American Hospital Association™
Advancing Health in America

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Subject: No Surprises Act – Good Faith Estimates and Advanced Explanation of Benefits

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) looks forward to working with you on implementing the good faith estimates and advanced explanation of benefits (EOB) required by the No Surprises Act. We are very supportive of efforts, such as these, to better help patients access the information they need as they prepare for their care, including price information. **The new law appropriately supports getting patients what they need to make care decisions. However, a number of operational details must be established to make implementation of these policies technologically feasible. We urge you to work with all affected stakeholders to address these issues in the most efficient way possible to ensure patients have access to accurate pricing information.**

Over the last several years, patients have seen increased access to information about their health care costs as a result of technological advances and federal and state policies. Now, most patients have access to several different types of estimates from many different sources, including the patient's provider, their insurance company (if insured), state-based websites and private companies (see attachment 1). Depending on the source of the estimates and the inputs included (e.g. common ancillary services,

other providers), these estimates will assuredly vary, and we continue to be concerned that introducing new options that are not aligned to what already exists will hinder, not help, patients' understanding of their cost obligations. **First and foremost, we urge the agency to take steps to align the different price transparency policies that exist today to minimize any confusing or conflicting information for patients. Doing so also will help mitigate the substantial new costs added to the health care system of implementing each of these distinct policies.**

The different types of estimates that exist today include:

- *Patient-specific, pre-service cost estimates.* These estimates provide patients information on what they should expect to pay based on their individualized insurance information and require coordination of information across providers and insurers. Hospitals and insurers have historically had processes in place to develop these estimates on a case-by-case basis as patients request them, either in-person or over the phone. More recently, many hospitals and insurers have each created web-based, self-service tools that patients can use to search for cost estimates. These types of tools entered the market a few years prior to the Hospital Price Transparency[1] and Transparency in Coverage[2] rules, but were not widely adopted before 2020. The increase in vendors in this space, lower costs to implement, and the new federal requirements are all attributing to more widespread adoption across the field.

  Patient-specific, cost estimator tools typically use a combination of provider-specific information (such as historic claims and provider-payer contract terms) and coverage details (such as where the patient is in their deductible and their co-payment amounts) to create an individualized pre-service estimate. These estimates may vary depending on which details are included in the estimate. For example, some estimate algorithms are sophisticated enough to include the ancillary services most likely to be included based on patient-specific information, whereas others include the ancillary services most commonly associated with the service, regardless of patient characteristics. This variance can depend on the sophistication of the tool, as well as the relationship between the hospital where the service is provided and the physicians delivering the services.

- *Average price comparison tools.* For more generalized information on the price of health care services, there are a number of tools that allow users to look up and compare average prices of services. The averages can be based on a geographic area (e.g., state, county) or a particular provider/hospital or payer. There are a number of these tools in the market now, ranging from state-based initiatives, such as the NH HealthCost, to privately run search engines, such as FAIR Health. Generally, these tools use historic claims data, such as from a

[1] 85 FR 58432
[2] 85 FR 72158

state's all-payer claims database, to calculate estimates. These types of tools have been available for the longest amount of time but have never been widely used by consumers. This likely is because they give only the total average price and cannot predict what the patient portion will be.

- *Payer-specific negotiated rates for services.* The Hospital Price Transparency Rule and Transparency in Coverage Rule[3] require hospitals and insurers to publicly release their negotiated rates (and, for insurers, out-of-network allowed amounts) in machine-readable files. These files are not particularly useful for a patient, as they include thousands of data points in a format that is not easy to navigate. In addition, many of the rates included in the spreadsheets may not be applicable for a given patient's situation as the rate could be adjusted based on the quality outcome of the service, whether multiple services are being delivered at the same time, or any of a number of other factors. Despite these limitations in the data, some private vendors are trying to use the files to create more consumer-friendly tools. These tools, however, likely will be less reliable than the patient estimator tools, which use more sophisticated modeling that relies on historic claims information and can more accurately bundle all of the items and services relevant to a particular episode of care.

