AMERICAN ACADEMY OF FAMILY PHYSICIANS

November 11, 2022

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

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

Dear Secretary Becerra:

On behalf of the American Academy of Family Physicians (AAFP), representing 127,600 family physicians and medical students across the country, I write in response to the request for information (RFI) from the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor (the Departments) regarding future rulemaking for the advanced explanation of benefits and good faith estimate requirements of the No Surprises Act, as published in the September 16, 2022 version of the *Federal Register*.

Background

The Departments seek comments on considerations for implementing the Advanced Explanation of Benefits (AEOB) requirements that were included in the No Surprises Act (NSA) and enacted into law as part of the Consolidated Appropriations Act, 2021 (CAA). According to the Departments, the statute requires:

1. Clinicians and health care facilities to inquire if an individual scheduling an item or service is enrolled in a group health plan or group or individual health insurance coverage.

2. If the individual is enrolled in a plan or coverage and is seeking to have a claim for such item or service submitted to such plan or coverage, providers and facilities must provide to the plan, issuer, or carrier, a good faith estimate (GFE) of the expected charges for furnishing the scheduled item or service (and any items or services reasonably expected to be provided in conjunction with those items or services, including those provided by another provider or facility), along with the expected billing and diagnostic codes for these items or services.

3. Upon receiving a GFE, group health plans and health insurance issuers offering group or individual health insurance coverage send a covered individual, through mail or electronic means, as requested by the covered individual, an advanced explanation of benefits in clear and understandable language. The AEOB must be provided no later than 1 business day after the plan, issuer, or carrier receives the GFE. However, if such item or service was scheduled at least 10 business days before such item or service is to be furnished (or if the covered

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individual requested the information) the plan, issuer, or carrier must provide an AEOB to the covered individual within 3 business days after the date on which the plan, issuer, or carrier receives the GFE or request.

4. The AEOB must include the following information:

    a. The network status of the provider or facility;

    b. The contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the covered individual can obtain information on providers and facilities that are participating;

    c. The GFE received from the provider or facility;

    d. A GFE of the amount the plan or coverage is responsible for paying;

    e. The amount of any cost sharing which the covered individual would be responsible for paying with respect to the GFE received;

    f. A GFE of the amount that the covered individual has incurred towards meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage as of the date of the AEOB;

    g. disclaimers indicating whether coverage is subject to any medical management techniques (including concurrent review, prior authorization, and step-therapy or fail-first protocols);

    h. The AEOB must also indicate that the information provided is only an estimate based on the items and services reasonably expected to be furnished, at the time of scheduling (or requesting) the item or service, and is subject to change; and any other information or disclaimer the plan, issuer, or carrier determines is appropriate and that is consistent with information and disclaimers required under this section of the statute.

The Departments deferred enforcement of the AEOB requirement for patients with health insurance coverage, given several complex issues related to implementation and enforcement. The AAFP strongly supported this delay.

The statute also requires that clinicians and facilities provide GFEs directly to uninsured or self-pay patients seeking to schedule a service. The GFE regulations are currently in effect and the AAFP has repeatedly shared concerns with the burden of implementing GFEs for these patient populations.

General Comments

The AAFP is supportive of ending surprise medical bills for patients and has long supported federal policies promoting price transparency and health care affordability. We are pleased that the Departments implemented broad patient protections beginning on January 1, 2022. However, we note that the NSA focuses on unanticipated medical bills from air ambulance providers, hospitals, emergency departments, and out of network clinicians and facilities. **Congress did not intend for the NSA to impose burdensome regulatory requirements on primary care practices, who**

typically are in-network, provide high-value care to patients who have chosen to see them, and are already overburdened with administrative tasks.

As mentioned previously, the AAFP has repeatedly shared concerns regarding the administrative burdens imposed on primary care practices by the recently implemented GFE requirements for uninsured and self-pay patients. While we appreciate recent HHS guidance clarifying expectations for physicians, other clinicians, and facilities providing GFEs, family physicians continue to report that the GFE requirements are overly burdensome. Given that most primary care patients will opt to submit claims to their insurance provider for their care, **the AAFP is deeply concerned that, once implemented, the AEOB requirements will add a much greater level of administrative burden and further diminish staff time devoted to caring for patients. We urge the Departments to minimize new administrative requirements on primary care practices**, given that Congress did not intend to target in-network, high-value primary care services with the passage of the NSA.

In addition to being inconsistent with the spirit of the NSA, AEOB requirements for primary care are likely to lead to confusion and frustration for patients. Primary care practices are typically patients' first point of contact within the health care system. Often, patients schedule appointments with their primary care physician due to the onset of new or worsening symptoms and the physician evaluates the patient to determine next steps. Before seeing the patient, it will be incredibly challenging for the practice to make a reasonable determination about the patients' condition or the resulting tests, treatments, referrals, or other services that may be needed. Requiring practices to generate the GFE will force them to guess, which will result in an inaccurate or irrelevant AEOB being sent to the patient, undermining the overall goal of the AEOB requirements.

