



# UnityPoint Health

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January 29, 2020

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

Sunita Lough, Deputy Commissioner  
Services and Enforcement, Internal Revenue Service

Preston Rutledge, Assistant Secretary  
Employee Benefits Security Administration, Department of Labor

RE: CMS-9915-P- Transparency in Coverage; published in Vol. 84, No. 229 Federal Register 65464-65523 on November 27, 2019.

*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

Dear Administrator Verma, Deputy Commissioner Lough and Assistant Secretary Rutledge:

UnityPoint Health (“UPH”) appreciates the opportunity to provide comments in response to the proposed rules for group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee. Through more than 32,000 employees, our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 home health agencies throughout our 9 regions, UPH provides care throughout Iowa, western Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 6.2 million patient visits.

UnityPoint Health respectfully offers the following comments to the proposed regulatory framework.

## **PRICE TRANSPARENCY GENERALLY**

**UPH is committed to price transparency efforts that are meaningful to consumers and enable consumers to make informed health care decisions in conjunction with other factors such as quality, experience and other patient satisfiers.** Out-of-pocket costs are the costs that are most meaningful to consumers, as it is the amount for which they are responsible. Out-of-pocket costs are most readily available from a consumer’s insurer or health plan and may be obtained by contacting the health plan directly. In this proposed rule, UPH is pleased that the departments are examining health plans as a source of vital pricing information. As opposed to a health care provider, the third-party insurer will

have access to the consumer’s contract rates and specific benefits, such as deductibles, co-pays or co-insurances. The insurer also has the ability to give the consumer the full out-of-pocket costs that would include the hospital, physician and any other normal services for the episode of care. Insurers currently provide cost/liability information in a pre-authorization process as well as in an explanation of benefits document.

As with the proposed rule for hospitals, we believe that this rule offers a similarly overly prescriptive approach to price transparency. As an alternative, **we encourage the departments to take steps to facilitate the development and voluntary adoption of patient cost-estimator tools and resources by convening stakeholders to identify best practices, recommending standards for common features of cost-estimator tools and developing solutions to common technical barriers.** Stakeholder input in this process, both from consumers, providers and health plans is urged.

### **PUBLIC DISCLOSURE OF NEGOTIATED RATES**

As stated in our response to the OPPI rule, we are extremely concerned that this provision raises legal concerns and anti-competitive issues for providers. This proposal for health plans both lacks statutory authority and violates the Affordable Care Act itself.

**Lack of Statutory Authority Under the Affordable Care Act (ACA)**: On its face, the proposal suffers from a clear, basic, and overriding flaw: the absence of a nexus to its purported underlying statutory authority. **The proposed disclosure requirement does not further the statutory objective of promoting transparency in coverage.** The departments, therefore, lack the legal authority to compel the public disclosure of such highly sensitive and confidential pricing information.

The departments rely in the first instance on section 1311(e)(3) of the ACA as their purported authority to compel broad and public disclosure of negotiated rates information. Section 1311(e)(3) is titled “Transparency in coverage” and provides that each health insurance exchange must “require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, [and] the State insurance commissioner, and make available to the public,” eight statutorily enumerated types of information related to coverage (e.g., claims payment policies and practices, periodic financial disclosures, data on enrollment). Section 1311(e)(3) also includes a catch-all provision that requires disclosure of “[o]ther information as determined appropriate by the Secretary.” The departments assert that negotiated rates are “other information” that is a proper subject of disclosure under the catch-all provision.

As section 1311(e)(3)’s heading, as well as its context, make clear, however, all of the information subject to disclosure under section 1311(e)(3) must be related to “[t]ransparency in coverage.” This means that, where the Secretary designates “other information” for disclosure under section 1311(e)(3)’s catch-all provision, that other information must further transparency in coverage, just as the statutorily enumerated types of information do.

