPY	83036	GLYCOSYLATED HEMOGLOBIN TEST
45380	COLONOSCOPY AND BIOPSY	83550	IRON BINDING TEST
45385	COLONOSCOPY W/LESION REMOVAL	84153	ASSAY OF PSA TOTAL
47562	LAPAROSCOPIC CHOLECYSTECTOMY	84439	ASSAY OF FREE THYROXINE
47563	LAPARO CHOLECYSTECTOMY/GRAPH	84443	ASSAY THYROID STIM HORMONE
49505	PRP I/HERN INIT REDUC >5 YR	84460	ALANINE AMINO (ALT) (SGPT)

AHIP Codes	Descriptors	AHIP Codes	Descriptors
49585	RPR UMBIL HERN REDUC > 5 YR	84703	CHORIONIC GONADOTROPIN ASSAY
49650	LAP ING HERNIA REPAIR INIT	85025	COMPLETE CBC W/AUTO DIFF WBC
52310	CYSTOSCOPY AND TREATMENT	85027	COMPLETE CBC AUTOMATED
57288	REPAIR BLADDER DEFECT	85610	PROTHROMBIN TIME
57454	BX/CURETT OF CERVIX W/SCOPE	87591	N.GONORRHOEAE DNA AMP PROB
58565	HYSTEROSCOPY STERILIZATION	87804	INFLUENZA ASSAY W/OPTIC
58662	LAPAROSCOPY EXCISE LESIONS	87880	STREP A ASSAY W/OPTIC
63030	LOW BACK DISK SURGERY	88141	CYTOPATH C/V INTERPRET
66984	CATARACT SURG W/IOL 1 STAGE	88150	CYTOPATH C/V MANUAL
70450	CT HEAD/BRAIN W/O DYE	88305	TISSUE EXAM BY PATHOLOGIST
70551	MRI BRAIN STEM W/O DYE	90460	IM ADMIN 1ST/ONLY COMPONENT
70553	MRI BRAIN STEM W/O & W/DYE	90471	IMMUNIZATION ADMIN
71275	CT ANGIOGRAPHY CHEST	90474	IMMUNE ADMIN ORAL/NASAL ADDL
72100	X-RAY EXAM L-S SPINE 2/3 VWS	90656	IIV3 VACC NO PRSV 0.5 ML IM
72110	X-RAY EXAM L-2 SPINE 4/>VWS	90686	IIV4 VACC NO PRSV 0.5 ML IM
72141	MRI NECK SPINE W/O DYE	92014	EYE EXAM&TX ESTAB PT 1/>VST
72148	MRI LUMBAR SPINE W/O DYE	92507	SPEECH/HEARING THERAPY
72157	MRI CHEST SPINE W/O & W/DYE	92523	SPEECH SOUND LANG COMPREHEN
72170	X-RAY EXAM OF PELVIS	93000	ELECTROCARDIOGRAM COMPLETE
72193	CT PELVIS W/DYE	93350	STRESS TTE ONLY
72197	MRI PELVIS W/O & W/DYE	93798	CARDIAC REHAB/MONITOR
73030	X-RAY EXAM OF SHOULDER	93922	UPR/L XTREMITY ART 2 LEVELS
73080	X-RAY EXAM OF ELBOW	93970	EXTREMITY STUDY
73110	X-RAY EXAM OF WRIST	93971	EXTREMITY STUDY
73130	X-RAY EXAM OF HAND	95115	IMMUNOTHERAPY ONE INJECTION
73140	X-RAY EXAM OF FINGER(S)	95117	IMMUNOTHERAPY INJECTIONS
73221	MRI JOINT UPR EXTREM W/O DYE	95810	POLYSOM 6/> YRS 4/> PARAM
73562	X-RAY EXAM OF KNEE 3	95811	POLYSOM 6/>YRS CPAP 4/> PARM
73610	X-RAY EXAM OF ANKLE	97014	ELECTRIC STIMULATION THERAPY
73620	X-RAY EXAM OF FOOT	97032	ELECTRICAL STIMULATION
73630	X-RAY EXAM OF FOOT	97035	ULTRASOUND THERAPY
73718	MRI LOWER EXTREMITY W/O DYE	97110	THERAPEUTIC EXERCISES