As we mentioned in our previous comments, front desk staff are not equipped to evaluate patients' conditions or determine what level of service they may require. Patients may also be uncomfortable sharing clinical information with these administrative staff. For all of these reasons, we recommend a series of exceptions the Departments should implement for primary care in our comments below. We also highlight other technical challenges that should be addressed before implementing the AEOB requirements in any health care setting.

Transferring Data from Providers and Facilities to Plans, Issuers, and Carriers

The Departments seek comments on regulatory standards for transferring GFE and AEOB data from providers and facilities to plans, issuers, and carriers. The AAFP has supported HHS' efforts to promote the use of fast health care interoperability resources (FHIR)-based application programming interfaces (APIs) for the real time exchange of health care data. We agree that FHIR holds promise. However, **FHIR-based standards are not sufficiently mature at this time to be used to implement AEOB requirements.** Existing FHIR implementation guides (IGs) are often not developed or sufficiently tested for real-world use in physician practices, particularly those that are small, rural, and/or serve marginalized communities.

FHIR-enabled API adoption can also impact medical practices with limited resources. While FHIR is being adopted by the largest electronic health record (EHR) vendors, hundreds of smaller EHR and health information technology (health IT) vendors have yet to implement FHIR APIs—many of whom support independent medical practices. The health care ecosystem is diverse, comprised of small, solo, and rural medical practices along with large health systems. Large and sophisticated academic medical centers are uniquely different environments than small, solo, and rural medical practices.

EHR vendors supporting many of our members' smaller practices are struggling with FHIR adoption. Administrative and workflow disruptions have an outsized impact on these less-resourced health care facilities. **HHS' policy recommendations should therefore consider low- and under-resourced physician organizations.**

Given these challenges with FHIR standards, the AAFP is concerned that there is no existing standard to efficiently and effectively transmit GFE and AEOB information from physician practices to payers and back to both physician practices and patients. **The Departments must not implement the AEOB requirements until a standard is developed, thoroughly tested in real-world settings, and ready for use by physician practices.**

Privacy and Clinical Decision Making

The AAFP notes that the implementation of the AEOB requirements will provide insurers with additional clinical information before services are rendered by physicians and other clinicians, and therefore could result in undue interference by insurers in clinical decision making. We are deeply concerned that payers will effectively use GFE data from physicians to implement prior authorization (or other utilization management processes) for every service. This would be a completely untenable situation for family physicians, other clinicians, and their patients. Insurers could also use GFE/AEOB data to steer patients to certain clinicians or facilities, inappropriately encourage or suggest certain treatment options, or modify contracts with physician practices. **Action is needed to ensure that health insurers will use the GFE/AEOB data they receive in a responsible manner. Before AEOB requirements are implemented, the Departments must clearly outline regulations requiring insurers to separate data systems and teams processing GFE and AEOB data from other insurer functions. The AAFP strongly encourages the Departments to explore other safeguards to protect patients' health information and the patient-physician relationship.**

Administrative Burden and Practice Workflow

The Departments seek comment on how AEOBs should be handled for patients who have secondary or tertiary coverage from Medicare, Medicaid, TRICARE, or another payer. Notably, the AEOB requirements do not apply to these payers. **The AAFP believes the process of submitting information to a secondary or tertiary payer and modifying the AEOB based on resulting secondary or tertiary should be the responsibility of the patient's primary insurance company.** Physician practices are not equipped to and should not be charged with collating cost-sharing and coverage information across payers.

Existing data demonstrate that the current volume of administrative tasks is untenable for physician practices and recent implementation of the GFE requirement only worsened these burdens. In 2019, 69 percent of AAFP independent practice owners indicated in an internal survey that reducing administrative burden was their top concern. An October 2022 report from Definitive Healthcare notes that physicians are leaving the workforce at record numbers and citing administrative tasks as the primary driver of their burnout. According to the Medical Group Management Association's (MGMA) Annual Regulatory Burden report, 89 percent of respondents believed the overall regulatory burden on their medical practice increased over the last 12 months. Over 80 percent of practices rated surprise billing and GFE requirements as very or extremely burdensome, second only to prior authorizations. In addition, over 80 percent of respondents believe the GFE requirements for uninsured or self-pay patients increased administrative burden in their

practice and almost **90 percent of respondents are concerned with additional administrative burden related to the implementation of the AEOB requirements.**

The AAFP is concerned that the implementation the AEOB requirements will overwhelm practices and exacerbate ongoing staffing shortages. According to the National Center for Health Statistics, approximately 8 percent of Americans were uninsured in the first quarter of 2022. Conversely, over 61 percent of Americans are covered under commercial health insurance, whose care would be subject to the AEOB requirements. Many family medicine practices currently operate on tight margins with limited employees. These practices may comprise one or two physicians with a limited number of clinical and administrative staff to perform multiple job functions. Unfortunately, these practices are limited in their ability to hire additional personnel due rising costs and low payment rates across payers. Practices will instead be forced to divert staff who are scheduling appointments, answering patients' questions, processing existing claims, and performing other essential practice functions to focus on developing GFEs and sharing them with health plans. Ultimately, this could delay care for patients and cause practices to limit appointment availability.

