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November 7, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin Walsh
Secretary
U.S. Department of the Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Ms. Kiran Ahuja
Director
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

RE: Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals (RIN 0938-AU98) CMS-9900-NC

Dear Secretary Becerra, Secretary Walsh, Secretary Yellen, and Director Ahuja:

The Association of American Medical Colleges (AAMC and the Association) welcomes the opportunity to submit comments on the request for information entitled "Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals" 87 *Fed. Reg.* 56905 (September 16, 2022), issued by the Departments of Health and Human Services, Labor, and Treasury and the Office of Personnel Management (the Departments).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

This request for information (RFI) asks for feedback on how the Departments should operationalize the requirement for providers to issue a good faith estimate (GFE) for insured patients. Under the requirements, providers would send the GFE to the patient's insurance plan which in turn would

generate an Advanced Explanation of Benefits (Advanced EOB) for the patient. This letter outlines the AAMC's concerns and recommendations in response to the RFI.

Ensure Patients' Access to Medically Necessary Care

The AAMC and its members support safeguards to protect patients from surprise medical bills and inform patients of their cost-sharing liabilities for health care items and services. Hospitals have developed online calculators for patients to access cost information about certain procedures to assist patients and their families with understanding their cost-sharing liability. Patients can see the cost of some services and the associated cost sharing depending on whether they utilize health insurance or not. However, the AAMC and its members are deeply concerned that some patients, including those with insurance coverage, may delay needed care based on their cost-sharing liability.

As outlined in the No Surprises Act, insurance plans will be required to send patients enrolled in their plans an Advanced EOB outlining the cost of the scheduled items and services, how much the insurance plan will pay, and the patient's cost-sharing liability. Without additional information on whether a patient may qualify for some form of financial assistance that is not reflected on the Advanced EOB, we are concerned that some patients will forgo needed care because they cannot pay. For example, a patient diagnosed with cancer could require a PET scan to determine the extent of their cancer and to develop a treatment plan. However, the cost-sharing liability noted on the Advanced EOB could lead the patient to choose not to undergo the scan, potentially limiting access to all possible treatment options. Complex health insurance arrangements with differing patient cost-sharing liability should not put patients in the position of having to forgo needed care because they cannot afford it.

Although hospitals have in place financial assistance programs, not all patients may qualify. As required by the Internal Revenue Service through the tax code, not-for-profit hospitals must have in place policies that specify the criteria that must be met to qualify for free care (sometimes referred to as charity care) or financial assistance which includes reduced cost and/or payment plans. Qualifying for assistance typically requires the patient to submit an application to the hospital followed by a review and determination of how much assistance, if any, for which the patient qualifies. This process is time consuming and can take several weeks, sometimes because it takes time for patients to provide the needed information. Providers will be unable to determine the discounted charges to include in the good faith estimates until they receive information on the patient's eligibility for financial relief. Given the GFE requirements, if the service or item can be delayed without harming the patient, a provider will most likely wait until after a determination is made regarding the financial assistance for which the patient qualifies before scheduling a procedure to ensure that the patient receives an accurate good faith estimate.

Delay Implementation of the Advanced EOB for Insured Patients Until a Standardized Framework is in Place

To promote greater price transparency, the No Surprises Act requires health plans to deliver an Advanced EOB to patients before care is provided. Insurers create the Advanced EOB by using a good faith estimate of expected charges from providers. Providers must transmit the GFE at least 3

business days before the service is furnished and no later than one business day after the service is scheduled. For services scheduled more than 10 business days in advance, the provider needs to furnish the information within 3 business days of the patient requesting an estimate or scheduling a service.

Today, many individuals are enrolled in health plans such as high-deductible health plans or short-term limited duration plans that require them to shoulder more of the costs of care, making them particularly sensitive to their out-of-pocket costs. The AAMC understands the importance of price transparency for patients to ensure that they understand their out-of-pocket costs when seeking health care. Many of our nation's teaching hospitals have already responded to this call by developing price estimator tools at their institutions, which allow patients to access their coverage and cost-sharing information as it applies to the services they are seeking.

