Meeting: June 5, 2024
TO: Members of The Office of Management and Budget
RE: CY 2025 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Changes and Payment Rates (CMS-1809)

RIN: 0938-AV35

OVERVIEW
In the three-and-a-half years since the Hospital Price Transparency Rule (45 C.F.R. 180.50), which has its genesis in the Outpatient Prospective Payment System (OPPS) Rule, went into effect, the vast majority of U.S. hospitals are still not fully complying. We are looking to The Office of Management and Budget, as it reviews the next the OPPS rule, to enact measures that would strengthen and better enforce the existing rule.

We have made progress, but need to go further to fully realize, systemwide health-care price transparency, which will not only enable health-care consumers to save money by comparison shopping but will also lower the price of care and coverage by introducing market competition. As the cost of care and coverage go down, access will go up, and our nation will become healthier as outcomes improve.

Given that nearly 90% of American voters want health-care price transparency, that over half have delayed medical care because they fear the unknown prices and potential financial ruin, and that more than 100 million Americans are burdened with medical debt, which is the leading cause of bankruptcy, this matter is of utmost urgency. That said, we are grateful for all that the Department of Health and Human Services and the Centers for Medicare and Medicaid have done to enact this rule, despite considerable industry resistance.

ABOUT POWER TO THE PATIENTS
A national nonprofit advocacy group, Power to the Patients was founded solely for the purpose of making sure that all Americans were aware of their right to know the price of their health care up front and were able to easily access those prices, as the law requires. To that end, we respectfully ask the Office to consider the following recommendations that would move existing policies toward ones that would achieve better results.

PROPOSED CHANGES AND SUGGESTIONS
Thus, we at Power to Patients respectfully ask your committee to consider with the following changes to the hospital price transparency provisions of the upcoming OPPS proposed rule. These provisions would protect and empower patients, hold hospitals accountable, promote compliance and create a competitive health-care market that would drive down costs and increase access.

1. ***Require hospitals to post only real, actual, binding prices in dollars and cents. Eliminate price estimates, averages and "expected allowed amounts." In the machine-***

readable file, move from the "expected allowed amount" to an actual price in dollars and cents, not an estimate or average.

Eliminate estimator tools*.* Patients need binding prices. Hospital price estimator tools provide patients with one price based on their plans, and it is not a guaranteed price. It is just an estimate. At Power to the Patients, we have received hundreds of letters from patients who received a price estimate that came nowhere near what they were ultimately billed. (Please see patient stories at the end of this document.)

For price transparency to unleash market competition, lower health-care costs and truly protect and empower patients, consumers need full access to real prices. Price estimator tools and "expected allowed amounts," while well intentioned, harm patients and undermine the intention of true, systemwide health-care price transparency, by giving unreliable numbers.

Change "expected allowed amounts" to real prices. While we appreciate the office's efforts to ensure that hospitals do not enter meaningless information in their pricing files, such as formulas, percentages, zeros, and NAs, and instead fill fields with only amounts in dollars and cents, the option of having hospitals provide an average price or an "expected allowed amount" does not fully fix the problem. Such averages or estimates are harmful as they do not provide consumers with price certainty, nor do they hold hospitals accountable for their charges.

The absence of real prices in dollars and cents not only harms patients trying to shop for value, but also further limits access to critical pricing data needed by employers and unions and hinders the ability of technology developers to aggregate accurate information to create shopping tools.

When all consumers of health care – patients, workers, employers, and unions – can see and compare prices across payers and plans, and also see cash prices, they can choose where to receive care for the best value. Thorough, accurate, accessible and binding prices are essential. Only when hospitals show all actual prices, can price competition take effect empowering consumers and lowering health-care costs.

2. ***Make clear in the rule that hospitals must post all types of standard charges for all items and services that it offers.***

The CY 2024 OPPS rule, in referring to an online guidance document from CMS, allows that a hospital will be considered compliant if it posts only one standard charge type. The original price transparency rule requires hospitals to post several standard charge types: gross prices, discounted cash prices, minimum and maximum negotiated rates, and prices by payer and plan. To ensure that hospitals don't use this guideline as a way to avoid posting all prices, we recommend that CMS clarify in the rule that all types of standard charges must be posted for all items and services.

3. ***Require hospitals to use a standard wide CSV-format template, as criteria for compliance with the OPPS rule.***

CMS has developed a recommended — but not required — template for hospitals to use to post their pricing data. By requiring hospitals to post their machine-readable files in a standard

format that is both human-readable and machine-readable in wide CSV formats, consumers will be able to access all prices more readily for comparison.

In the absence of a required template, hospitals are continuing to obfuscate prices by posting them in files that humans can't access, such as JSON files. When patients or other health-care consumers can't see prices, they can't verify whether their bills are correct, leaving them no way to easily dispute their charges.

Requiring all hospitals to use a uniform, standard template complete with accurate, precise dollar figures associated with each payer and plan would allow technology companies to readily produce comparison shopping tools to provide consumers easy-to-access prices.

4. ***Require senior hospital executives to attest to prices.***

The CY 2024 OPPS Rule added a much-needed and appreciated attestation requirement, assuring that hospitals would account for and stand behind their posted prices. We would like to propose that the agency go further and require that senior C-level hospital executives complete this attestation. Just as when these officers submit Medicare cost reports, make these attestations material to receiving reimbursements for Medicare, Medicaid or any other federal government payments. This additional accountability will help ease the burden of enforcement for CMS.