The No Surprises Act adds another avenue for patients to access cost information: the advanced EOBs. Insurers will be responsible for producing the advanced EOBs for patients that schedule or are considering health care services, utilizing the good faith estimates of charges sent by the provider. The advanced EOBs will include helpful information including how much the insurer and patient should each expect to pay for the service, where the patient is in terms of meeting their deductible and out-of-pocket maximum, and if the service is subject to any medical management such as prior authorization. We are very supportive of this provision, as we believe it can provide the patient accurate and timely information on the cost of their care and other important information about their coverage for a particular service. However, the law created a very tight timeline of Jan 1, 2022 to implement this provision, and we are concerned that implementing this provision without alignment with the other price transparency policies could result in more confusion for patients about their expected cost for care. For example,

- What is the scope of this provision? We interpret the statute to only require the advanced EOB "upon request" for certain scheduled services. However, if the policy were to be implemented to require an advanced EOB for all scheduled services, patients could receive this estimate after having sought out cost information in another way. Given the variation in inputs and approaches identified above, there is a very real likelihood that the information could conflict. **We strongly urge the agency to only require the advanced EOB upon patient request.**

[3] Goes into effect January 1, 2022.

- When a patient calls their provider for an estimate, can the provider still develop an estimate through their own process or does the request automatically trigger an advanced EOB?
- If multiple options remain for patients, how can the field better educate consumers about the considerations for when to use one of these pathways over another?

We strongly urge the agency to work with a multi-stakeholder work group of patients, providers, insurers and technology vendors to clearly define a common objective for pricing tools, agree to the most useful tool(s) for patients, and develop a standard approach for implementation. We may not be able to create one single source of truth, but we should strive to collectively focus our limited resources on those efforts that are most likely to be used by and be of benefit to patients. We continue to stand by those estimates generated using patient-specific care and coverage information, such as what is required for the advanced EOB.

Generating the advanced EOB, however, will require new technology and information flows. Ideally, providers and payers would adopt a single standard approach to ensure that patients have a consistent experience requesting and receiving advanced EOBs and that the estimates are accurate. Developing such standards takes time, and we estimate the field will need at least 24 months to achieve full implementation. The remainder of this letter focuses on our technical questions and concerns regarding implementation.

Information Exchange Formats

Patients, providers and health plans must collect and transmit information at several key stages during the creation of an advanced EOB. To ensure that the advanced EOBs are reliable and do not add significant additional cost to the health care system, we recommend that CMS issue regulatory guidance on the following:

- *Alerting Affected Providers*. For many scheduled services, multiple providers will participate in delivering patient care. For example, a scheduled hip replacement surgery likely will include services provided by a facility, surgeon and anesthesiologist. For the advanced EOB to be accurate, it should include information on all of these components of the episode of care. Presumably, however, the patient only will request an advanced EOB (or good faith estimate) from one of the providers – in this example, likely either the surgeon or the facility. Therefore, one of the first steps that must occur is alerting all providers involved in the patients' care that a request has been received so that they can submit their respective charges and codes to the insurer.

  Although requiring the provider who receives the request to alert the other providers/facilities seems logical, this would require a workflow change that will take time to implement. Additionally, there is not currently an automated means

of completing this request, which would therefore require the provider to complete this step manually.

- *Delivery of Good Faith Estimate to Health Plans*. To streamline administrative processes across the health care system, the Health Insurance Portability and Accountability Act (HIPAA) established standard electronic transactions for information exchange between providers and health plans. The HIPAA standards enable providers to use a consistent method of transmitting information to all of the various health plans with whom they do business, resulting in reduced timelines and significant health care savings. According to the 2020 CAQH Index, the U.S. medical industry saves $9 billion annually through the utilization of standard electronic transactions.

  The current HIPAA standard claims transaction (5010 X12 837I/837P) does not allow providers to send advanced, preliminary claims to health plans for the creation of an advanced EOB. X12, the national standards group that develops and maintains these standards, has created the "Health Care Predetermination" transaction to carry preliminary claims information, but this transaction is not mandated under HIPAA, and its capabilities have not been incorporated into provider/payer systems and workflows.