73721	MRI JNT OF LWR EXTRE W/O DYE	97112	NEUROMUSCULAR REEDUCATION
74177	CT ABD & PELV W/CONTRAST	97113	AQUATIC THERAPY/EXERCISES
74183	MRI ABDOMEN W/O & W/DYE	97140	MANUAL THERAPY 1/> REGIONS
76536	US EXAM OF HEAD AND NECK	97530	THERAPEUTIC ACTIVITIES

AHIP Codes	Descriptors	AHIP Codes	Descriptors
76700	US EXAM ABDOM COMPLETE	97535	SELF CARE MNGMENT TRAINING
76705	ECHO EXAM OF ABDOMEN	97811	ACUPUNCT W/O STIMUL ADDL 15M
76770	US EXAM ABDO BACK WALL COMP	97813	ACUPUNCT W/STIMUL 15 MIN
76805	OB US >/= 14 WKS SNGL FETUS	99203	OFFICE/OUTPATIENT VISIT NEW
76811	OB US DETAILED SNGL FETUS	99204	OFFICE/OUTPATIENT VISIT NEW
76813	OB US NUCHAL MEAS 1 GEST	99205	OFFICE/OUTPATIENT VISIT NEW
76817	TRANSVAGINAL US OBSTETRIC	99385	PREV VISIT NEW AGE 18-39
76818	FETAL BIOPHYS PROFILE W/NST	99386	PREV VISIT NEW AGE 40-64
460	SPINAL FUSION (POSTERIOR)	84134	ASSAY OF PREALBUMIN
470	KNEE REPLACEMENT	84436	ASSAY OF TOTAL THYROXINE
473	SPINAL FUSION (ANTERIOR)	84480	ASSAY TRIIODOTHYRONINE (T3)
621	BARIATRIC SURGERY - LAPAROSCOPIC	84484	ASSAY OF TROPONIN QUANT
743	HYSTERECTOMY	85007	BL SMEAR W/DIFF WBC COUNT
10021	FNA W/O IMAGE	85018	HEMOGLOBIN
10040	ACNE SURGERY	85730	THROMBOPLASTIN TIME PARTIAL
10060	DRAINAGE OF SKIN ABSCESS	86039	ANTINUCLEAR ANTIBODIES (ANA)
10140	DRAINAGE OF HEMATOMA/FLUID	86147	CARDIOLIPIN ANTIBODY EA IG
10160	PUNCTURE DRAINAGE OF LESION	86200	CCP ANTIBODY
11000	DEBRIDE INFECTED SKIN	86300	IMMUNOASSAY TUMOR CA 15-3
11056	TRIM SKIN LESIONS 2 TO 4	86304	IMMUNOASSAY TUMOR CA 125
11100	BIOPSY SKIN LESION	86336	INHIBIN A
11101	BIOPSY SKIN ADD-ON	86592	SYPHILIS TEST NON-TREP QUAL
11200	REMOVAL OF SKIN TAGS <W/15	86644	CMV ANTIBODY
11602	EXC TR-EXT MAL+MARG 1.1-2 CM	86665	EPSTEIN-BARR CAPSID VCA
11721	DEBRIDE NAIL 6 OR MORE	86677	HELICOBACTER PYLORI ANTIBODY
11730	REMOVAL OF NAIL PLATE	86703	HIV-1/HIV-2 1 RESULT ANTBDY
11900	INJECT SKIN LESIONS </W 7	86704	HEP B CORE ANTIBODY TOTAL
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<	86708	HEPATITIS A ANTIBODY
12011	RPR F/E/E/N/L/M 2.5 CM/<	86762	RUBELLA ANTIBODY
17000	DESTRUCT PREMALG LESION	86765	RUBEOLA ANTIBODY
17003	DESTRUCT PREMALG LES 2-14	86780	TREPONEMA PALLIDUM
17250	CHEM CAUT OF GRANLTJ TISSUE	86803	HEPATITIS C AB TEST
20550	INJ TENDON SHEATH/LIGAMENT	86850	RBC ANTIBODY SCREEN
20551	INJ TENDON ORIGIN/INSERTION	87040	BLOOD CULTURE FOR BACTERIA
20553	INJECT TRIGGER POINTS 3/>	87046	STOOL CULTR AEROBIC BACT EA

