

November 15, 2022

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

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

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

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

Dear Secretaries Becerra, Yellen and Walsh:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to provide comments in response to the Departments of Health and Human Services, Treasury, and Labor (the Departments) Request for Information (RFI) regarding advanced explanation of benefit (AEOB) and good faith estimate (GFE) requirements under the No Surprises Act (NSA).

Illinois hospitals have long worked with patients, health plans and state lawmakers to simplify the billing system and lessen the financial burden faced by all patients, regardless of insurance status. IHA looks forward to our continued partnership with the Departments to realize our mutual goal of ensuring patients have access to high-quality, affordable, and timely healthcare.

We are particularly supportive of documentation that gives patients an accurate, personalized estimate of their out-of-pocket costs prior to the delivery of healthcare items and services. At the same time, IHA appreciates that the Departments have

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delayed enforcement of both the AEOB and GFE for covered individuals provisions of the NSA until interested parties can identify the best standard for data transfer from providers and facilities to plans and issuers.

Ensuring a secure and accurate data transfer process is paramount to make the AEOB and GFE provisions of the NSA meaningful for covered patients. At the same time, it is critical that whatever data transfer process is finalized be actionable for all providers, including but not limited to those providers that work with our underserved and marginalized communities. To that end, the Departments should take steps to ensure that the AEOB process does not impose exorbitant financial burdens on providers, results in a document that patients can easily understand, and does not result in unnecessary duplication of effort. With these overarching goals in mind, IHA submits the following comments.

### **Coordination of Price Transparency Tools**

Since 2015, the Centers for Medicare & Medicaid Services (CMS) has required hospitals to post their chargemasters on public facing websites. Thus began the rollout of a series of price transparency policies that increased patient access to information about their healthcare costs. IHA and Illinois hospitals strongly support providing patients with the tools and information necessary to make informed decisions on where and how to access the healthcare system.

Currently, most patients have access to cost estimates from myriad sources, including but not limited to hospital websites, payer websites (if insured), state websites, claims databases, and employers. These estimates vary based on the available inputs used to generate potential costs.

Three of these estimates are established in regulation and overseen by CMS: hospital price transparency requirements, transparency in coverage requirements, and AEOB and GFE requirements under the NSA. The hospital price transparency rule requires hospitals to make available on a public-facing website a machine-readable file of charges and negotiated rates, and a consumer-friendly shoppable services file or price-estimator tool. Similarly, health plans must make available a machine-readable file of all negotiated rates, as well as a consumer-friendly tool that provides estimates for covered items and services. Finally, the NSA provides patients with a pre-service estimate based on patient-specific factors, such as the patient's current out-of-pocket obligations and care plan.

The cost estimates produced by these tools will inevitably vary. For example, a hospital estimate would reflect standard charges, negotiated rates, and any hospital discounts. However, hospital files would not reflect information on patient copays, deductibles, and out-of-pocket maximums. Health plan web-based tools on the other hand would be able to incorporate these details, providing an estimate that better reflects the true cost of an item or service for a specific patient.

We appreciate CMS' intent to have all of these tools work together to increase transparency and lower the cost of healthcare. Unfortunately, these policies frequently overlap, leading to duplicative information which often conflicts across sources and may ultimately confuse patients. **We urge CMS and the Departments to review current price transparency requirements and work to eliminate overlap and duplication by identifying the most appropriate price transparency resource for specific patient needs.**

Specifically, the AEOB and GFE requirements under the NSA provide more accurate out-of-pocket cost data for uninsured and insured individuals alike, compared to the requirement to post 300 shoppable services on a hospital website. The uninsured GFE reflects all financial assistance or other discounts the patient is eligible for, while the AEOB better reflects out-of-pocket responsibilities of insured patients because it mirrors how a claim will be adjudicated against the health plan's payment rules.

Requiring AEOBs/GFEs and shoppable price estimator tools may lead to patient confusion if a patient uses both. When a patient receives both an AEOB and uses the hospital's shoppable services tool, more often than not the patient will receive two different out-of-pocket estimates. Confusion will continue should the patient also use their health plan's online shoppable service tool to obtain a third estimate, which will likely conflict with both the AEOB and the hospital shoppable services tool estimates. The intent of these rules was to encourage patients to shop across providers, not shop across estimation tools.

Additionally, both hospitals and health plans are posting machine-readable files containing all negotiated rates. However, the health plan machine-readable file provides a more comprehensive source of data for hospital prices compared with an individual hospital's machine-readable file because it includes all of the providers a patient could go to for a specific item or service.

