No Surprises Act
Good Faith Estimate / Advanced EOB
Standards-based Approach

White Paper by Cooperative Exchange*, The National Clearinghouse Association

Industry Affairs and Emerging Trends Committees

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* The Cooperative Exchange (CE) is comprised of 23 of the leading clearinghouses in the US. The views expressed herein are a compilation of the views gathered from our member constituents and reflect the directional feedback of the majority of its collective members. CE has synthesized member feedback and the views, opinions, and positions should not be attributed to any single member and an individual member could disagree with all or certain views, opinions, and positions expressed by CE.

Cooperative Exchange
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Introduction

On December 27, 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021[1], Public Law 116-260.

The No Surprises Act (NSA) seeks to protect consumers from surprise medical bills and includes transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations and other health plan and provider provisions and consumer protections.

Section 111 - **Consumer protections through health plan requirement for fair and honest advance cost estimate. (summary)**

- Requires health plans offering group or individual health insurance to provide an "Advanced Explanation of Benefits" to give consumers transparency for each scheduled item or service:
  - the network status of the provider or facility,
  - good faith estimates of provider or facility charges, the plan payment responsibility, and the patient payment responsibility,
  - additional disclaimers.

Section 112. Patient protections through transparency and patient-provider dispute resolution. (summary)

- Health care providers and facilities must verify, three days in advance of service and not later than one day after scheduling of service, what type of coverage the patient is enrolled in and provide notification of the good faith estimate of the expected charges for scheduled items or services.
- Requires the Secretary of HHS to establish a patient-provider dispute-resolution process for uninsured individuals for charges that are substantially in excess of the estimate.

This white paper provides a rational justification to pursue a standards-based approach to realize the vision of the GFE/AEOB provisions of the NSA, specific to insured beneficiaries, primarily leveraging existing, broadly adopted, and mature X12 administrative transactions.

Problem Statement

Since their inception in ~2004 and likely due to the rising cost of health care and cost-shifting to consumers, high-deductible health plans (HDHPs) and their associated tax incentivized health savings accounts (HSAs) have continued to grow in adoption. An HDHP is a health insurance plan with lower premiums and higher deductibles with an emphasis on coverage for preventative care and consumer fiscal responsibility through higher copayments and/or

[1] https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf

deductibles paid via the insured's HSA (their money) until they reach their annual out-of-pocket maximum. According to the State Health Access Data Assistance Center (SHADAC) based on 2019 data, the percentage of private-sector employees enrolled in high-deductible health insurance plans is 50.5%[2].

As out-of-pocket expenses shift from insurers and employers to individuals and employees, consumers require the ability to make informed decisions for their cost of health care purchases, much like purchasing decisions for other goods and services.

Regardless of the type of health plan and/or in or out-of-network status of the provider, the need to maintain consumer confidence is paramount. The estimation of the cost of scheduled healthcare items or services must be *personalized and accurate* (with standard disclosures) to the patient and their specific plan coverage and benefits. If not, consumers will quickly lose confidence and continue to be "surprised" resulting in additional burden on the consumer compliant process.

While the No Surprises Act describes requirements for which the named federal secretaries must develop regulation, the NSA does not specify how the industry is to technically meet the legislated requirements nor the underlying standards needed to support the technical provisions requiring interoperable data exchange.

High-Level Solution

The concept of an "Advanced Explanation of Benefits" is not new to the healthcare industry.

The following X12 published standards[3], which are available for use today, provide existing support for "Predetermination of Benefits" workflow. X12 version (v)5010 is the current HIPAA-named transaction standard. We assume for purposes of this white paper that X12 version (v)8020 will be the next HIPAA-named standard.

Health Care Eligibility Benefit Inquiry and Information Response

- The HIPAA 005010X279A1 Health Care Eligibility/Benefit Inquiry and Information Response (270/271) "5010 270/271" and 008020X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271) standards and associated Operating Rules provide the network status of the provider or facility and patient coverage and benefit information. No change is required to support the provider network status and eligibility and coverage of items/services. Working as designed.
  - Adoption of the 5010 270/271 is 84% for medical and 64% for dental[4].

