NEMOURS CHILDREN'S HEALTH | Well Beyond Medicine

Corporate Administration

10140 Centurion Parkway North
Jacksonville, FL 32256

November 15, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Attention: CMS-9900-NC

Dear Administrator Brooks-LaSure:

On behalf of Nemours Children's Health, thank you for seeking early input on future requirements related to the No Surprises Act (NSA), including advanced explanations of benefit (AEOBs) and the corresponding process for providers to supply payers with good faith estimates (GFEs) when a patient schedules an item or service with a health care provider or facility.

ABOUT NEMOURS CHILDREN'S HEALTH

Nemours Children's Health is one of the nation's largest multistate pediatric health systems, which includes two free-standing children's hospitals and a network of more than 70 primary and specialty care practices. Nemours Children's seeks to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also caring for the health of the whole child well beyond medicine. Nemours Children's also powers the world's most-visited website for information on the health of children and teens, Nemours KidsHealth.org.

The Nemours Foundation, established through the legacy and philanthropy of Alfred I. duPont, provides pediatric clinical care, research, education, advocacy, and prevention programs to the children, families and communities it serves.

GENERAL COMMENTARY

Nemours generally supports policies that increase patients' understanding of the cost of their care. We understand the desire among policymakers, both in Congress and the Administration, to increase transparency and competition in health care. Health care costs rise to the top of family, state and national budgets. However, we caution that the increasing regulatory burden on providers related to price transparency results in a rise in operational cost and subsequently, the overall cost of care, without delivering accurate, actionable information to most patients. Without specific coverage, benefit and authorization information, which only a patient's health insurance plan can provide, provider's price estimates will always be inaccurate. The level of precision needed to produce an *accurate* GFE, either for a patient or a payer, is often not possible at the stage during which these estimates are required. Yet, we believe that offering GFEs is the right thing to do, and we have been providing them since before passage of the NSA.

Given the nascent stage of NSA regulation implementation, we cannot yet assess its impact on patient choice or overall cost of care. Further, we do not have a clear picture of industry-wide compliance with existing rules, which we note have yet to be finalized. Implementation

of the two existing interim final rules has been costly and burdensome, even with enforcement discretion on multiple provisions. We are currently working to understand and achieve readiness to comply with co-provider or facility GFE responsibilities for self-pay individuals, which will begin on January 1, 2023. This will be an entirely new workflow without the near-term option for technology assistance or automation. This means it will require significant manual resources.

We also caution the Departments on future regulatory actions that would levy monetary or other penalties on health care providers for issuing GFEs that are later deemed inaccurate. There are myriad scenarios in which the care plan changes during the scheduled appointment, depending on what is discovered when the provider examines the patient. This is true across the full continuum of care, from well visits to complex surgeries, and everything in between. If the provider issues an estimate in good faith, we strongly discourage the Departments from levying penalties for inaccuracy.

Again, we understand the desire to reduce costs and increase transparency, and fully acknowledge that these regulations are required under laws passed by Congress. Yet we urge the Departments, in partnership with Congress, to seek additional opportunities to reduce friction, and thereby cost, within the system. Policy solutions to address the following points of friction and overhead cost should be considered every time new technology mandates are introduced into health care regulation:

1. Resolve the issue of multiple provider identifiers (e.g. through a national provider directory)
2. Devise a consistent, national strategy for patient matching and identification
3. Consider the addition of authorization automation to certified health IT technology to support providers in completing large volumes or authorizations for services.
4. Develop consistent privacy laws across states, including consent policies (opt in vs opt out) for exchanging patient information.

We believe that addressing these persistent challenges would achieve much larger cost savings than nearly any other proposal, including those contained within price transparency and NSA regulations.

NEMOURS' RESPONSES AND RECOMMENDATIONS

A. Transferring Data from Providers and Facilities to Plans, Insurers and Carriers

1. **Using FHIR-Based API for Real-Time Exchange of AEOB and GFE data**
   In general, Nemours supports the use of a FHIR-based API for the exchange of AEOB and GFE data to comply with requirements under the NSA. However, it will be important for the Departments to consider several elements related to such exchange.

   First, while FHIR is the correct architecture, there are many facility types that are not well positioned, financially or otherwise, to adopt technical standards like this, even though they may be subject to requirements under the NSA. Second, even for larger providers like Nemours, who are better positioned for adoption and uptake of new technology standards and processes, success will depend on the timeline and solutions developed by electronic health record (EHR) vendors. Under the best circumstances, this process will require significant time and resources. Technology solutions and provider workflows will not achieve a state of readiness for at least 2 years after requirements are final.