AHIP Codes	Descriptors	AHIP Codes	Descriptors
20600	DRAIN/INJ JOINT/BURSA W/O US	87070	CULTURE OTHR SPECIMN AEROBIC
20605	DRAIN/INJ JOINT/BURSA W/O US	87077	CULTURE AEROBIC IDENTIFY
20610	DRAIN/INJ JOINT/BURSA W/O US	87081	CULTURE SCREEN ONLY
20612	ASPIRATE/INJ GANGLION CYST	87086	URINE CULTURE/COLONY COUNT
31231	NASAL ENDOSCOPY DX	87088	URINE BACTERIA CULTURE
31237	NASAL/SINUS ENDOSCOPY SURG	87101	SKIN FUNGI CULTURE
31575	DIAGNOSTIC LARYNGOSCOPY	87186	MICROBE SUSCEPTIBLE MIC
36475	ENDOVENOUS RF 1ST VEIN	87205	SMEAR GRAM STAIN
50590	FRAGMENTING OF KIDNEY STONE	87210	SMEAR WET MOUNT SALINE/INK
51741	ELECTRO-UROFLOWMETRY FIRST	87324	CLOSTRIDIUM AG IA
51798	US URINE CAPACITY MEASURE	87389	HIV-1 AG W/HIV-1 & HIV-2 AB
52000	CYSTOSCOPY	87491	CHYLMD TRACH DNA AMP PROBE
52332	CYSTOSCOPY AND TREATMENT	87510	GARDNER VAG DNA DIR PROBE
55250	REMOVAL OF SPERM DUCT(S)	87653	STREP B DNA AMP PROBE
58100	BIOPSY OF UTERUS LINING	87661	TRICHOMONAS VAGINALIS AMPLIF
58558	HYSTEROSCOPY BIOPSY	87801	DETECT AGNT MULT DNA AMPLI
58563	HYSTEROSCOPY ABLATION	87807	RSV ASSAY W/OPTIC
58571	TLH W/T/O 250 G OR LESS	88112	CYTOPATH CELL ENHANCE TECH
58661	LAPAROSCOPY REMOVE ADNEXA	88142	CYTOPATH C/V THIN LAYER
58671	LAPAROSCOPY TUBAL BLOCK	88175	CYTOPATH C/V AUTO FLUID REDO
59000	AMNIOCENTESIS DIAGNOSTIC	88312	SPECIAL STAINS GROUP 1
59025	FETAL NON-STRESS TEST	88313	SPECIAL STAINS GROUP 2
59400	OBSTETRICAL CARE	88342	IMMUNOHISTO ANTB 1ST STAIN
59510	CESAREAN DELIVERY	90632	HEPA VACCINE ADULT IM
59610	VBAC DELIVERY	90633	HEPA VACC PED/ADOL 2 DOSE IM
62322	SPINAL INJECTION FOR PAIN MANAGEMENT	90649	4VHPV VACCINE 3 DOSE IM
64493	INJ PARAVERT F JNT L/S 1 LEV	90658	IIV3 VACCINE SPLT 0.5 ML IM
64721	CARPAL TUNNEL SURGERY	90672	LAIV4 VACCINE INTRANASAL
67028	INJECTION EYE DRUG	90681	RV1 VACC 2 DOSE LIVE ORAL
69210	REMOVE IMPACTED EAR WAX UNI	90707	MMR VACCINE SC
69436	CREATE EARDRUM OPENING	90710	MMRV VACCINE SC
70486	CT MAXILLOFACIAL W/O DYE	90715	TDAP VACCINE 7 YRS/> IM
70491	CT SOFT TISSUE NECK W/DYE	90716	VAR VACCINE LIVE SUBQ
71045	CHEST X-RAY	90732	PPSV23 VACC 2 YRS+ SUBQ/IM

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71046	CHEST X-RAY	90734	MENACWYD/MENACWYCRM VACC IM
71047	CHEST X-RAY	90736	HZV VACCINE LIVE SUBQ
71048	CHEST X-RAY	90746	HEPB VACCINE 3 DOSE ADULT IM
71101	X-RAY EXAM UNILAT RIBS/CHEST	90791	PSYCH DIAGNOSTIC EVALUATION