Further burdening these practices with administrative requirements and financial challenges will negatively impact patients' primary care access. The current environment has caused many primary care practices to close their doors, sell to health systems and other corporations, or stop contracting with insurance companies, including Medicare and Medicaid.[i] Evidence clearly shows that these trends increase prices, do not improve quality, and can worsen access to care.[ii][iii][iv] In light of the potential harmful consequences on primary care practices and their patients, coupled with the fact that primary care practices were not intended targets of the NSA, the AAFP urges the Departments to exempt certain primary care patients and services from the AEOB requirement:

1) **Exempt preventive services that individual, group, and self-insured health plans are required to cover without cost-sharing under the Affordable Care Act.** Plans that aren't subject to section 2713 of the ACA often cover preventive services to offer a competitive benefits package to retain employees. AEOBs are unnecessary for services for which most patients are guaranteed coverage without cost-sharing. This exception would reduce the need for practices to divert staff to issue GFEs where they're not needed.

2) **Provide an exception in cases where the patient chooses to forgo receiving an AEOB.** Patients may wish to waive the AEOB for several reasons, including to avoid potential care delays caused by the GFE/AEOB development process. Given the purpose of the AEOB is to inform patients of expected costs, practices should not be required to undergo the process of producing a GFE and transmitting it to the plan if the patient explicitly indicates they do not want the estimate. In primary care, it is likely that many services will result only in a predictable co-pay or coinsurance amount for which a patient may not need an AEOB.

3) **Allow primary care practices to provide an abbreviated GFE/AEOB for new patients or in other situations where they cannot reasonably determine what the relevant diagnostic and procedure codes are.** As we have noted previously, practices are often unable to fully understand a patient's condition and the services they will need if the patient has never been seen before or is presenting with a brand new problem/complaint. The abbreviated GFE/AEOB would include a range of expected charges but would not include diagnostic or procedure codes. This will lessen the potential for GFE requirements to cause

care delays, address the unnecessary and inappropriate burden on patients and administrative staff, and result in a more positive experience for patients.

The Departments should allow primary care practices to issue one GFE annually (and therefore have the patient receive a single AEOB) for ongoing, longitudinal primary care services, including those related to the monitoring and treatment of chronic conditions. The same "batching" of GFE/AEOBs should be permitted for acute conditions or other care that will require recurring appointments with a primary care physician. This would lessen the burden of developing a GFE for primary care practices, who often see patients with chronic or other ongoing conditions at a regular cadence. It is also consistent with recent guidance HHS released to providers regarding the GFE requirement for uninsured and self-pay patients.

The Departments should not impose time frames on practices for generating GFEs and sending them to insurers. Requiring physician practices to generate GFEs within a certain timeframe of when a patient requests an appointment or other service could worsen care delays or force physician practices to schedule services further out. Practices already strive to care for patients within a timely manner, including by accounting for the patients' clinical condition and other factors.

Finally, the Departments should require health insurers to send the AEOB that is being sent to the patient to the physician practice that submitted the GFE information for that AEOB. This will enable shared decision making between physicians and patients about the best treatment plan and the corresponding cost to the patient. It will also help practices answer patient questions about differences between an AEOB and the EOB patients receive after care is furnished.

Thank you for the opportunity to provide comments on the RFI. Please contact Meredith Yinger, Manager, Regulatory Affairs at (202) 235-5126 or myinger@aafp.org with any questions or if you wish to discuss our comments further.

Sincerely,

Sterling N Ransone, Jr MD FAAFP

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

Cc: The Honorable Martin J. Walsh, Secretary, U.S. Department of Labor
The Honorable Janet Yellen, Secretary, U.S. Department of the Treasury

[i] 1 COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020. Physicians Advocacy Institute. June 2021. Available at: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf

[ii] Ho, V., Metcalfe, L., Vu, L. et al. Annual Spending per Patient and Quality in Hospital-Owned Versus Physician-Owned Organizations: an Observational Study. J GEN INTERN MED 35, 649–655 (2020). https://doi.org/10.1007/s11606-019-05312-z

[iii] Scheffler RM, Arnold DR, and Whaley CM. Consolidation Trends in California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices. September 2018. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0472