   Finally, the most salient concerns are: 1) whether exchange will be required as point-to-point with each payer, or whether all data will be sent to a clearinghouse for distribution to the payers, and 2) the lack of data transmission standards. In our experience, complex

integration with a single point-to-point exchange pathway takes approximately four months with existing data transmission standards. Exchanging GFEs and AEOBs, for which there is currently no data transmission standard, will compound the difficulty in establishing point-to-point data exchange, and increase the timeline. Multiply this by a multitude of point-to-point exchange partners, and the time, resources and burden on providers increase by orders of magnitude.

Nemours strongly recommends the creation and use of a federally funded data clearinghouse rather than requiring point-to-point exchange between providers and payers. Further, the Departments must establish data transmission standards to support GFE and AEOB exchange.

2. **Privacy Concerns with Transfer of AEOB and GFE Data**
   There are several potential privacy concerns that should be considered as GFE and AEOB information is exchanged. First and foremost, we remind the Departments that the pediatric health care environment differs greatly from the adult environment. All minors have enumerated rights to privacy and confidentiality with respect to health care, as provided under HIPAA and various state statutes. ***We strongly recommend that the Departments include specific protections for minors when promulgating future regulations to implement NSA requirements.***

   Often, minor patients are not the health plan subscriber and would not receive the AEOB when issued. The Departments should take steps to ensure that parents/guardians, as plan subscribers, do not receive AEOBs for confidential care scheduled by a minor patient. Similarly, for minor children in the custody of the state, AEOBs should not be issued to anyone other than the patient for scheduled, confidential care.

   More broadly, there are systemic challenges outside the scope of this rule related to accurate documentation and maintenance of health insurance status. These challenges could result in GFE information being delivered to the wrong insurance provider/plan. Providers should be held harmless if this occurs.
   Further, providers and payers may be required to provide GFEs and AEOBs to patients who are simply shopping for, not scheduling, health care services. (We provide further comment on this potential requirement in Section B.). Ostensibly, this prospective AEOB information, which is likely to contain inaccuracies based on lack of information (e.g. clinical diagnosis, consult, etc.), could be shared with payers, including employer-based plans. Patients are protected from adverse action with respect to health care claims.

   We urge the Departments to ensure patients have full protection from any adverse action resulting from information provided and/or shared through a GFE or AEOB.

3. **Impact of Health IT Certification on AEOB/GFE Exchange**
   From our position as a large health system with certified EHR technology and years of support through the Meaningful Use (MU) program, ***we strongly recommend that the Departments leverage the health IT certification program to support AEOB/GFE exchange.*** If vendors are not required to provide technology solutions within the EHR platform as a condition of maintaining certification, it is likely that providers will bear the cost of expensive enhancements to their EHR product in order to comply with exchange requirements.

   However, to the extent that providers and facilities covered under NSA regulations do not overlap with those who have been required to purchase certified EHR technology,

leveraging the health IT certification program to support AEOB/GFE exchange will provide limited benefit. We encourage the Departments to collaborate with the Office of the National Coordinator for Health IT (ONC) to determine whether there is complete overlap.

In the instance that there are providers/facilities that are required to comply with NSA regulations but have not been required to purchase certified EHR technology, the Departments should take steps to support them or provide exceptions. Small, rural and other providers face well-documented resource challenges which could preclude them from purchasing new technology.

B. Other Policy Considerations

1. **Information Provided on GFE Created for Payers**
   In general, Nemours urges the Departments to consider appropriate differences between GFEs provided to patients and those provided to payers. For example, when a patient is shopping for services, there will almost never be a diagnosis code included on the GFE because that patient has not been evaluated. Further, at our hospitals and practice locations, it is our organizational policy not to schedule with diagnosis codes. This means the GFE for scheduled services would not include a diagnosis code either.

   Further, in contrast to the GFE given to patients under NSA regulatory requirements, GFEs given to payers should not include an estimated patient responsibility. The payer will have more detailed information on patients' coverage and benefits and will produce a more accurate estimated patient financial responsibility on the AEOB.

   We recommend that diagnosis codes not be required in GFEs that are provided to payers except in cases where coverage/patient responsibility is dependent on a specific diagnosis. Further we recommend that patient financial responsibility not be required in GFEs provided to payers.

