



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted to <https://www.regulations.gov/>

September 21, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1695-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for Potential CMS Innovation (CMS-1695-P)

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Hospital Outpatient Prospective Payment System proposed rule, which includes a request for information (RFI) on price transparency: improving beneficiary access to provider and supplier charge information.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

ASHA requests that CMS clarify whether the price transparency RFI applies to Medicare Advantage and Medicaid as well as traditional Medicare.

As foundational tenets, ASHA is committed to: 1) improving patients' access to information on the price of their care, and; 2) protecting patients from unexpected financial exposure. ASHA recommends that CMS adopt requirements similar to Section 7 (Requirements for Participating Facilities with Non-Participating Facility-Based Providers) of the National Association of Insurance Commissioners (NAIC) Health Benefit Plan Network Access and Adequacy Model Act. The NAIC Network Adequacy Model Act offers financial protections to patients by limiting their OOP costs in emergency and non-emergency situations via a mediation process between the payer and provider.¹ In non-emergency situations, the patient's costs may be reduced or eliminated based on the outcome of the mediation; opposed to emergency situations where the patient is guaranteed protection from the bill.

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) solicits input on ways to make more useful pricing information available to patients. ASHA appreciates the opportunity to provide comments on the following questions outlined in the RFI:

- How should CMS define “standard charges” in various provider and supplier settings?
- Should providers and suppliers be required to disclose out-of-pocket (OOP) costs before a service is furnished?
- How can CMS help beneficiaries better understand how copays and coinsurance are applied to each service covered by Medicare?

How should CMS define “standard charges” in various provider and supplier settings?

When considering how to define “standard charges,” CMS must keep in mind that “total charges,” “amount payable,” and “patient responsibility” all have different meanings. **ASHA maintains that Medicare patients are more interested in knowing their OOP costs rather than the “standard charge” for a particular item or service** since more than 90% of Americans have health insurance coverage—of which 14% are covered by Medicare.² Given the structure of the U.S. health care system, it is ultimately the payer who determines an individual’s financial obligations. That information also depends on whether the health plan covers the service and the cost-sharing requirements imposed by the plan.

ASHA asserts that it is not the provider’s or the supplier’s responsibility to provide information on what Medicare pays for a particular service. **Therefore, ASHA recommends that CMS create a consumer-friendly resource to highlight key aspects of the Medicare Physician Fee Schedule in hardcopy and/or on the internet in a machine-readable format that providers or suppliers could direct patients to, as needed.**

Should providers and suppliers be required to disclose OOP costs before a service is furnished?

The provision of health care is complex, and often the exact course of treatment is unknown in advance or may change depending on the unique needs of the patient. ASHA does not recommend requiring providers and suppliers to give cost estimates for services given the inherent uncertainty of health care. In addition, the patient’s level of understanding of their health care coverage may make providing appropriate pricing information more challenging. For example, patients in high-deductible health plans can be initially overwhelmed and surprised by their OOP costs and it is outside a provider’s or supplier’s scope of practice to discuss such a complicated issue.³ **Therefore, ASHA recommends that CMS convene a multi-stakeholder workgroup (e.g., providers, payers, patients) to discuss how price transparency, health literacy, and the sharing of information on health plan benefit structures such as cost-sharing can be improved.**

How can CMS help beneficiaries better understand how copays and coinsurance are applied to each service covered by Medicare?

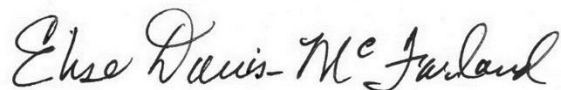
In lieu of requiring providers and suppliers to provide cost estimates to patients, ASHA suggests that CMS develop an OOP cost comparison tool and Summary of Benefits and Coverage (SBC) document for Medicare.⁴ The OOP cost comparison tool, which is currently

used by consumers in the federally-facilitated marketplaces, allows consumers to see estimates of total spending (i.e. premiums, cost-sharing) across various health insurance plans. Another benefit of the OOP cost comparison tool is that consumers are able to select a utilization level for each family member—low, medium, or high—and can see what each level means in terms of estimated costs related to physician visits, rehabilitation sessions, and prescriptions.

The current SBC document provides clear, transparent, consistent, and comparable information about health plan benefits and coverage to 180 million Americans. Individuals receive the SBC when shopping for or enrolling in coverage at each new plan year and within seven business days of requesting a copy. The Uniform Glossary of Terms (Uniform Glossary) helps consumers understand commonly used terms in health insurance.⁵ A report from 2013 found that 51% of Americans did not understand basic health insurance terms such as premium, deductible, and copay.⁶ Together, the SBC and Uniform Glossary documents can improve consumers' health literacy by explaining, in plain language, a health plan's insurance coverage and benefit offerings. The OOP cost comparison tool and the SBC allow consumers to not only understand their health care costs, but also empowers consumers to select the right plan or health care provider that meets their unique needs. **ASHA encourages CMS to adopt similar price transparency tools for Medicare beneficiaries in support of CMS' goal to promote consumer choice.**

Thank you for the opportunity to provide comments on the RFI on price transparency. If you or your staff have any questions, please contact Daneen G. Sekoni, MHSA, ASHA's director for health care policy, health care reform, at dsekoni@asha.org.

Sincerely,



Elise Davis-McFarland, PhD, CCC-SLP
2018 ASHA President

¹ National Association of Insurance Commissioners. (2015). *Health Benefit Plan Network Access and Adequacy Model Act*. Retrieved from <https://www.naic.org/store/free/MDL-74.pdf>.

² Henry J. Kaiser Family Foundation. (2017). *Health Insurance Coverage of the Total Population*. Retrieved from: <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

³ Henry J Kaiser Family Foundation. (2017). *Listening to Trump Voters with ACA Coverage: What They Want in a Health Care Plan*. Retrieved from <http://kff.org/health-reform/issue-brief/listening-to-trump-voters-with-aca-coverage-what-they-want-in-a-health-care-plan/>.

⁴ Centers for Medicare & Medicaid Services. (n.d.). *The Center for Consumer Information & Insurance Oversight*. Retrieved from <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/>.

⁵ U.S. Centers for Medicare & Medicaid. (n.d.). *Glossary of Health Coverage and Medical Terms*. Retrieved from <https://www.healthcare.gov/sbc-glossary/>.

⁶ Alliance for Health Reform.(2015). *Health Literacy and Health Insurance Literacy: Do Consumers Know What They Are Buying?* Retrieved from http://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-Literacy-Toolkit_163.pdf.