  To avoid creating significant administrative waste and added business costs, we recommend that CMS establish a HIPAA administrative standard for the transmission of good faith estimate information from providers to health plans. Historically, HIPAA administrative transactions are enforced 24 months following publication, which allows providers and health plans sufficient time to upgrade their systems and incorporate the new workflows. Accordingly, we recommend that CMS delay enforcement of the regulation by 24 months from the final publication date of the transaction.

- *Delivery of Advanced EOB to the Patient.* The legislative requirements call on health plans to deliver the advanced EOB directly to the patient. This differs from the current claims workflow that requires plans to send remittance information to the providers along with their claims payment.

  The statute does not establish the transmission method and format for the health plan to deliver the advanced EOB to the patient. For the advanced EOB to be useable, patients must be able to understand its contents and securely receive it in a timely manner. Typically, patients receive information concerning their benefit payments from health plans through the mail, but that process is likely too slow for this purpose. Additionally, using email could prove insecure for the delivery of patient health information. **In order to ensure that patients can use the advanced EOB, CMS should identify a secure electronic method of delivery and delineate the appropriate advanced EOB content format.**

Unanticipated Additions or Changes in Procedures

To deliver the most accurate financial picture to a patient, health care providers need to provide an accurate account for each expected charge for which they will bill as part of a procedure. However, quality patient care frequently involves adjusting based on patient-specific, unanticipated medical needs that present at the time of treatment. In fact, a number of scheduled services rely on day-of pathology to determine the appropriate course of care, such as the amount of an intravenous drug. **In order to ensure that providers are able to provide medically necessary care, CMS should specify that good faith estimates are subject to change based on patient-specific, non-routine care.**

Additionally, certain procedures involve a high-variance in medically necessary care based on coding issues, complexities in care, and more dynamic patient needs. In such instances, an advanced EOB would have a higher frequency of providing inaccurate financial responsibilities. **In order to protect the reliability and accuracy of the advanced EOB, we urge CMS to limit this program to routine, low-variance procedures.**

Other Billing Issues

In order to promote advanced EOBs that accurately reflect the content and financial responsibilities of an eventual claim for services, providers and health plans need additional guidance regarding the following additional billing issues:

- *Coordination of Benefits/Multiple Insurers*. Following a service, health plans have coordination of benefits policies in place dictating how claims are paid for patients with multiple insurers. Such policies include a multi-stage process involving the delivery of patient claims information between various health plans for adjudication. It is unclear how this process would work for an advanced EOB, particularly given the rapid time requirements. **We request that the agency provide clarity around how the advanced EOBs should work when a patient has multiple forms of coverage and specify in guidance that providers are only required to share the good faith estimates with the primary insurer.**

- *Additional Information Needed to Process Claims.* Frequently, health plans and providers engage in multiple communications concerning a claim prior to final adjudication. While claims' timeframes permit such interaction, the advanced EOB deadlines make such communications infeasible. **CMS should release information as to how plans and providers are to address good faith estimates that require additional information for adjudication.**

- *Prior Authorization/Utilization Management*. Health plan prior authorization and other utilization management programs are frequently barriers to whether patient care qualifies for coverage. These processes frequently take multiple days or

even weeks. **In order to ensure that patients are not misled into obtaining care for which plans deny coverage, advanced EOBs should clearly indicate that their financial information may be subject to additional plan utilization management policies that could reduce or eliminate the indicated plan payment amounts.**

- *Order of Adjudication.* As a result of high deductibles, cost-sharing, and tiered benefit structures for differing treatments, the order in which a patient's claims are processed may have a significant impact on their financial responsibility. For example, if a service for which a plan offers 80% coverage is processed against the deductible before a service with 60% coverage, the patient's expected cost would be significantly less than if those claims were reversed. **In order to prevent this issue, CMS should issue clear guidelines to ensure that plans process claims in the same order as they do a preceding advanced EOB.**

We look forward to the opportunity to work with you on the good faith estimates and advanced EOB policies. Please contact me if you have any questions or feel free to have a member of your staff contact Molly Smith, group vice president for policy, at 202-626-4639 or MollySmith@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President

Attachment 1: Patient Options for Cost Information Prior to Care