2. **When to Provide GFE to Payer**
   Nemours strongly believes that providers should only be required to provide GFEs to payers when an item or service is scheduled. Requiring providers to send GFEs to payers based on a patient's inquiry (e.g. shopping for services) would result in significant burden to both providers and payers, and may lack specificity and accuracy. Instead, we believe the self-service tool provided by payers, under separate regulation, is sufficient for patients with health insurance when shopping for services. If items or services are not yet available on the self-service tool, patients should seek an AEOB from their insurer.

3. **Notifying Payer about Consent to Waive Protections**
   Nemours' understanding of existing regulation under the NSA is that providers are already required to provide payers with signed consent forms (waiving NSA protections) within a reasonable timeframe after consent is obtained. Whether providers are able to inform payers as part of or concurrently with newly required GFEs will depend on the technology solutions developed (as discussed in Section A. above). Nemours prefers that consent notifications to the payer are reported separately (e.g. not in the same document) from the GFE provided to the payer.

   With respect to the broader requirement to inform payers about the status of consent, Nemours strongly believes providers should only be required to inform payers when consent is obtained. We do not support requirements on providers to inform payers of

any other status related to consent, including when the provider intends to seek consent or if the patient has declined to give consent. However, when consent has been obtained and the payer has been informed, but a patient subsequently revokes consent, providers should inform payers of the change in consent status.

With respect to the timeline for informing payers of obtained consent, we urge the Departments not to require less than one day, even in instances where the service is provided on the same day that consent was obtained. With respect to services scheduled at least 3 days out, we prefer for GFE and consent timelines to align so that providers are not tracking multiple timeline requirements for documents that are required to be sent concurrently. Further, we again note that success will be dependent on technology solutions with the EHR.

4. **Displaying Cost Information on AEOB**
   Nemours supports requirements for an AEOB provided to a patient that has given consent to balance bill to explicitly reflect that NSA or state-based protections do not apply. We believe the AEOB should specifically state that the data is premised on the patient's waiver of protections against balance billing, and the AEOB should reflect two different sets of cost and benefit data showing the difference between their financial responsibility with and without consenting to waive their protections. If the payer is unaware of the patient's consent status, the AEOB should not reflect both sets of data. Having a separate set of data that is unexpected and likely does not apply would cause more confusion for patients.

   We recommend that the AEOBs include information related to prior authorization, including whether the item/service requires prior authorization, and a statement explicitly outlining that nothing provided on the AEOB is a guarantee of coverage, and that the patient financial responsibility included in the AEOB is only an estimate.

   Additionally, we recommend that the AEOB explicitly state that cost information only applies to the current benefit year and will expire on the last day of the current benefit year.

5. **Coordination with Self-Service Tool**
   For patients who are shopping for services to get a general sense of cost and compare across covered providers, coordination with the self-service tool should be encouraged. Shoppers should be reminded numerous times while use the self-service tool or reviewing GFEs that they are only getting estimates. It is very difficult to get accurate results with limited (or in the case of self-service, incorrectly entered) information.

   For patients with scheduled items or services, directing them to the self-service tool will likely cause further confusion. The best estimate for their scheduled item or services will be the AEOB because the payer has the most information, drawing from the patient's coverage plan and the GFE provided by the health care provider. Yet, it remains the case the AEOBs are simply an estimate and may not accurately reflect the final patient responsibility. It is critical to ensure that patients understand this. Additionally, receipt of an AEOB does not guarantee authorization or coverage.

6. **Covered Services for Which AEOBs are Required**
   If payers are required to provide AEOBs for all covered items and services (rather than a subset) in the first implementation year, an enormous burden will be placed on providers to create and send GFEs. Currently, the Departments provide enforcement discretion on

requirements for providers to produce GFEs for insured patients. This enforcement discretion is both welcome and appreciated, as providers master processes and workflows to provide GFEs to self-pay patients. This has been a difficult and labor-intensive undertaking and has yet to include the creation of GFEs with information from multiple providers.

Nemours strongly recommends that the Departments limit requirements to provide AEOBs to a subset of covered items and services in the first two years of implementation. This is consistent with the compliance cadence of previous, related rules.

7. **Requirement to Provide AEOB to Providers**
   Nemours strongly urges the Departments to require that AEOBs be shared with providers at the same time they are shared with patients. Providers need the information on the AEOB related to patient responsibility to calculate any necessary deposits, co-payment or co-insurance amounts.