[2] statehealthcompare.shadac.org
[3] www.x12.org - X12 has granted express permission to reference its copyrighted materials in this white paper.
[4] 2020 CAQH Index Report

Dental Health Care Claim

- The HIPAA 005010X224A2 Health Care Claim: Dental (837) "5010 837 Dental" standard already accommodates a provider "Predetermination of Benefits" claim submission. No change is required to support the predetermination/estimation of items/services in the Dental industry. Working as designed.
  - Adoption of the 5010 837 Dental is 82%[4].

Professional and Institutional Health Care Claim

- The 008020X323 Health Care Claim: Professional (837) "8020 837 Professional" and 008020X324 Health Care Claim: Institutional (837) "8020 837 Institutional" standards also support predetermination of benefits claim submissions.
  - The 8020 837 Professional and 8020 837 Institutional standards are published and available for industry use but adoption of these standards has not yet been realized pending potential X12 & NCVHS recommendations and HHS rulemaking.
  - The current HIPAA 005010X222A1 Health Care Claim: Professional (837) "5010 837 Professional" and 005010X223A2 Health Care Claim: Institutional (837) "5010 837 Institutional" standards do not support predetermination of benefit claim submission.
    - Modifying the HIPAA 5010 837 Professional and 5010 837 Institutional standards for industry use via X12 errata and subsequent HIPAA rule-making regulatory process would be untimely and complicated given that version 8020 is the next assumed HIPAA named transaction standard.
    - Adoption of the 5010 837 Professional standard is 96%[4].
  - There are also 005010X291 Health Care Predetermination: Professional (837) and 005010X292 Health Care Predetermination: Institutional (837) stand-alone standards specific to "Predetermination" transaction workflows.
    - Adoption of these non-HIPAA standards in the industry has not been realized and is negligible. Where deployed, production metrics of these predetermination standards can be referenced to report and inform the ability to meet the requirements of the NSA and the needs of the industry.

Health Care Claim Status Request and Response

- The 008020X329 Health Care Claim Status Request and Response (276/277) can be used to communicate the status of predetermination claim submissions. Front matter (1.4.7) has been added to the v8020 standard specific to predeterminations.
  - Current medical adoption of the HIPAA standard is 72%[4].

Health Care Claim Payment/Advice

- The HIPAA 005010X221A1 Health Care Claim Payment/Advice (835) "5010 835" and 008020X322 Health Care Claim Payment/Advice (835) "8020 835" standards provide support to return a "No Payment" remittance in response to a predetermination claim submission. No change is required to support the predetermination/estimation EOB remittance response for submitted items/services. Working as designed.
  - 5010 835 medical adoption is 57%, dental is 25%[4].

Acknowledgement & Status Reporting

- The 005010X231 Implementation Acknowledgment For Health Care Insurance (999) and 008020X335 Implementation Acknowledgment For Health Care Insurance (999) supports the acknowledgment of predetermination/estimation workflows essential for control and audit. Working as designed.
  - Medical adoption of electronic acknowledgements is 98%[4].
- The 008020X330 Health Care Claim Acknowledgment (277) standard provides claim/service-level reporting feedback acknowledging the validity and status of predetermination or billed claims.

Given the mature and broad adoption of X12 HIPAA standards and existing support for predetermination of benefit workflow, X12 standards are well positioned to support industry interoperable GFE/AEOB workflow functionality.

Solution Details

When a specified item or service is scheduled for an insured individual and a good faith estimate is required, a predetermination claim submission would be initiated by the provider/facility. The provider's existing scheduling workflow is executed which includes the good faith estimate (GFE).

The patient's eligibility and benefit status are confirmed, the intended services are codified, and the service codes are sent to the health plan to be estimated via the predetermination claim standard. Facilities, resources, or providers who are part of the care are also notified or scheduled per established process; these organizations each send the codified services they intend to perform to the individual's health plan to be estimated.

