Progress Toward Advanced Explanation of Benefits (AEOB) Rulemaking and Implementation

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The No Surprises Act (NSA) establishes new consumer protections from unexpected medical bills. The NSA protections include requirements that help consumers by giving them information about expected out-of-pocket costs for health care items and services before care is provided. For example, under the NSA, providers and facilities are required to give uninsured (or self-pay) individuals a personalized good faith estimate (GFE) of their expected charges for a health care item or service upon scheduling or at the individual's request. For individuals with certain types of commercial insurance, the NSA requires providers to send the GFE (referred to as the insured GFE) to the individual's health plan or issuer (payer). The GFE must include expected costs for each item or service, including those expected to be furnished by other providers. The payer must then use the GFE to create an advanced explanation of benefits (AEOB) that includes the provider's or facility's expected charges, the portion the payer expects to cover, and the patient's expected cost-sharing liability. This information will help patients understand their expected costs before items or services are furnished and allow them to make cost-conscious decisions about their care. Patients can also use estimates to compare prices among providers. The AEOB represents an important advancement in patient price transparency and is a critical part of the NSA's patient protections.

The Centers for Medicare & Medicaid Services (CMS) is working with agencies across the Department of Health and Human Services (HHS), as well as the Departments of Labor, the Treasury (the Departments) and the Office of Personnel Management (OPM), to implement the GFE and AEOB requirements in stages. Using this approach, the Departments and OPM can better ensure each stage is informed by thorough research and collaboration with impacted stakeholders and, importantly, supported by appropriate technical standards for data sharing between providers and payers. This deliberate, incremental approach will ensure that patients get meaningful and actionable information about their care.

Background

As the first stage of implementation, HHS issued regulations in 2021[1] on the GFE for uninsured (or self-pay) individuals, and those provisions are currently in effect.[2] In response to stakeholder requests that the Departments and OPM first establish standards for the exchange of GFE and AEOB data between providers, payers, and patients, the Departments and OPM deferred enforcement of GFE requirements for insured individuals and AEOB requirements, pending future rulemaking. Because the insured GFE and AEOB will require payers and providers to exchange health data in a way that has not been done before,

[1] 45 CFR 149.610; Requirements Related to Surprise Billing; Part II, 86 FR 55980 (October 7, 2021), available at https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii.

[2] HHS is exercising its enforcement discretion, pending future rulemaking, in situations where a GFE provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities. More information can be found at https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf.

technology will need to adapt to ensure that providers and payers can comply. This deferment allows providers, payers, and vendors enough time to build and implement the technology and business processes necessary to support this exchange.

The Departments and OPM are incorporating lessons learned from implementing the uninsured (or self-pay) GFE provisions as well as industry feedback from the preliminary development of GFE and AEOB data exchange standards as we develop proposed rules on insured GFE and AEOB provisions and technical requirements. The Departments and OPM have been, and continue to be, engaged in a number of efforts that will help inform successful rulemaking and implementation of the insured GFE and AEOB requirements. Below are a few examples.

Request for Information (RFI) Summary

On September 16, 2022, the Departments and OPM published a Request for Information (RFI) that sought comments from interested parties on a number of issues related to AEOB and insured GFE provisions, including recommendations on exchanging data between providers and facilities to payers, and the economic impacts of implementing these requirements.[3] The Departments and OPM received 285 comments from providers, payers, vendors, consumer and patient advocates, and other stakeholders. Commenters provided a wide variety of feedback, including information and recommendations related to:

- The exchange of GFE and AEOB data;
- The exchange of GFE information when multiple providers are involved;
- Patient privacy concerns;
- How surprise billing protections should be represented on the AEOB;
- Exemptions for small and rural providers; and
- Supporting underserved and marginalized communities.

The Departments and OPM are carefully considering this feedback as we engage in rulemaking on these provisions.

Many commenters agreed that sufficient testing of any data standards used in the exchange of GFE and AEOB information is essential to successful implementation, regardless of standards or workflow. Commenters stressed that testing should occur not just in test environments but must also be conducted in real-world settings by clinicians and health information professionals, as their involvement is critical to identifying challenges and opportunities and sharing lessons learned before a national rollout.

Research with Users

In addition to soliciting industry-wide feedback through the RFI, CMS conducted a study with the support of the Digital Service at CMS (DSAC)[4] into the health care industry's business and technological needs and the capabilities of providers, payers, and other stakeholders related to the insured GFE and AEOB.

[3] Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals, 87 FR 56905 (September 16, 2022), available at https://www.federalregister.gov/documents/2022/09/16/2022-19798/request-for-information-advanced-explanation-of-benefits-and-good-faith-estimate-for-covered.
[4] More information can be found at https://www.cms.gov/digital-service-cms.

Interviews with providers and payers, as well as third parties such as electronic health records vendors, clearinghouses, and standards development organizations, helped provide the Departments and OPM with a more nuanced understanding of the business processes, communication norms, technical resources, and interdependencies of the multiple stakeholders who would be involved in generating insured GFEs and AEOBs.