5. ***Educate consumers of their right to know prices to up front through a public awareness campaign.***

Because seeking out health-care prices will be a new behavior for Americans, include a provision in the rule that would require CMS or HHS to conduct a broad public awareness campaign informing consumers of their right to know prices, and how to find them. Require hospitals and clinics to distribute materials, post signs, and indicate prominently on their websites' home pages that patients have the right to know prices, that they are available, and where to find them.

Finally, on behalf of all health-care consumers — patients, workers, employers, unions, and taxpayers — we thank OMB for the opportunity to share our perspectives and recommendations. Please read actual patient stories below for examples of why health-care price transparency is so necessary, and how, once fully realized, will be transformative.

Marni Jameson Carey
President, Power to the Patients

POWER to the PATIENTS

PATIENT CASES ILLUSTRATING WHY WE NEED PRICE TRANSPARENCY

VIRGINIA —Jennifer Volk, of Fredericksburg, Virginia, had the same prenatal tests at two centers and the bill at one was seven times higher.

Last year, when Jennifer Volk was 20 weeks pregnant, her obstetrician told the expectant mother she needed specialized fetal testing every two weeks to monitor the infant's progress. Ms. Volk found two centers nearby that offered the non-invasive ultrasound tests to measure umbilical blood flow. Though the tests at the two centers were exactly the same, the bills were miles apart.

At Maternal Fetal Specialists the bill for the umbilical ultrasound (076820) was $395. Five miles away at HCA Spotsylvania Regional Medical Center the charge was $2,726, seven times more. She wished she'd known before she racked up thousands of dollars of unnecessary charges, which has put a stranglehold on her family's finances.

Price transparency would have revealed this wide price variation and saved this young family thousands of dollars.

TENNESSEE—Laurie Cook, age 50, of Nashville, Tennessee, asked for and received a $5,500 written estimate to have one ovary removed. Then she got a bill for $61,000.

An elementary school teacher, wife, and mother of two, Laurie Cook had her left ovary removed in January 2023, at Centennial Medical Center, in Nashville, which is part of the HCA Tristar Health System. Ms. Cook had coverage through a Christian Medi-Share plan. Because her "household requirement" (Medi-Share's equivalent of a deductible) was $12,000, she knew she would have to front the money up to that amount. So, she deliberately sought out the price.

She got a written estimate from the hospital for $5,535. She confirmed the estimate the morning of her surgery. She paid her surgeon separately in full $783. She was in an out of the hospital in just a few hours. Anesthesia time was 124 minutes. She had no complications. Then she received an itemized bill from the hospital for $61,314.

She pushed back, but eventually, her health plan paid $25,025. The hospital balance billed her for an additional $8,798, plus she has a separate surprise $2,200 anesthesia bill. The hospital has sent her to collections.

Estimates don't work. Patients need actual up front, all-in prices.

MICHIGAN — Devonaire Lesure had insurance through his employer, so he thought his gallbladder surgery would be covered. Then he got a bill for $20,000.

Five years ago, Devonaire Lesure was working for a company that helped Medicaid patients enroll in Medicaid. He had health insurance, a Cigna Obamacare plan, through his employer. In early 2019, he developed abdominal pain so extreme he went to the hospital. In the emergency room at Sparrow Hospital, in Lansing, Michigan, the doctor diagnosed gallstones, and recommended he have his gallbladder removed.

"I figured, I should be good. I have insurance through my company," he said. "I showed them my insurance card, and everything was cool, but they never went over how much it would cost." Devonaire recovered quickly, but he still hasn't recovered from the hospital bill that came for $20,000. "But what about my insurance?" he argued. This, apparently, was what he owed after insurance paid their portion.

Since then, he has been paying $250 a month, and still owes $15,000. He's had to move back home and live with his mother, because he can't afford housing with this debt. Today, he makes $40,000 a year selling Medicare Advantage plans and also doing food demonstrations in grocery stores on weekends.

Price transparency will usher in price competition driving prices down across all hospitals and protecting patients like Mr. Lesure from excessive overcharges. Gallbladder surgery at the Surgery Center of Oklahoma, for instance, costs around $7,000.

ARIZONA — Theresa Schmotzer, age 49, of Phoenix, refused to believe a hospital's inflated estimate of $28,000 for a procedure she needed. She found a real price on a pricing tool on the PatientRightsAdvocate.org website of $3,000.

In March 2024, Theresa Schmotzer, a widow, mother of two teenagers, and occupational therapist, needed outpatient laparoscopic fibroid surgery. To find out what it would cost, she contacted Gilbert Medical Center in Phoenix and her insurance company, Cigna. She got the run around. "No one could tell me what the contracted amount was for this procedure," she said. When the hospital finally gave her a number, it was an astronomical $28,000. She was supposed to fork over 15%, or $4,200 up front.

She kept researching. A medical professional, she could see that Medicare's reimbursement rate was less than $1,000. "How could my 15% co-pay be four times what Medicare pays in full?" she rightly wondered. Then she found the PatientRightsAdvocate.org price finding tool, and the information that neither the hospital nor her insurance carrier would provide. The total contracted price for her procedure under her insurance plan was around $3,000. Her share was $781. She told both the hospital and her insurance company where they could find the price, then paid the hospital $781 up front, and had the procedure with financial certainty. When she got her Explanation of Benefits, the amount matched that shown on the online pricing tool.

Shopping Pays: When prices are transparent, patients can arm themselves with real prices and protect their financial health. # # #