The health plan receives codified predetermination claim submissions from each provider and facility engaged in the patient period of care, applies the patient's benefits, and generates a 5010 835 or 8020 835 Predetermination Pricing Only – No Payment explanation of benefits remittance advice. The predetermination remit includes the provider or facility submitted charge amount, the plan payment responsibility, the patient payment

responsibility, and any other adjustments to calculate the anticipated payment upon furnishing or rendering the scheduled item or service. Remittance Advice Remark Codes could be utilized to communicate required disclosures (e.g., "N183 - Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits." The health plan would return the 5010 835 or 8020 835 predetermination response back to each provider or facility engaged in the patient period of care. The machine readable 5010 835 or 8020 835 standard could be rendered as a consumer-friendly Advanced EOB for presentation to the individual via their choice of communication method (U.S. mail, patient portal, individual's mobile device, etc.) The AEOB would contain information about how the services would be adjudicated according to the patient's specific plan benefits and would include all required disclaimers (i.e., estimate is in good faith).

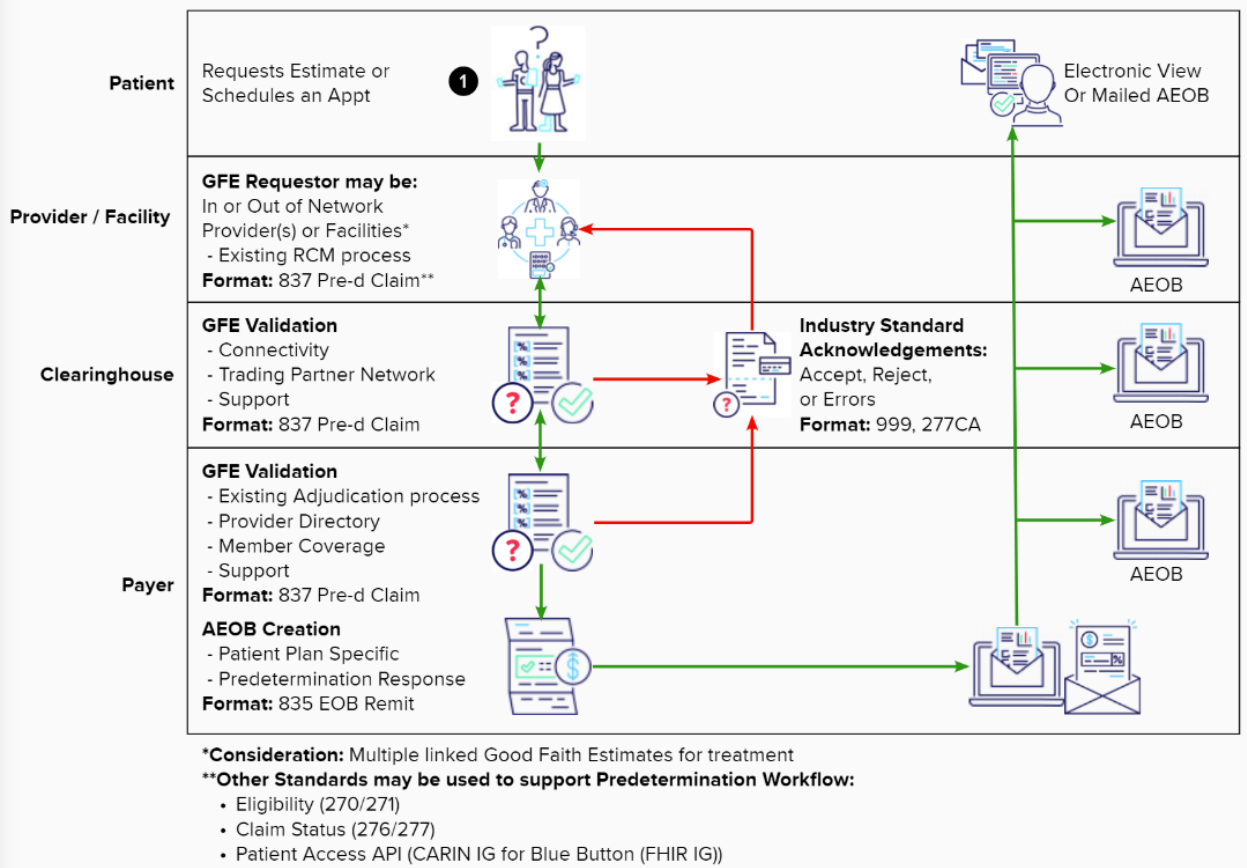
Once the items or services are furnished or rendered, providers and facilities initiate their existing billing process. The billing staff retrieves the estimate, confirms the codified services were performed as estimated (or adjusts), then submits a HIPAA standard 5010 837 Professional or 5010 837 Institutional file to the health plan as a billable claim for payment.