We supported the decision by the Departments to delay implementation of provisions in the Public Health Service Act (section 2799B-6(2)(A)) which would require providers and facilities to furnish GFEs to **all** individuals and instead supported that initially the good faith estimate would be limited to individuals who are uninsured (or self-pay). We believe it is important to continue to delay enforcement of the application of this provision to insured individuals until a standard industry process for information exchange can be adopted through regulations to ensure timely and accurate estimates can be provided.

Require Each Billing Provider to Submit a GFE to Insurers Only for Items and Services They Directly Bill

We urge the Departments not to adopt a convening provider/co-provider framework for the insured population that is similar to what was established for uninsured and self-pay good faith estimates. For uninsured and self-pay patients, the rule requires that the convening provider or facility contact all applicable co-providers and co-facilities no later than 1 business day after the request for the GFE is received or after the primary item or service is scheduled and the patient requests submission of expected charges for the items or services. Creating GFEs that include services providing by convening providers and other co-providers and co-facilities is challenging. It requires providers and facilities to establish systems and procedures for providing and receiving the required information from other providers and facilities. AAMC members report that it is difficult and costly to operationalize this process for the uninsured and self-pay patients. To create these GFEs, providers are implementing new workflows (often manual) and communication channels to exchange information between providers in addition to having to purchase costly technology updates to support these processes.

While we understand the value of investing time and resources to provide this information to uninsured/self-pay patients, furnishing these GFEs for insured patients differs significantly from uninsured patients. The good faith estimates provided to uninsured/self-pay patients provides them with information directly from the provider about their expected out-of-pocket costs. In contrast, good faith estimates prepared by providers for insured patients and sent to insurers would not be an accurate measure of the patient's actual out-of-pocket costs. To determine out-of-pocket costs for an insured patient, the insurer applies claims edits, contractual requirements, and health care

coverage/benefits to the information received from the provider. In order for a GFE to be used by a payer to produce an Advanced EOB, the provider would need to include codes on the GFEs, (e.g., modifiers, revenue codes) that the payer would use to adjudicate the claim and determine a patient's expected cost sharing. Furnishing the information to payers is further complicated when both professional and facility providers are involved in the patient's care. The forms and electronic transactions used to report claims information are significantly different for institutional providers (UB-04/837I) and professional providers (CMS-1500/837P), and these forms require different information for the insurers to determine patient cost-sharing responsibility.

Applying the convening provider/co-provider framework to insured patients will result in excessive burden for providers and is likely to result in patients' confusion over their health care costs and possibly delayed care. The volume of comprehensive GFEs that providers would need to create if this requirement is applied to the insured population would be overwhelming. Since the time frame to gather the information for the GFE from co-providers and co-facilities is so short, providers may need to wait to schedule treatment. Furthermore, the burden of gathering this information is unnecessary since insurers are already capable of processing claims from distinct providers.

There is also the concern that requiring co-providers to supply proprietary information on rates to the convening provider could violate confidentiality agreements between the providers and insurers and antitrust laws. Convening providers should be held harmless if co-providers refuse to share rates due to contractual agreements with insurers.

Given the difficulty of implementation and the limited value to the insured patients, we urge CMS to allow each billing provider to submit their own GFE to the health plan only for items and services that will be billed to the patient's health plan. The responsibility for combining the GFEs into one Advanced EOB should rest with the insurers. Since insurers already receive and process claims from distinct providers, it is unnecessary to require the convening provider to obtain the information about charges from other providers. Accurate Advanced EOBs could be best established by leveraging existing provider and health plan workflows, standards, and technologies for claims submission and adjudication.

Align Prior Authorization and Advanced EOB Requirements

Prior authorization is a tool that payers often use to manage utilization of certain medical services. Prior authorization refers to a requirement by insurers to obtain approval of health care items, services, or medications before the care is furnished. Insurers have long used prior authorization and other utilization management tools to determine prior to payment whether they will cover the cost of the care. The standards used to determine coverage are typically developed by plans themselves.[1] However, the process for obtaining prior authorization can vary significantly among insurers, including the amount of required information and the insurers turnaround time. These requirements and potential for slow response times from insurers can delay needed medical care. Further, denials

[1] https://www.kff.org/policy-watch/examining-prior-authorization-in-health-insurance/

by insurers can often result in patients forgoing medically necessary care or abandoning prescription drugs at the pharmacy counter.