8. **Payers' Request for GFE Based on Patient Request for AEOB**
   Nemours asks that the Departments carefully consider the required timeline for producing a GFE requested by the payer, and limit requests to a subset of covered items and services for the first two years. When a patient schedules an item or service, the process to create a GFE and AEOB is automatically triggered. Therefore, if a patient requests an AEOB from the payer without having a scheduled item or services, it is most likely that they are interested in shopping for services.

   In cases where patients are shopping for services, we recommend that patients be directed to the self-services tools that already exist. However, if providers are required to issue GFEs to payers for patients shopping for services, we recommend that providers have a minimum of 3 business days to provide the GFE to the payer. This is consistent with current regulations requiring providers to deliver a GFE to patients upon request.

   We also recommend that the AEOB reflect whether the patient has scheduled an item or service, or whether the patient simply requested the information as part of an effort to shop for items or services.

9. **Specified Item or Service**
   In determining which items or services have low utilization or significant variation in costs for the purposes of modifying AEOB timing requirements, ***it is Nemours' strong belief that the Departments should first determine a limited set of common items and services for which AEOB timing will not be modified. For at least the first two years of implementation/compliance, all items and services not on the list of commons items and services should be treated as specified items or services for which AEOB timing may be modified to allow additional time.*** This is justified by the newness of this process, the reliance the industry has on technology vendor solutions, and the time it takes to implement and adjust to regulatory change. The items or services on the common list could align with those required under various other price transparency regulations.

   Beyond the first two years of implementation, the Departments should consider additional factors when determining which items or services should be specified items or services. Items or services involving the use of implantable devices, infusion medications,

genetic medications, blood products, organs, blood transfusions, and cardiac procedures should be strongly considered for specified items or service designation. The cost and utilization of these items and services vary widely from patient to patient and are highly specialized for each individual. Further, it requires significant amounts of time to obtain price estimates from vendors for many of these items or services and develop a detailed care plan, particularly for complex and/or high acuity cases.

We believe the designation of specified items and services will vary by provider or facility type, which is why we strongly recommend starting with a set of common items and services for which AEOB timing is not modified and allow modification for everything else for the first two years.

With regard to how AEOB timing should be modified for specified items and services, ***we recommend that providers be given no less than 10 days to complete and provide a GFE to payers for items and services that are elective in nature and scheduled at least two weeks out.*** If the specified item(s) and/or service(s) are emergent, providers need flexibility to provide a GFE that may be less accurate because of the inability to get vendor information in a timelier manner and a lack of time to develop a detailed care plan.

10. Verification of Coverage

The Departments ask 1) whether providers already verify coverage and 2) whether additional burden would be created for verification requirements under NSA AEOB regulation. At Nemours, our staff does already complete coverage verification, though on a different timeline than is suggested/required for GFEs and AEOBs. Our staff encounter the following challenges, which could be compounded by AEOB requirements, when completing coverage verification:

- Verification of coverage takes time, and a patient's coverage often changes between scheduling and the date of the appointment.
- Though there is an industry standard for the verification of services, the process remains unreliable because payers often to not adhere to the industry standard.
- In cases where authorization is required and provided, coverage and payment are not guaranteed. Final coverage determinations are not completed until the claim is submitted.
- Our hospitals and practices do not engage in order-based scheduling, which means our staff (scheduling and financial teams involved in the GFE process) are not always aware of the specific services or tests that will be performed during an appointment. Further, in many cases, clinical decisions about items and services are not made until the appointment occurs. This applies to office visits, surgeries and inpatient admissions.
- Some insurance plans have benefit limits that complicate the verification process (e.g. limited number of covered physical therapy appointments).
- Currently, authorizations are completed within 21 days of a scheduled item or service, even if the appointment is scheduled more than 21 days out, to make sure we are as accurate as possible.
- Some items and services are scheduled beyond the end of the benefit year, rendering GFEs and AEOBs obsolete. Benefits, authorizations, charges and contracted rates may change in a new benefit year, even though the appointment was previously scheduled.

If requirements related to GFEs and AEOBs increase the speed or volume of these verification processes, providers will experience substantially increased burden. There

may be potential for technology solutions to assist in the automation of some verification processes, though we expect those products to be expensive.

Further, the Departments ask whether relying on an individual's representation of their enrollment in a health plan or coverage would alleviate burden. ***Nemours believes this approach would not alleviate provider burden, would increase patient burden, and would compound existing challenges with accuracy and privacy.*** Understanding insurance plans and coverage is already challenging enough for patients; we do not believe compounding that burden would be helpful or appropriate. Further, if/when inaccurate coverage information is provided and verification is not required, there is risk that the wrong payer could inappropriately receive protected health information.