Predetermination/Estimation workflow using X12 standards has been in production supporting the Dental industry since October 2003.

Regarding NSA Section 112 where a health care provider or facility is required to provide a health plan notification of the good faith estimate of the expected charges with the expected billing and diagnostic codes for any such item or service *"(including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility)"*. The Cooperative Exchange considers the concept of coordinating, collecting, and submitting health plan notification of an aggregated GFE with billing and diagnostic codes in conjunction with another provider or health care facility unrealistic and unimplementable. The concept of a "collection" of items/services from multiple providers/facilities of differing specialties and unrelated organizational associations, for a given insured beneficiary, does not exist in the billing of these same items/services. Each provider, facility, or organizational entity utilizes a distinct "Billing Provider" when submitting charges for items/services.

Leveraging existing X12 standards and workflows, the GFE/AEOB process has an abundance of opportunities for synergies. RCM billing software design can be leveraged to eliminate duplication of effort by enabling the final claim to be billed from the estimate significantly reducing burden on the provider and/or facility. RCM reporting software can be designed to use both the estimate and paid claim information to accurately forecast cash flow and reconcile revenue.

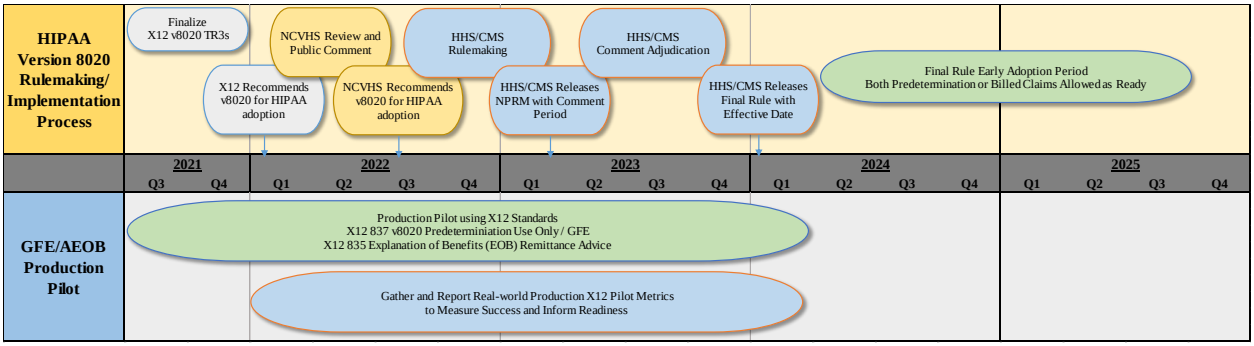
Illustration leveraging X12 standards to support GFE/AEOB functionality:



The 5010 835 or 8020 835 EOB Remittance is shared with each stakeholder in the predetermination / estimation workflow. Consumers will have an opportunity to receive a user-friendly Advanced Explanation of Benefits (AEOB) rendering of the EOB remittance (in clear and understandable language) via their choice of delivery method and relationship with each stakeholder.

Illustration showing a theoretical timeline of the steps involved in the HIPAA rulemaking and implementation process and piloting X12 v8020 standards for the estimation/predetermination use case in parallel.