The departments cannot lawfully require disclosure of negotiated rates information under section 1311(e)(3) because it relates to price – not coverage. While the departments attempt to link the two by stating that the negotiated rates are a necessary input for some cost-sharing calculations, this is itself a

concession that the disclosure of negotiated rates information, in and of itself, furthers only price transparency, as opposed to the statutorily required objective of promoting coverage transparency. Moreover, the departments’ separate proposal mandating the disclosure of estimated cost-sharing liability and accumulated financial responsibility means that the disclosure proposed here does nothing to further promote cost-sharing transparency in this regard.

In addition, the departments are proposing to require public disclosure of information that the departments themselves are statutorily required to protect against such disclosure. As the departments themselves recognize, negotiated rates are typically held as “trade secrets” or other “confidential commercial information.” Congress has enacted robust statutory regimes, such as the Trade Secrets Act, the Privacy Act, and the Freedom of Information Act (FOIA), that expressly protect such highly sensitive and confidential information from public disclosure when it is obtained by the Government. The departments are now proposing to require health plans to publicly disclose the very same types of information that the departments are statutorily prohibited from making public. The departments may not compel third parties to do indirectly what the departments themselves may not do directly.

**APA Violation:** The reasoning underlying this proposal is arbitrary and capricious in violation of the APA. The departments rely on five assertions for requiring broad and public disclosure of negotiated rates information:

- First, uninsured consumers will use negotiated rate information to select health care service providers.
- Second, negotiated rate information will be used by individuals who wish to “evaluate available options [in the] group or individual market.”
- Third, public disclosure of negotiated rates “is necessary to enable consumers to use and understand price transparency data in a manner that will increase competition, reduce disparities in health care prices, and potentially lower health care costs.”
- Fourth, requiring public disclosure of negotiated rates will help employers that sponsor group health plans in rate negotiation.
- Fifth, requiring public disclosure of negotiated rates will “assist health care regulators in . . . oversee[ing] health insurance issuers.”

**None of these assertions pass muster under the APA and all rely on statutorily improper considerations or are otherwise indefensible.** Indeed, the first four assertions are not even grounded in statutorily cognizable considerations. All four are ultimately premised on the departments’ conjecture that the proposed disclosure of pricing information will better let consumers “judge the reasonableness of provider prices and shop for care at the best price.” As discussed above, this argument relies on the flawed premise without a meaningful linkage to the statutory objective of “[t]ransparency in coverage.”

The first four assertions are also misplaced because they are not grounded in any rationale applicable to qualified health plans (QHPs). Section 1311(e)(3) of the ACA concerns transparency in coverage for health plans seeking certification as QHPs from a health insurance exchange. Thus, any disclosure requirement must first find a basis in furthering transparency in coverage under QHPs. Accordingly, the departments may not rely on their proffered rationales relating to the uninsured, employers that

sponsor group health plans, consumers shopping more broadly for health insurance coverage beyond QHPs, or governmental health benefit programs – or vague and speculative pronouncements about alleged benefit to the health care system generally – to justify their proposal.

Finally, the conclusion that the proposal will benefit health care consumers is not supported. If anything, requiring disclosure of negotiated rates information is likely to compound confusion among consumers rather than promote more informed decision-making.

The fifth attestation is invalid as well. Public disclosure of highly sensitive and confidential pricing information on the grounds that state insurance regulators might find such information helpful is not justified. To begin with, state regulators already have access to this information. Furthermore, to the extent that the departments were interested in providing such information to state regulators, they could invoke alternative authorities, such as sections 1322(c)(1) and 1321(a)(1) of the ACA, to do so that would avoid public disclosure. Finally, even under section 1311(e)(3) of the ACA, “[t]he Exchanges shall . . . make available to the public...other information” only “as determined appropriate by the Secretary.” Here, the Secretary has properly determined that the “other information” at issue (i.e., the negotiated rates information) is “appropriate” to be made available only to state regulators.

We are pleased to provide comments to the proposed regulations. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Government and External Affairs at [sabra.rosener@unitypoint.org](mailto:sabra.rosener@unitypoint.org) or 515-205-1206.

Sincerely,



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UnityPoint Health