Requiring both hospitals and health plans to post machine-readable files of negotiated rates is duplicative and unnecessary, and we urge CMS to reconsider imposing this requirement on both entities. As stated above, hospitals were already posting their chargemasters prior to the 2020 implementation of the hospital price transparency rule. From a comprehensiveness standpoint, the next logical step is to have health plans provide a consumer-friendly price comparison tool that incorporates out-of-pocket spending. Such tools will be available under the Transparency in Coverage rule on Jan. 1, 2023.

But perhaps more important than shopping behavior and duplicative efforts, these requirements ultimately hinder CMS' goals to increase price transparency and reduce healthcare costs. The current requirements introduce too many data points to the system that, due to variation in implementation guidance and output requirements, may not match up. Thus, instead of making healthcare cheaper and more consumer friendly, CMS is inserting additional costs to the system and further clouding the public's understanding of how to shop

and interact with the system. **Simply put, price transparency tools should empower patients, not deter them from seeking care. If patients do not understand the information presented across various tools and healthcare entities, they may be intimidated and forgo care altogether. Therefore, we respectfully ask CMS and the Departments to reevaluate these tools, and eliminate any requirements that are duplicative and fail to advance healthcare price transparency.**

#### **API Solutions and Provider Burden**

**Illinois hospitals support the adoption of a standardized process for completing AEOBs and GFEs that is accepted by all providers and health plans while limiting implementation costs.**

While IHA appreciates the Departments' interest in implementing the Fast Healthcare Interoperability Resources (FHIR) application programming interface (API), we have many concerns about mandating this standard. Instead, we urge the Departments to utilize the existing claims adjudication process, and not the FHIR API, as the foundation for producing and transmitting AEOB/GFE data.

The FHIR API solution put forth by the Departments concerns IHA for several reasons. First, it is our understanding that FHIR-based standards have not been widely implemented, piloted, or tested. Second, due to the lack of testing, mandating the use of the FHIR API will result in a longer implementation period and delay the delivery of valuable cost information to covered patients. Finally, requiring the FHIR API will significantly increase implementation costs, many of which will be passed on to patients and unnecessarily increase the cost of healthcare.

**The goal for AEOB and GFE implementation should be to ensure providers and health plans agree to a standard that builds off of systems largely already in place.** Luckily, the groundwork for this goal already exists: **we urge CMS to implement a uniform standard using the existing claims adjudication process as a foundation.**

Building off the current claims adjudication system addresses many of the other concerns presented by the Departments in this RFI. Currently, hospitals transmit claims to health plans using the 837 X12 payment transaction standard. Health plan claims systems are built to accept this transaction and process claims against the health plan's claims adjudication logic. Existing infrastructure could easily incorporate an X12 "pre-claim" transaction to accept GFE data and create an AEOB.

Alternatively, requiring the migration to a FHIR API will require both providers and health plans to build and implement FHIR models, unnecessarily increasing expenses that will likely be passed on to consumers. Further, hospitals and health plans will incur additional costs to retain consultants, hire new IT and administrative staff, and train existing staff to implement and maintain a FHIR API based standard. This would come at a time when many hospitals are facing unprecedented financial troubles, with more than half of hospitals across the U.S. operating at

negative margins.<sup>1</sup> Additionally, some Illinois hospitals have indicated they do not have the physical space to house additional IT and administrative staff. Thus, the individuals working to utilize and maintain a FHIR API would likely need to work from home, increasing security concerns and costs to ensure data are protected.

To that end, IHA and our members believe that protecting patient data is of the utmost importance. Certainly the increased transfer of data between providers and health plans required for AEOBs introduces more opportunity for data breaches and human error. The degree to which AEOBs create new data security concerns depends on the solution adopted by the Departments for data transmission. Should the Departments rely on preexisting systems already designed to securely and privately transmit the same information contained in an AEOB, the need to develop additional security controls will be minimal. If the Departments require new technology and data transfer processes, they would need to carefully review the specifications to guarantee privacy and security issues do not arise.

Finally, to ensure patient understanding and optimize the utility of AEOBs, it is paramount that the providers also have access to the information communicated by health plans to their patients through these documents. This is particularly important for hospitals and physicians caring for underserved and marginalized communities. Such providers often operate at lower total margins and lower operating margins than other hospitals in their markets.<sup>2</sup> Any finalized AEOB or GFE requirements must not require unrealistic overhead expenses for such providers. Providers that are unable to implement a secure, efficient information exchange process in a cost-effective way risk reverting to manual processes that would monopolize limited staff resources and potentially reduce or delay care. Building off of pre-existing claims processing technology will mitigate the cost of implementing the AEOB process.