- NOTE: Timeline estimations below are for guidance / visualization purposes only and do not reflect actual target or regulated dates.



The concept of *real-time* processing of claims and predetermination estimates is not new and is supported in X12 standards. Both X12 and WEDI have published guidance on the utilization of standard X12 transactions to support an integrated solution with defined results. Many payers have hesitated to implement real-time claim processing due to the aspects of medical management technique review and other processes that require intervention before adjudicating a claim for payment. The NSA statute requires health plans/issuers to provide an advanced explanation of benefits in a time-constrained manner, and given the potential of significant volumes of transactions, necessitates efficient and timely EDI processing of GFEs and AEOBs. Under the NSA statute, health plans / issuers are only required to *disclose* when items/ services are subject to medical management technique, and as such, systems processing of predetermination / estimation requests could be conducted in real-time providing a timely EOB remittance response. With real-time processing, the payer would generate a predetermination EOB remittance for each provider's predetermination GFE submission and payers and/or vendors would be positioned to logically aggregate the predetermination EOBs from all providers involved in a period of care to present a consolidated AEOB.

In the healthcare industry today, administrative EDI workflows involving claim codification, editing, submission, reporting, adjudication, and return remittance information is based on X12 transaction standards. While there are other standards and formats that could and may be developed, the industry is coalescing more and more on X12 standards as foundational to realizing the GFE/AEOB provisioned requirements for insured individuals. If other standards were mandated for GFE/AEOB implementation, the cost and complexity factors would increase substantially, requiring almost a ground-up development and deployment effort, where adoption timelines will certainly be long and most likely not met.

Industry Benefits / Value Proposition

- ✓ Leverages ***existing*** Provider Billing / RCM Vendor / Clearinghouse / Payer workflows, reporting, and contractual network relationships/infrastructure already supporting billions of healthcare administrative transactions.
- ✓ Enables a ***near-term*** glidepath to inform insured individuals of their estimated cost of care allowing consumers to make informed decisions. Note: does not address "*quality*" of care in the consumer decision-making process.
- ✓ GFE/Advanced EOB workflow would be an ***ideal use case*** to pilot the predetermination functionality of the X12 v8020 standards which are the next assumed version of HIPAA. This could then inform the effective date for the full transition to the updated HIPAA standards and minimize potential billing and payment disruptions to provider operations and cash flow. As the dental industry has been supporting pretermination of benefits workflows in production since October 16, 2003, real-world production metrics can be referenced to report and inform the ability to meet the requirements of the NSA and the needs of the industry.
- ✓ Accelerates the industry ***transition*** from batch to real-time workflows and broadens adoption of fully electronic and automated HIPAA-mandated transaction standards.
- ✓ Given the current infrastructure investments and high adoption of X12 transactions mandated to support administrative health care EDI in the United States, ***X12 standards*** are the optimal near-term option to realize the required patient / plan specific GFE/AEOB cost estimates to meet consumer needs and expectations.

Summary / Call to Action

The objective of this white paper is to shed light on established X12 transaction standards and existing infrastructure already in place to support the ***billing*** of health care items/services:

- ✓ Established provider and facility revenue cycle management (RCM) systems/solutions and reference fee schedules.
- ✓ Leverages the provider effort to codify services for estimation to then bill for services once rendered.
- ✓ Support for atypical provider types
- ✓ Support for coordination of benefit workflows (both via eligibility and claim standards)
- ✓ Utilization of established and secure connectivity methods
- ✓ Maintains existing contractual, trading partner, and business associate agreements
- ✓ Leverages existing networks and trading partner relationships

- ✓ Established and mature vendor and clearinghouse systems and solutions
- ✓ Maintains patient, provider, plan-specific benefit and cost accuracy via established vendor/clearinghouse/payer systems processing:
    - Patient eligibility & benefits and provider network status
    - Claim validation and predetermination (estimation) or adjudication (payment) processing
    - Claim status request / response
    - Electronic remittance advice / advanced explanation of benefits and cost
    - Transaction acknowledgement /auditing and error or status reporting.

