



Charles N. Kahn III  
President and CEO

November 15, 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 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

Re: Request for Information; Advanced Explanation of Benefits and Good Faith Estimate  
for Covered Individuals, 87 Fed. Reg. 56,905 (Sep. 16, 2022) (CMS-9900-NC)

Dear Secretaries Becerra, Walsh and Yellen:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to submit comments to the Department of the Treasury, Department of Labor, and Department of Health and Human Services (HHS), regarding their *Request for Information, Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals* (RFI), published in the Federal Register (87 Fed. Reg. 56,905) on September 16, 2022. The FAH and its members strongly support the *No Surprises Act*, which first and foremost ensures that patients have in-network coverage and cost-sharing obligations in circumstances where the patient has no reasonable control over the network status of the facility or health care providers administering care. The FAH has maintained that surprise medical bills of all types (including those that result from improper payer denials or limitations on coverage) burden patients and our health care delivery system and should be eliminated in a manner that protects patients and preserves market negotiation of network rates between health plans and providers, consistent with Congress’s intent. Moreover, the FAH continues to support policies that provide patients and insureds with access to clear, accurate, and actionable coverage and cost-sharing information.

The FAH also believes that consumers and patients benefit when providers’ compliance obligations are streamlined and enable the efficient delivery of care and services, and therefore it strongly urges the HHS, the Department of Treasury, and the Department of Labor (collectively the “Departments”) to ensure that implementation of the *No Surprises Act’s* advance explanation of benefits (AEOB) requirements and good faith estimate (GFE) requirements is ***streamlined, standardized, automated, and minimizes regulatory burdens*** by coordinating with existing processes and requirements and adopting national standards and processes that will be deemed compliant. A regulatory approach that focuses on efficiencies and value will allow patients to make informed decisions and receive timely care at a lower cost. Such an approach would streamline and standardize the exchange of GFE, AEOB, coverage and eligibility verification, and prior authorization information between and among providers and payers. In contrast, approaches that necessitate manual communication of GFE information among facilities and providers or require non-standardized and non-automated GFE submissions to payers (*e.g.*, through a payer-specific portal that uses two-factor authentication) would impose undue burden on providers and facilities and unnecessarily risk the provision of inaccurate or incomplete information. Likewise, failing to coordinate the GFE processes with payers’ processes for obtaining prior authorization and/or verifying eligibility and coverage would create improper burdens on providers and create inaccurate and confusing AEOBs that provide cost-sharing information without any assurance of coverage.

### **Standardizing and Facilitating Data Exchange Among Providers**

The *No Surprises Act* describes coordinated GFEs that contain the preparing provider’s or facility’s expected charges along with those “reasonably expected to be . . . provided by another health care provider or health care facility.”<sup>1</sup> At present, however, there is no standardized process for exchanging GFE information among providers and facilities. Recognizing that the systems and processes necessary for receiving and providing GFE information between and among providers are not in place, HHS temporarily committed to “exercise enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay)

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<sup>1</sup> Public Health Services (PHS) Act § 2799B–6(2), 42 U.S.C. § 300gg-136(2).

individual does not include expected charges from co-providers or co-facilities.”<sup>2</sup> ***Because the circumstances that prompted this enforcement discretion persist today, the FAH urges HHS to continue to exercise such discretion until national standards for transmitting GFEs are in place and to expand this enforcement discretion to apply to GFEs for insured patients as appropriate when the AEOB and GFE requirements for such patients take effect.***

Since the promulgation of the Interim Final Rule on GFEs for uninsured and self-pay patients, hospitals and health systems have invested significant resources to develop GFE workflows for consolidating GFE information, but this process is still largely manual, non-standardized, and unreliable. The GFE rules for uninsured patients identify the scheduling provider as the convening provider in most circumstances. For most hospital-based services, this scheduling provider or facility would generally be the admitting physician. Although the admitting physician may be the provider best positioned to provide the clinical information necessary to generate the GFE, most physician practices lack the infrastructure and workforce necessary to fulfill the obligations of the convening provider, particularly where there is no standardized transaction for transmitting GFE information and the process is largely manual.

On the other hand, hospitals are not well positioned to serve as convening providers because they are dependent upon the treating physician to provide clinical information about the patient and the intended treatment. Moreover, despite some hospitals’ comparative sophistication with automated processes, the process of gathering GFE information from physicians and other providers is still largely a burdensome, manual one that is heavily dependent on non-standard data transmissions (*e.g.*, faxes). And even where some hospitals may be positioned to set up automated processes for requesting, transmitting, and compiling GFE information with some of their physicians, the process is likely to remain manual for care involving non-employed physicians and others.