Under the No Surprises Act, only disclaimers indicating whether coverage is subject to any medical management techniques, including prior authorization, will be required on the Advanced EOB. (p. 56906). We recommend that the Advanced EOB state whether the items and services referenced in the GFE and Advanced EOB are authorized and therefore will be covered by the insurer. This will decrease confusion for the patient and hopefully expedite the prior authorization process. Additionally, the insurer should be required to inform the provider of the approval / denial of the prior authorization. The Departments noted in a previous interim final rule with comment[2] that nonparticipating providers' ability to obtain information related to prior authorization or care management imposed by the insurer could be burdensome, as nonparticipating providers and facilities typically do not have access to these requirements. Including prior authorization determinations on the Advanced EOB will inform patients about whether the items and services will be paid even if performed by a nonparticipating provider.

However, the information in the Advanced EOB should not be used to make determinations related to medical necessity that relies on clinical judgment. While the provider furnishes its best estimate of services that will be provided, it may not provide all the clinical documentation that supports the need for furnishing the services until the service is billed. We urge the Department of Health and Human Services in coordination with the Office of the National Coordinator for Health Information Technology to work to streamline prior authorizations processes by establishing a standardized prior authorization process, including requirements that health plans issue prior authorization determinations in a timely manner to ensure access to medically necessary care is not delayed. This includes optimizing the use of electronic prior authorization capabilities within the certified health information technology to reduce burden for providers.[3]

Do Not Require the Notice and Consent Waiver be Sent to the Insurer with the GFE

The RFI asks whether at the time a GFE is submitted a provider or facility should be required to inform the insurer of the patient's decision to waive certain surprise billing restrictions, thus allowing balance billing. (p. 56908). Providers should not be required to submit to the insurer notice and consent documents indicating that a patient agrees to be balance billed. Currently, there is no standardized format for submitting these documents. Notice and consent is typically not obtained at the time of scheduling, which generates the requirement for a GFE. Patients usually make the appointment via telephone and therefore would not be able to sign a notice and consent document. Therefore, we do not believe the waiver information should be associated with submission of the GFE.

Leverage Price Transparency Tools to Minimize Burden on Patients and Providers

The RFI seeks feedback on ways to optimize the use of internet-based self-service tools to inform patients of their cost-sharing liabilities. (p. 56909). The Departments should leverage existing price

[2] 86 FR 36908
[3] https://www.aamc.org/media/60126/download

transparency tools, including the use of online calculators to provide patients with estimates of care. Some hospitals have developed comprehensive online calculators to assist patients in understanding their out-of-pocket costs. The online, self-service tools developed by plans could potentially save time in producing an Advance EOB, particularly when services are scheduled less than 72 hours in advance, when a patient is referred to a provider the same day, and for services that have a fixed cost sharing such as a copayment. Plans' internet-based tools will also provide patients with real-time information about cost-sharing, particularly where they are in fulfilling their deductibles. Additionally, the Departments should consider not requiring a GFE for in-network services with a fixed patient copayment, such as certain office visits (e.g., evaluation and management codes).

Verifying Patients' Eligibility for Coverage Rests with the Insurers

Providers and facilities may not fully understand the extent of a patient's insurance coverage simply based on the information the patient provides or the information on the insurance card. While an eligibility check to confirm insurance coverage is a preliminary step a provider or facility may take, this high-level check may not convey the type of coverage the patient has nor whether the items and services that may be included on the GFE will be covered. For example, the provider or facility may not know that a patient is in a plan that offers limited coverage, or whether the patient is in a plan that is not subject to the No Surprises requirements, such as a short-term, limited-duration plan. Therefore, the plans and issuers are in the best position to determine and convey to providers patients' eligibility and accurate information about coverage of certain services, rather than providers and facilities relying on patients' information or information on an insurance card.

CONCLUSION

Thank you for the opportunity to provide input on this request for information on operationalizing the Advanced EOB to inform patients about their cost-sharing liability and ensure appropriate payment to providers. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at mmullaney@aamc.org and Gayle Lee at galee@aamc.org.

Sincerely,

Rosha C. McCoy MD

Rosha Champion McCoy, M.D., F.A.A.P.
Acting Chief Health Care Officer

cc: David J. Skorton, M.D., AAMC CEO and President
Ivy Baer, JD, MPH, Senior Director and Regulatory Counsel