The same industry standards and infrastructure in place today supporting BILLIONS of patient/plan centric healthcare transactions can be leveraged to estimate items / services in the same manner as billing for items / services to maximize operational and fiscal investments already made by the industry and minimize burden for all stakeholders.

Pursuing a standard other than X12 would not be practical given the existing infrastructure and standards already in place that could be leveraged to support the GFE/AEOB functionality.

Therefore, Cooperative Exchange ***strongly*** recommends adopting industry established X12 standards leveraging pretermination of benefits workflows already supported in published and ready for use implementation guides. We realize that any approach will require industry effort and expense for all stakeholders involved but we feel the approach outlined in this white paper leverages and builds upon the infrastructure, standards, and operational workflows that are successfully meeting industry needs today, while advancing the industry in a logical and pragmatic manner for tomorrow. We will continue to actively participate in all standards development initiatives to further a standards-based approach toward providing health care price and quality transparency enabling consumers to make informed decisions for their health care needs. We encourage HHS to issue industry guidance and develop regulations adopting X12 standards to support the technical GFE/AEOB provisions of the No Surprises Act.

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Chairs: Mike Denison, Industry Affairs Committee

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About the Cooperative Exchange

The Cooperative Exchange is a nationally recognized association representing the healthcare clearinghouse industry in the United States. Our 23 clearinghouse member companies represent over 90% of the nation's clearinghouse organizations and process over 6 billion healthcare claims, reflecting over 2 trillion dollars in billed services annually. Our association members enable nationwide connectivity between over 1 million provider organizations, more than 7,000 payers, and 1,000 Health Information Technology (HIT) vendors. The Cooperative Exchange truly represents ***the U.S. healthcare electronic data interchange (EDI) interstate highway system*** enabling connectivity across all lines of healthcare eCommerce in the United States.

Cooperative Exchange member clearinghouses support both administrative and clinical industry interoperability by:

- Managing tens of thousands of entities and connection points
- Exchanging complex administrative and clinical data content in a secure manner
- Supporting both real-time and batch transaction standards
- Enabling interoperability by normalizing disparate data to industry standards
- Delivering flexible solutions to accommodate varying levels of stakeholder readiness (low tech to high tech)
- Providing strong representation and participation across all national healthcare standard and advocacy organizations with many of our members holding leadership positions

Therefore, we strongly advocate for EDI standardization and administrative simplification within the healthcare industry.

Appendix A – Abbreviations, acronyms, and definitions

AEOB – Advanced Explanation of Benefits

CMS – Centers for Medicare & Medicaid Services

EDI – Electronic Data Interchange

EOB - Explanation of Benefits

HDHP – High Deductible Health Plan

HHS – Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HSA – Health Savings Account

GFE – Good Faith Estimate

NCVHS – National Committee on Vital and Health Statistics

NSA – No Surprises Act

Predetermination of Benefits - A pre-service statement from a payer to a provider of what benefits may be payable at the time the service is rendered, provided all relevant factors remains the same. A predetermination request includes all data necessary to fully adjudicate a claim except for date(s) of service. Synonym: Predetermination, Health Care Estimation, Estimator

Predetermination Request - A pre-service request for a statement of the exact benefits that would have been paid had the predetermination request been an actual claim. A predetermination request includes all data necessary to fully adjudicate a claim except for date(s) of service. Synonym: Estimation Request, Health Care Estimation Request, Request for Health Care Estimation

Predetermination Status Request - A request for status on a predetermination request.

RCM – Revenue Cycle Management

Appendix B – resources

This appendix should be used to provide a list of additional resources that may be beneficial for the readers

Dental Predetermination Data Elements & Example

- https://x12.org/examples/005010x224/example-3-predetermination-benefits

The X12 implementation guides referenced in this white paper are available in Glass, X12's online viewer. For more information, please visit x12.org/licensing