As part of this research, DSAC spoke with solo provider practices, small- and medium-sized practices, hospitals of various sizes, and integrated health care systems. These providers were selected to represent different regions of the U.S., urban and rural patient populations, and various levels of broadband connectivity and technology capabilities. A variety of provider types were represented, including primary care providers, surgeons, anesthesiologists, radiologists, Critical Access Hospitals, and behavioral health providers. Across the wide range of providers DSAC spoke with, many were concerned about strains on staff and financial resources, expected timelines, and diagnosing and identifying expected services for patients they have not yet seen.

In addition, DSAC spoke with payers of different sizes serving a broad range of states, including integrated payer-providers. Each payer walked DSAC through its existing claims process, mapping out which parts are automated and which require manual intervention. Their challenges brought to light the need for an efficient, automated way to process GFEs, as well as concerns around timing, liability, and content of GFEs.

DSAC's research also concludes, consistent with RFI comments, that most providers could not currently generate a GFE that would include items and services provided by providers outside their organization. The research indicates that communication channels between providers in different organizations are limited and inconsistent. These findings further emphasize that the development of standards supporting the exchange of GFE information between providers is critical to implementing insured GFE and AEOB requirements.

Based on these conversations, DSAC researchers recommended that the Departments and OPM propose a single data exchange standard for the receipt of GFEs by payers and the transmission of AEOBs from payers to providers. DSAC researchers reported that without an industry-wide data standard, the insured GFE and AEOB provisions will be harder to implement and, ultimately, less successful, as providers and payers may adopt solutions that are not interoperable and may continue to use time-consuming manual methods to exchange data. Such an approach might yield AEOBs for patients that are not timely, difficult to understand, inconsistent across different payers or settings of care, or even inaccurate. However, DSAC researchers also emphasized that they did not believe any currently published technical standards would be sufficient to meet insured GFE and AEOB provisions, without further development. As a result, new standards may need to be developed to ensure a successful implementation of the AEOB requirements.

DSAC's research also suggests that Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR)-based standards and Application Programming Interfaces (APIs) hold promise as the basis for developing efficient and effective insured GFE and AEOB transmission methods, as further discussed below.[5] DSAC's research noted that, considering the development and testing that will be required, HL7 FHIR has advantages as an open standard—meaning anyone can access the standard, freely implement

[5] See https://www.hl7.org/fhir/.

it, and recommend changes. A number of interviewees noted this flexibility as a major strength of HL7 FHIR, in the context of new and evolving use cases such as the insured GFE and AEOB. CMS is also tracking the development of other standards that could support the exchange of GFE and AEOB information. Like many RFI commenters, the research recommended that a pilot or demonstration project should be conducted with the standards and technologies that will potentially be involved in the AEOB process.

Finally, CMS uncovered a number of provider misconceptions about the GFE for uninsured (or self-pay) individuals, particularly regarding the applicability of the requirements. To help address this issue, CMS is developing additional educational materials for providers. For example, in the spring of 2024, CMS plans to publish a new set of Frequently Asked Questions (FAQs) that address common provider inquiries. Previously published FAQs about the uninsured (or self-pay) GFE are available at https://www.cms.gov/marketplace/resources/regulations-guidance#Good_Faith_Estimates.

HL7 Da Vinci Patient Cost Transparency Workgroup

Based on comments in response to the RFI, our conversations with stakeholders, and research conducted by DSAC, the Departments and OPM are exploring opportunities to promote real-world testing of the implementation guide being developed by the HL7 Da Vinci Patient Cost Transparency Workgroup.

Efforts to develop technical standards for exchanging GFE and AEOB information are industry-led. Although industry has made progress in this area, more work is needed before implementing a nationwide, standards-based exchange of this information. As previously expressed by the Departments and OPM, the HL7 FHIR standard holds potential for supporting the interoperable exchange of insured GFE and AEOB information between providers, payers, and patients.[6] For this reason, the Departments and OPM have been closely following the work of the Workgroup, which is developing technical guidance to support these information exchanges using HL7 FHIR-based APIs.

On March 30, 2023, the Workgroup published the Da Vinci Patient Cost Transparency Implementation Guide Release 1, which includes detailed guidance for providers to transmit GFEs to payers, for payers to transmit AEOBs to patients, and optionally for payers to return AEOBs to the initiating provider using HL7 FHIR-based standards.[7] The Workgroup has also started the second phase of this implementation guide, which will include guidance using HL7 FHIR-based standards supporting the exchange of GFE information when multiple providers are involved.

While technical standards for insured GFE and AEOB implementation are still being developed, a potential real-world pilot or demonstration project of these standards may provide meaningful feedback for future iterations of data exchange standards and more complex use cases, as well as help guide future policy decisions. The Departments and OPM look forward to continuing to engage with industry

[6] See, e.g., Interoperability and the Connected Health Care System (December 8, 2021), available at https://www.cms.gov/blog/interoperability-and-connected-health-care-system; Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals, 87 FR 56905 (September 16, 2022), available at https://www.federalregister.gov/documents/2022/09/16/2022-19798/request-for-information-advanced-explanation-of-benefits-and-good-faith-estimate-for-covered.

[7] Patient Cost Transparency Implementation Guide (March 30, 2023), available at https://hl7.org/fhir/us/davinci-pct/STU1/.

partners and other affected stakeholders to implement an efficient process for creating meaningful protections for patients from unexpected medical bills.