U.S. PIRG

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November 14, 2022

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

The Honorable Martin J. Walsh
Secretary
U.S. Department of 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

The Honorable Chiquita Brooks-LaSure,
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS - 9908 - IFC
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Secretaries Becerra, Yellen, and Walsh, and Administrator Brooks-LaSure:

On behalf of U.S. PIRG (Public Interest Research Group) and our state affiliates, thank you for the opportunity to submit comments on the Request for Information on Advanced Explanation of Benefits (AEOBs) and Good Faith Estimates (GFEs)[1], important consumer provisions required by the Consolidated Appropriations Act of 2021. PIRG is a nonprofit public interest consumer advocacy organization that speaks out for a healthier, safer world which includes promoting policies that support the delivery of high value health care. For too long, patients have been unable to predict the cost of health services when they schedule care. Strong rules ensuring accurate and reliable estimates of scheduled care are essential to help families understand their financial responsibilities.

We request consideration of our comments below and are happy to discuss these ideas further.

General comments. With rising health care prices, even insured families face significant out-of-pocket costs. We've heard from patients who now delay care or avoid treatment because they fear an unknown medical bill and the impact that bill could have on their family. Health care services are one of the very few expenses that families must pay for without knowing the cost before they receive the service.

[1] Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals Federal Register, September 16, 2022. https://www.federalregister.gov/documents/2022/09/16/2022-19798/request-for-information-advanced-explanation-of-benefits-and-good-faith-estimate-for-covered?utm_medium=email&utm_campaign=subscription+mailing+list&utm_source=federalregister.gov

We have been excited to see the strides we've made in the past few years with a dramatic increase in the amount of health care price transparency. Hospitals[2] and health plans[3] must now post prices of health services. Advances in technology have enabled complex health pricing data to be collected and shared in a more timely fashion. Though important to informing overall health policy, these detailed databases are not helpful to insured individuals who want to know what they will have to pay for needed treatment. We know the health care industry has been calling for delays in any implementation or enforcement of the requirement to provide AEOBs to patients. Providers argue that we must wait for "established standards" and "automated workflows" before any AEOB should be required. Without these uniform systems, the industry claims it is difficult for providers to share good faith estimates with health plans and plans argue without that information, it is impossible to provide AEOBs to patients.

This excuse is hard to accept. It's been two years since the passage of this requirement. And we know that claims and negotiated rates are obtainable because providers are often quick to submit billing codes and other information to plans for payment, and patients get EOBs shortly afterwards. The information is already flowing when it comes to sending the "bills" after the health services are delivered, so it is difficult to believe that these systems can't be adjusted to make an advanced estimated bill available to patients. Patients deserve to know their cost of scheduled care in advance and should be able to rely on that AEOB to make appropriate financial decisions as it relates to their medical treatments. We urge you to swiftly move from this request for comments to formal rulemaking. Every month of delay in implementing AEOB rules is another month during which some patients will hesitate to seek care because of unknown costs, or will schedule care but then be overwhelmed by their financial obligations that they couldn't anticipate.

QUESTIONS: *Are there any approaches that the Departments and OPM should consider, or flexibility that should be provided (such as an exception or a phased-in approach to requiring providers and payers to adopt a standards-based API to exchange AEOB and GFE data), to account for small, rural, or other providers, facilities, plans, issuers, and carriers? If the Departments and OPM were to provide such flexibility, what factors should they consider in defining eligible providers, facilities, plans, issuers, and carriers?*

RESPONSE:
Do not delay implementing the AEOB requirements but if necessary to ensure more complete accuracy and reliability to the provision of AEOBs, a phase-in might be appropriate. However, we urge full implementation of AEOB requirements before the end of 2023 for *at least* the most commonly scheduled procedures and treatments. For a limited phase-in, we recommend considering the same procedures identified in the hospital transparency law: at least 300 "shoppable services" that a patient can schedule in advance. Hospitals already have developed databases for these charges, and plans should already know the negotiated rates for these services.

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[2] 45 CFR §180.60, https://www.federalregister.gov/d/2019-24931/p-1030 and https://www.cms.gov/hospital-price-transparency

[3] 26 CFR § 54 https://www.govinfo.gov/content/pkg/FR-2020-11-12/pdf/2020-24591.pdf and https://www.cms.gov/healthplan-price-transparency

However, it is also essential to recognize the need for reliable advanced cost information to be provided for patients with particularly complex or unique individualized care treatment. We recommend consideration of a cost-threshold to trigger the requirement of an AEOB, even if it is not within the most commonly "shoppable services" list.