71250	CT THORAX W/O DYE	90792	PSYCH DIAG EVAL W/MED SRVCS
71260	CT THORAX W/DYE	90832	PSYTX W PT 30 MINUTES
72040	X-RAY EXAM NECK SPINE 2-3 VW	90833	PSYTX W PT W E/M 30 MIN
72050	X-RAY EXAM NECK SPINE 4/5VWS	90834	PSYTX W PT 45 MINUTES
72070	X-RAY EXAM THORAC SPINE 2VWS	90836	PSYTX W PT W E/M 45 MIN
72072	X-RAY EXAM THORAC SPINE 3VWS	90837	PSYTX W PT 60 MINUTES
72131	CT LUMBAR SPINE W/O DYE	90847	FAMILY PSYTX W/PT 50 MIN
72146	MRI CHEST SPINE W/O DYE	90853	GROUP PSYCHOTHERAPY
72156	MRI NECK SPINE W/O & W/DYE	92002	EYE EXAM NEW PATIENT
72158	MRI LUMBAR SPINE W/O & W/DYE	92004	EYE EXAM NEW PATIENT
72192	CT PELVIS W/O DYE	92012	EYE EXAM ESTABLISH PATIENT
72195	MRI PELVIS W/O DYE	92083	VISUAL FIELD EXAMINATION(S)
73000	X-RAY EXAM OF COLLAR BONE	92133	CMPTR OPHTH IMG OPTIC NERVE
73070	X-RAY EXAM OF ELBOW	92552	PURE TONE AUDIOMETRY AIR
73090	X-RAY EXAM OF FOREARM	93015	CARDIOVASCULAR STRESS TEST
73100	X-RAY EXAM OF WRIST	93303	ECHO TRANSTHORACIC
73120	X-RAY EXAM OF HAND	93307	TTE W/O DOPPLER COMPLETE
73560	X-RAY EXAM OF KNEE 1 OR 2	93320	DOPPLER ECHO EXAM HEART
73564	X-RAY EXAM KNEE 4 OR MORE	93880	EXTRACRANIAL BILAT STUDY
73565	X-RAY EXAM OF KNEES	94010	BREATHING CAPACITY TEST
73590	X-RAY EXAM OF LOWER LEG	94060	EVALUATION OF WHEEZING
73600	X-RAY EXAM OF ANKLE	94375	RESPIRATORY FLOW VOLUME LOOP
73650	X-RAY EXAM OF HEEL	94726	PULM FUNCT TST PLETHYSMOGRAP
73660	X-RAY EXAM OF TOE(S)	94727	PULM FUNCTION TEST BY GAS
73700	CT LOWER EXTREMITY W/O DYE	94729	CO/MEMBANE DIFFUSE CAPACITY
73722	MRI JOINT OF LWR EXTR W/DYE	95004	PERCUT ALLERGY SKIN TESTS
73723	MRI JOINT LWR EXTR W/O&W/DYE	95860	MUSCLE TEST ONE LIMB
74022	X-RAY EXAM SERIES ABDOMEN	95861	MUSCLE TEST 2 LIMBS
74150	CT ABDOMEN W/O DYE	95886	MUSC TEST DONE W/N TEST COMP

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74160	CT ABDOMEN W/DYE	96110	DEVELOPMENTAL SCREEN W/SCORE
74170	CT ABDOMEN W/O & W/DYE	96365	THER/PROPH/DIAG IV INF INIT
74176	CT ABD & PELVIS W/O CONTRAST	96366	THER/PROPH/DIAG IV INF ADDON
74178	CT ABD & PELV 1/> REGNS	96374	THER/PROPH/DIAG INJ IV PUSH
74181	MRI ABDOMEN W/O DYE	96375	TX/PRO/DX INJ NEW DRUG ADDON
76000	CHEST X-RAY	96376	TX/PRO/DX INJ SAME DRUG ADON
76001	CHEST X-RAY	96415	CHEMO IV INFUSION ADDL HR
76512	OPHTH US B W/NON-QUANT A	96417	CHEMO IV INFUS EACH ADDL SEQ
76514	ECHO EXAM OF EYE THICKNESS	97010	HOT OR COLD PACKS THERAPY