All of this indicates an acute need for technology and data standards that will support the transmission and compilation of GFE information between and among facilities and providers. Until such work is completed, the FAH urges HHS to continue to exercise enforcement discretion where GFEs fail to contain GFE information from all co-facilities and co-providers. At a minimum, where a convening provider does not receive a timely response to a request for GFE information from a co-provider or co-facility, the convening provider should not be liable for the failure to include that co-provider or co-facility’s GFE information or for errors in its own GFE information that result from the co-provider’s or co-facility’s failure to provide necessary clinical information.

### **Standardizing and Facilitating the Transmission of GFEs to Payers**

Full implementation of the *No Surprises Act*’s GFE requirements also necessitates standardized processes for transmitting GFE information from providers and facilities to plans, issuers, and carriers. Previously, the Departments highlighted the “challenges of developing the technical infrastructure necessary for providers and facilities to transmit to plans and issuers” the GFEs for insured individuals and properly deferred enforcement of this requirement. The RFI

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<sup>2</sup> Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980, 56,023 (Oct. 7, 2021).

appropriately highlights the potential use of Health Level 7 (HL7<sup>®</sup>) Fast Healthcare Interoperability Resources (FHIR<sup>®</sup>) standards as holding potential for supporting these transactions. But the FAH is deeply concerned that the RFI focuses on merely “encourag[ing]” the use of any particular data or transaction standard and at the Departments’ conclusion that “no law or regulation currently requires plans, issuers, carriers, providers, or facilities to use a specific transaction standard to exchange AEOB or GFE data.” ***At a minimum, the FAH urges the Departments to develop national standards and processes that can be used by providers and facilities to fulfill their obligations under section 2799B-6(2) of the PHS Act regardless of any plan- or issuer-specific data standards or processes.***

The FAH believes that HHS’s regulatory authority to establish standards for other health care transactions (*e.g.*, claims) is sufficient to provide authority to establish such standards for GFE transactions with issuers and plans. The GFE that would be transmitted to a plan or issuer by a provider or facility is tantamount to a health claim—except that it contains information on *reasonably expected* claims for items and services that have not yet been furnished and for which no payment is yet due. Although transactions “related to advance cost estimates . . . are not contemplated in section 1173(a)(2) of the Social Security Act,” GFE transactions fall within the health claims and health care payment transactions set forth in subsection (2)(A), (B), (E), and (H). The only difference is that these transactions relay reasonable expectations around claims (for purposes of facilitating the issuer’s or plan’s communication with the patient about coverage) rather than a complete claim that sets out services and items rendered and triggers the issuer’s or plan’s payment obligations. ***The FAH thus urges HHS to reevaluate the scope of its regulatory authority with respect to GFE transactions, which involve the transmission of claims data on a pre-claim basis.*** Even if HHS’s legal authority under section 1173(a)(2) does not extend to establishing data standards for GFE transmissions, the FAH strongly urges the Departments to adopt standards that providers and facilities may use to transmit GFE information to plans and issuers and be deemed compliant with the requirements of section 2799B-6(2) of the PHS Act, notwithstanding any plan’s or issuer’s preferences or processes.

It is of critical importance to the efficient implementation of the GFE requirements for insured patients that the process for transmitting GFE data become standardized across all plans and issuers in a manner that support automated processes. Even with such standardization, health facilities and providers will struggle to prepare and transmit GFEs to insurers for scheduled services. But, without standardization, the transactional cost of GFEs will excessively burden the health care delivery system and risk scheduling delays in order to satisfy regulatory requirements. Such standardization must apply both to the data structure as well as the processes for submission so that facilities and providers are not subject to plan- or issuer-specific requirements and processes. As noted in the RFI, many plans and issuers require providers to use payer-specific portals to submit prior authorization requests, producing a manual, payer-specific process. In addition, payers’ use of two-factor authentication and similar security measures in their portals makes each transaction on the portal more burdensome and costly to providers and facilities. Mandatory national standards that remove these barriers to routine transmissions between facilities or providers and plans or issuers and enable automation are critical to the efficient and effective implementation of the *No Surprises Act*’s GFE and AEOB requirements.