QUESTIONS*: Should a nonparticipating provider of non-emergency services be required to inform a plan, issuer, or carrier, as part of or concurrently with the GFE, whether the requested or scheduled items or services would be furnished with respect to the individual's visit to a participating facility? ? Should this requirement depend on whether the GFE was requested, as opposed to whether the furnishing of the items or services has been scheduled?*

In instances in which it is permissible for a nonparticipating provider or facility to request consent from an individual to waive the No Surprises Act's balance billing and cost- sharing protections, should the provider or facility be required to inform a plan, issuer, or carrier of the individual's consent, as part of or concurrently with providing the GFE, if it has already obtained the individual's consent? Should the nonparticipating provider or facility also be required to inform a plan, issuer, or carrier if the provider or facility intends to seek consent, or if the individual has already declined to give consent?

If a nonparticipating provider or facility is required to inform a plan, issuer, or carrier, as part of or concurrently with the GFE, about the status of a consent to waive the No Surprises Act's balance billing and cost-sharing protections, how should the notice and consent timing requirement be coordinated with AEOB and GFE timing requirements?

RESPONSE:

Reliable, accurate and uniform AEOBs. The RFI proposes many questions as to the information required by each entity in the creation of an AEOB. We urge the Departments to review the technical details with the goal of creating a uniform format that includes the necessary information to make the AEOBs as close to reliable and accurate as possible. With this first foray into providing patients *advance* notice of costs, we have an opportunity to finally put important financial information into the hands of consumers. Insured individuals are facing more and more out-of-pocket costs as health care prices rise and benefits are designed to keep premiums from rising too much while still covering those increased prices. As a result of this cost-shifting, patients face expensive unexpected bills which they can't avoid or prepare for.

However this new requirement offers a unique opportunity to provide families key information about the cost of their scheduled care. To be of any effect, it is important that AEOBs are reliable and accurate. We often hear from consumers that they stack their medical bills into a pile, dreading the day they have to open and decipher them. And many patients can't even rely on the bills they receive after care. In fact, one advocate has written a book entitled, Never Pay the First Bill - a testament that medical bills are unreliable and complex. We urge the department to launch this new initiative by creating a uniform AEOB form that all plans must use. Uniform formats will best facilitate conveyance of this information to patients. As consumer

advocates, a consistent format will allow us to educate patients on how to read and understand these new documents and help them develop the health literacy skills that are sorely lacking today. A uniform, reliable AEOB will go a long way to help consumers understand their costs and provide them the information they need to work through the bills when they do arrive. We recommend that patients receive an uniform AEOB first, and when they receive the follow up EOB, that it follows a comparable format with the AEOB restated in this same EOB. The forms should be written in clear language and offered in common languages for that health plan's beneficiaries.

Full exchange of information to assist patients in understanding their financial obligations. The exchange of information between providers and plans should be complete, so the patient can contact either the provider or the plan and receive the same answers relating to their financial obligations. Non-participating providers should be required to fully communicate with plans about their efforts to secure a Surprise Billing Waiver/Consent from any patients, whether consent was granted, and a copy of any executed waiver/consent form, including the amount of the estimate of costs for that out-of-network care. Without this full exchange of information, patients will be at a disadvantage, and the AEOB will not be reliable for a patient to know their expected costs for that care. For example, if only the provider has a copy of a signed Surprise Billing Waiver/Consent form, the health plan will be unable to give an accurate AEOB because it would not account for the out-of-network balance billing the patient will owe because they have waived their surprise billing protections. It is essential that both the providers and the plans are conveying the same information relating to what the patient will owe.

Timeliness is important for situations where non-participating providers intend to secure a waiver. Early notice would better help patients avoid unnecessary costs. With advance knowledge of a consent form, plans could assist patients who signed a waiver/consent form to find an alternative in-network provider. Patients could then cancel the waiver before services are delivered and thereby avoid additional expenses.

AEOBs also offer a unique opportunity for plans to flag to patients any requirements for "prior authorization" so patients have enough time to obtain it. If the plan highlights services that need "prior authorization" it will assist consumers and help them avoid denied claims.

AEOBs should not impede standard in-network primary care or preventive services. Although the AEOB should work to help patients benefit from price transparency, it should not stand in the way of patients receiving standard in-network primary care or preventive services. As such, if provision of AEOB means the patient cannot get a flu shot or preventive screening at the same time they are already in the doctor's office, the AEOB requirement should be waived, particularly if there is no or minimal cost-sharing required.