76642	ULTRASOUND BREAST LIMITED	97012	MECHANICAL TRACTION THERAPY
76775	US EXAM ABDO BACK WALL LIM	97016	VASOPNEUMATIC DEVICE THERAPY
76801	OB US < 14 WKS SINGLE FETUS	97026	INFRARED THERAPY
76815	OB US LIMITED FETUS(S)	97033	ELECTRIC CURRENT THERAPY
76857	US EXAM PELVIC LIMITED	97116	GAIT TRAINING THERAPY
76870	US EXAM SCROTUM	97124	MASSAGE THERAPY
76872	US TRANSRECTAL	97597	RMVL DEVITAL TIS 20 CM/<
76882	US LMTD JT/NONVASC XTR STRUX	98940	CHIROPRACT MANJ 1-2 REGIONS
77059	MRI BOTH BREASTS	98941	CHIROPRACT MANJ 3-4 REGIONS
77080	BONE DENSITY STUDY OF SPINE OR PELVIS	98943	CHIROPRACT MANJ XTRSPINL 1/>
78014	THYROID IMAGING W/BLOOD FLOW	99051	MED SERV EVE/WKEND/HOLIDAY
78306	BONE IMAGING WHOLE BODY	99173	VISUAL ACUITY SCREEN
78815	PET IMAGE W/CT SKULL-THIGH	99201	OFFICE/OUTPATIENT VISIT NEW
80069	RENAL FUNCTION PANEL	99202	OFFICE/OUTPATIENT VISIT NEW
80074	ACUTE HEPATITIS PANEL	99211	OFFICE/OUTPATIENT VISIT EST
80197	ASSAY OF TACROLIMUS	99212	OFFICE/OUTPATIENT VISIT EST
81001	URINALYSIS; MANUAL OR AUTO WITH OR WITHOUT MICROSCOPY	99213	OFFICE/OUTPATIENT VISIT EST
81003	URINALYSIS; MANUAL OR AUTO WITH OR WITHOUT MICROSCOPY	99214	OFFICE/OUTPATIENT VISIT EST
82043	UR ALBUMIN QUANTITATIVE	99215	OFFICE/OUTPATIENT VISIT EST
82044	UR ALBUMIN SEMIQUANTITATIVE	99243	OFFICE CONSULTATION
82248	BILIRUBIN DIRECT	99244	OFFICE CONSULTATION
82553	CREATINE MB FRACTION	99381	INIT PM E/M NEW PAT INFANT
82607	VITAMIN B-12	99382	INIT PM E/M NEW PAT 1-4 YRS
82627	DEHYDROEPIANDROSTERONE	99383	PREV VISIT NEW AGE 5-11

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82728	ASSAY OF FERRITIN	99384	PREV VISIT NEW AGE 12-17
82784	ASSAY IGA/IGD/IGG/IGM EACH	99387	INIT PM E/M NEW PAT 65+ YRS
82803	BLOOD GASES ANY COMBINATION	99391	PER PM REEVAL EST PAT INFANT
82947	ASSAY GLUCOSE BLOOD QUANT	99392	PREV VISIT EST AGE 1-4
82950	GLUCOSE TEST	99393	PREV VISIT EST AGE 5-11
82951	GLUCOSE TOLERANCE TEST (GTT)	99394	PREV VISIT EST AGE 12-17
83002	ASSAY OF GONADOTROPIN (LH)	99395	PREV VISIT EST AGE 18-39
83013	H PYLORI (C-13) BREATH	99396	PREV VISIT EST AGE 40-64
83516	IMMUNOASSAY NONANTIBODY	99397	PER PM REEVAL EST PAT 65+ YR
83540	ASSAY OF IRON	A288	GASTRIC BYPASS
83655	ASSAY OF LEAD	J0702	BETAMETHASONE ACET&SOD PHOSP
83718	ASSAY OF LIPOPROTEIN	J1745	INFLIXIMAB NOT BIOSIMIL 10MG
83880	ASSAY OF NATRIURETIC PEPTIDE		