### **Accessibility for Patients of Underserved and Marginalized Communities**

IHA supports the Departments' commitment to ensuring that health plan communications to covered individuals are accessible, linguistically tailored, and at an appropriate literacy level. According to HHS, only 12% of Americans have proficient health literacy skills,<sup>3</sup> with many adults experiencing difficulty completing routine health tasks such as understanding healthcare instructions or locating their nearest provider.

Explanation of Benefits (EOB) statements are often complex and difficult for many people to understand, regardless of their health literacy level. Patients may be confused about what services the EOB is referring to, and whether they owe any money out-of-pocket after receiving them. There is potential for this confusion to heighten with the issuance of an AEOB, as the AEOB may not reflect the final cost of the procedure depending on what occurs during the course of treatment. Therefore, the AEOB should be as clear as possible on the information it

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<sup>1</sup> <https://www.aha.org/system/files/media/file/2022/09/The-Current-State-of-Hospital-Finances-Fall-2022-Update-KaufmanHall.pdf>

<sup>2</sup> <https://www.aha.org/guidesreports/2022-10-21-exploring-metropolitan-anchor-hospitals-and-communities-they-serve>

<sup>3</sup> <https://www.hhs.gov/surgeongeneral/reports-and-publications/health-literacy/index.html>

provides the patient, what costs might be missing, and how a patient can reconcile the AEOB with their final EOB and bill.

Further, mandating language requirements for health plan AEOBs will help ensure that health plans are fully engaged in the important work of providing clear, transparent, and accessible information to patients about their benefits. Similar to the language requirements placed on providers for various NSA-mandated documents, we believe it is important for health plans to provide AEOBs in the language most easily understood by the patient, and have personnel on hand to help a patient with translation, if necessary. At a minimum, taglines in the top 15 languages should be made available on AEOBs to assist individuals for whom English is not the primary language.

### **Time and Cost Estimates**

IHA appreciates the Departments' attention to the potential burden AEOB and GFE requirements will place on providers and facilities. The cost and time burden varies by provider based on the capabilities of their electronic health records system, the employment arrangements of their clinical staff, and their ability to absorb and adapt to new workflows.

Using the current GFE requirements for uninsured and self-pay individuals as a guide, it is clear that our smaller, rural, and safety net providers are particularly worried about being able to add covered patients to their GFE workflows. One hospital reported placing the responsibility for the uninsured/self-pay GFE process on its already stretched Patient Financial Services staff, but will need additional staff when the requirement to include co-provider information is implemented. Further, many of the hospitals we surveyed indicated they have not yet established an electronic communication pathway with co-providers for GFE-related information exchange.

Given the current struggle to meet uninsured/self-pay GFE requirements, most Illinois hospitals are concerned about the additional resource lift the AEOB process for covered patients will require. Indeed, while Illinois hospitals agree that price transparency is a necessary benefit to patients, our members are concerned that there are no federal plans to help support hospitals and providers with this initiative from a cost perspective. **Our hospitals estimate it will cost between \$40,000 and \$1 million to implement these requirements, with health systems anticipating an additional \$2 to \$3.5 million in spending.**

Further, hospitals report that uninsured/self-pay GFEs regularly take between 10 and 15 minutes to produce, with some health systems averaging the creation of 1,500 GFEs per day. **IHA members state that they anticipate the need to hire an average of five full-time equivalent staff at the individual hospital level, and around 26 full-time equivalent staff at the system level, to comply with AEOB and GFE requirements.** As one hospital leader stated, hospitals and healthcare facilities should be focused on delivering needed care and services, not building and implementing tools that often go unused by patients.

**We do not believe Congress intended for the NSA to add such significant costs to the healthcare system, especially when one of the stated goals of the NSA was to help reduce healthcare spending. Cutting down on duplicative requirements would certainly help absorb the costs of complying with the NSA and free up hospital resources to employ and support staff providing patient care and services.** IHA and Illinois hospitals share the Departments' goals of providing patients with the information they need to make informed healthcare decisions. **Now is the time to reevaluate the price transparency policies implemented to date in an effort to make public-facing data and tools more actionable and informative.**

Thank you again for the opportunity to offer comments to the Departments on issues related to the AEOB and GFE for covered patients. We look forward to working with the Departments and our members to develop and implement policies and procedures that achieve the goals of the NSA.

Sincerely,

A.J. Wilhelmi,  
President & CEO