***Along similar lines, the FAH also strongly urges the Departments to build on existing data standards and, wherever possible, streamline processes such that the GFE submission is integrated in or coupled with other communications between the provider or facility and plans or issuers.*** For example, all providers are familiar with the data standards for claim forms, which contain fields for the essential insured GFE information (items and services along with corresponding charges) and enabling the plan or issuer to prepare the other elements of the AEOB (*e.g.*, the contracted rate, the plan or coverage’s responsibility, and cost sharing amounts). In addition, the Departments should work to ensure that the GFE process is streamlined with other exchanges of clinical and administrative data between the provider or facility and plan or issuer, including in particular prior authorization process and coverage and eligibility verification processes. This would align the GFE process with these other exchanges, while also ensuring that the GFE and AEOB process culminates in an AEOB that contains actionable coverage information.

Such streamlining is important not just from an efficiency and value standpoint, but also for purposes of avoiding confusion on the part of patients, providers, and facilities. ***The provision of an AEOB without any assurance of eligibility or coverage and without the plan’s or issuer’s prior authorization or medical necessity determination (or the status of the prior authorization request or medical necessity review) may result in the patient obtaining and the provider or facility furnishing items or services on the understanding that the plan or issuer will provide coverage and make payment.*** A subsequent partial or full denial due to non-coverage or the absence of authorization would result in an inappropriate surprise bill to the patient, contrary to the goals of the *No Surprises Act*.

In terms of the specific data included in the GFE, the FAH urges the Departments to limit that data to items necessary for the plan’s or issuer’s preparation of the AEOB, which contains the plan’s or issuer’s good faith estimate of “the amount the plan or coverage is responsible for paying” and “the amount of any cost-sharing” for which the patient would be responsible, among other items.<sup>3</sup> It is not necessary, for example, for the facility’s or provider’s GFE to include pricing data beyond an estimate of reasonably expected billed charges (*e.g.*, it would be unnecessary for the provider or facility GFE to include an estimate of the amount it expects the insured patient, plan, or issuer to pay for the item or service).

The FAH also urges the Departments to explore ways in which the volume of full GFE transmissions can be reduced while still achieving the goals of the GFE requirement for insured patients. For example, there are many high-volume services for which the GFE would be consistent from one patient to the next (*e.g.*, preventive items and services, evaluation and management visits). If a provider or facility could periodically provide insurers and plans with a “default” GFE for those items and services (or maintain a public list of gross charges for these services as hospitals already do pursuant to the Hospital Price Transparency regulations at 45 C.F.R. Part 180), this would enable the plan to provide the AEOB with only a scheduling notification in many cases. And, if patient-specific circumstances indicate that the default GFE is inappropriate in a particular case, the provider or facility could then transmit a patient-specific GFE. The FAH urges the Departments to explore this proposal and any other innovative

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<sup>3</sup> PHS Act § 2799A–1(f)(1), 42 U.S.C. § 300gg-111(f)(1).

approaches that could reduce the volume of GFE transmissions or otherwise alleviate burden on facilities and providers while still providing patients with access to actionable cost-sharing information.

**Other Policy Considerations**

The FAH supports requiring the plan or issuer to provide access to the AEOB to each provider and facility included in the GFE. Upon receipt of the AEOB, some patients may reach out to financial counselors or others at the facility or providers, and a facility or provider will be better positioned to address patient concerns if they also have access to the AEOB. In addition, for some providers and facilities, the AEOB may assist in the prompt and efficient collection of the patient’s cost-sharing obligation. Although the FAH believes that the Departments should require plans and issuers to provide facility and provider access to the AEOB, such access and the subsequent delivery of listed items and services should not constitute a waiver of any right that the provider or facility might have to dispute the plan’s or issuer’s payment obligations.

The FAH also appreciates the Departments’ exploration of approaches that account for secondary and tertiary payers. In order for the plan or issuer to generate the AEOB, it must determine its own “good faith estimate of the amount the plan or coverage is responsible for paying for items and services” and the patient’s cost-sharing amount.<sup>4</sup> Fulfilling these obligations for patients with multiple sources of coverage would necessitate assessing the patient’s other coverage as well. For example, where a patient has other coverage that is primary, an AEOB from a secondary payer that does not address coordination of benefits would improperly overstate the secondary payer’s responsibility for payment, creating consumer confusion. As part of the AEOB process, the plan or issuer should thus be required to verify whether the plan or coverage is primary or secondary, to address the scope of its payment obligation in the AEOB, and to transmit the GFE information to other plans or issuers as needed to ensure that the patient receives appropriate AEOBs.

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The FAH appreciates the opportunity to submit these comments on these important issues to patients and providers. If you have any questions, please contact me or any member of my staff at (202) 624-1500.

Sincerely,



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<sup>4</sup> PHS Act § 2799A-1(f)(1)(C), 42 U.S.C. § 300gg-111(f)(1)(C).