QUESTIONS: *Generally, how should the AEOB reflect the way in which the No Surprises Act's or a State's surprise billing and cost-sharing protections may affect an individual's benefits related to the items or services specified in an AEOB, and the individual's financial responsibility for these items or services?*

RESPONSE:

It is important that the AEOB be as complete and clear as possible to help the patient understand their expected costs after treatment. Applicable state or federal law should be applied when determining amounts reflected in the AEOB. If the AEOB does not reflect that individual patient's situation (whether state or federal law applies), it will not be complete and accurate, and the patient will inappropriately rely on it. An unreliable AEOB is of no use to anyone.

QUESTIONS*: In instances in which a plan, issuer, or carrier has been notified by a provider or facility that consent has been obtained from an individual to waive the No Surprises Act's or a State's surprise billing and cost-sharing protections, should the cost and benefit data in the AEOB explicitly reflect that those protections do not apply? Should the AEOB specifically state that the data is premised on the relevant provisions not applying as a result of the individual's consent? Should the AEOB reflect two different sets of cost and benefit data instead, one set reflecting that the No Surprises Act's or a State's surprise billing and cost-sharing protections do not apply, and one set reflecting the application of these protections (to account for the possibility that the individual might later revoke consent)?*

In instances in which the plan, issuer, or carrier, at the time it is preparing the AEOB, has knowledge that the No Surprises Act's or a State's surprise billing and cost-sharing protections would apply unless individual consent has been given, but the plan, issuer, or carrier does not know whether consent has been given by the individual to waive those protections, should the AEOB include two sets of cost and benefit data, one set that would apply if consent is given, and one set that would apply if consent is not given?

RESPONSE:

If the plan has knowledge that the scheduled care involves a non-participating provider, whether or not consent has already been obtained, the AEOB should reflect the variances in cost depending on whether the patient waives her/his protections. If the patient has signed the waiver/consent form, the AEOB should reflect the cost to the patient, including what the patient will owe based on the non-participating provider estimates in the waiver/consent form. It would also be helpful for that amount to be flagged with a notation of what the patient would pay if the consent is revoked. The alternative in-network amount should be included in a way that helps the patient find an in-network alternative provider and instructions on how to revoke any consent to obtain the cost savings. A new AEOB should be issued if the patient revokes consent.

A patient should never be asked to waive a consent form if the estimate provided in the form is not reflective of that patient's cost after insurance coverage is applied. Any waiver that has been

signed but has not included the cost estimate after insurance should be considered null and void.

AN UNASKED QUESTION and RESPONSE*:*

The RFI does not ask an important question: *Although the law makes clear that AEOBs are not binding, how do we ensure that providers and plans take their responsibility to develop AEOBs that are as close to accurate as possible?* We urge the Departments to create a mechanism that will provide an incentive for plans and providers to work hard to provide accurate, reliable and timely AEOBs. Without some obligation to ensure AEOBs represent a truly "good faith" estimate of what a patient will owe, patients could be left in the same place they are in today - hoping they can afford the care they have scheduled, but not really knowing what to expect in the final bills. We recommend the Departments implement a similar cap of $400 variance as established for patient-provider disputes when the patient is uninsured or is paying out-of-pocket for their care.

Closing

The implementation of AEOB requirements is ground-breaking. For the first time, patients will get a sense of how much a procedure will cost ahead of treatment, breaking a transparency barrier that's been in place for decades. There is no doubt that implementation will be complex and it is likely there may be some initial missteps. However, the sooner we begin, the sooner we can fix any problems.

With health care costs rising, and patients bearing more out-of-pocket costs, we have to do everything we can to give patients a reliable estimate of charges before care. The AEOBs can be the start to a national uniform medical bill - one which a patient can understand and count on to be accurate. This AEOB should be the first part of a multi-part medical bill that will include advance costs, the EOB and final amount due all in one document. Creating this form will help patients keep track of their financial obligations and help them in communications with plans and providers.

On behalf of U.S. PIRG and our state affiliates, we commend the Departments for seeking out comments to avoid potential problems in implementing the AEOB requirement. But it is now time to stand on the side of consumers and swiftly issue rules that establish the requirements to provide patients with the financial transparency they need and deserve.

Respectfully submitted,

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PIRG is a federation of independent, state-based, citizen-funded Public Interest Research Groups in 25 states, whose role is to find common ground around the commonsense solutions that will make our

future healthier, safer and more secure. We are part of The Public Interest Network, which operates and supports organizations committed to a shared vision of a better world and a strategic approach to social change. Learn more at uspirg.org.

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