More broadly, it is Nemours' strong belief that ***providers should not be responsible for determining what is or is not covered.*** Only payers have the final say on what they will or will not cover and/or pay for.

11. **Access and Understanding for Underserved and Marginalized Communities**
First and foremost, we note that most of the underserved and marginalized patient families that we see are enrolled in Medicaid or CHIP, which we understand to be outside the scope of NSA regulations. However, we acknowledge that individuals in several racial and ethnic groups have been marginalized and underserved in other ways as a result of systemic racism and policies that derive from that framework. It is critical that payers and providers ensure that all people have equal access to and understanding of the information provided in an AEOB and all other NSA materials, especially those outlining the rights afforded to them under the law. Further, payers and providers should ensure that their staff are trained to make no assumptions about an individual's coverage status, ability to pay, or any other related topic. ***We recommend adding a line informing patients about their right to an AEOB to patient rights and responsibilities disclosures and on enrollment information provided by their insurance plan. Additionally, we recommend that AEOBs be made available via multiple modalities including paper, email, electronic health record/patient portal, etc.***

The Departments should ***ensure that all materials, including AEOBs, should be written in accessible language and as simply as possible. We recommend defaulting to a 3rd grade reading level across all materials for all patient populations.*** Overall, we strongly support a consistent standard for language access across AEOBs and all other insurance-related materials. However, Nemours declines to recommend that existing language access requirements be adopted for AEOBs because we are unaware of their efficacy and impact. ***We encourage the Departments to develop more robust infrastructure to audit existing insurance materials for compliance with language access requirements and examine what barriers there may be to complying with existing language access requirements.***

Further, AEOBs should ***define key terms*** such as "cost," "charge," "patient responsibility," "copayment," "deductible," "coinsurance," "out-of-pocket max," and others related to information seen on the AEOB. Patients should also be given materials written in their primary language or be offered translation services when their AEOB or other documentation is not offered in their primary or preferred language. We also recommend that the Departments require payers to offer educational materials in interactive modalities, such as closed-captioned short videos, explaining what an AEOB is and how to read it.

We urge the Departments to require that AEOBs strongly emphasize that the document is an estimate, and their actual cost may differ after the services are delivered. This is because not all clinical decisions or actions are predictable prior to the appointment (as previously discussed). It is equally important that the AEOB clearly state what is and what is not the patient's financial responsibility. Yet, even with this additional clarity, we are concerned that the provision of an AEOB may discourage individuals from seeking care if they believe they cannot afford the estimated patient responsibility. The Departments should keep a very close watch on the potential unintended consequences, such as causing delays in care, particularly for marginalized and underserved patients.

Overall, we caution the Departments that accessibility of AEOB information could directly and indirectly impact patient engagement and appropriate utilization (e.g. for preventive and necessary care). ***We strongly recommend that the Departments audit AEOBs and other NSA materials for future compliance, and continuously assess the impact and efficacy of this set of regulatory requirements, including engaging focus groups of diverse patients.***

C. Economic Impacts

Though not included in the Departments' set of questions, Nemours encourages the Departments to consider the overall economic impact of these requirements as states, providers, health plans and federal programs shift toward value-based care arrangements. Under value-based payment and delivery arrangements, providers are increasingly accountable for the overall cost of care for their population, and continually seek ways to lower cost while improving quality. This includes such activities as ensuring patients seek the appropriate level of care (e.g. primary care vs emergency department care), emphasizing preventive and well-care, and carefully managing care plans for patients with medically complex and/or chronic care needs.

If patients are encouraged to shop for services and receive estimates that are, for reasons previously discussed, inaccurate, how will this impact the provider organization that is accountable for their total cost of care? We are concerned that the good intentions of the No Surprises Act could quickly result in unintended, negative consequences if these requirements are not very carefully considered and integrated into the larger health care ecosystem.

1. **Time and Cost Burden to Build and Maintain Standards-based API**

   As previously outlined, from a technical standpoint, complex integration for each point-to-point data exchange with a single external organization takes approximately four months. Additionally, significant time is spent negotiating legal arrangements with each end point for such exchange. A single legal agreement related to information exchange may take several months to negotiate and finalize. If providers are required to engage in point-to-point exchange with each payer individually, the time it will take to build these connections would be multiplied exponentially. As an illustrative example, the number of marketplace plans in Florida, one of four states in which we operate, exceeds 450. *In our view, this is the most critical factor to consider. This factor is far more impactful than the choice of technology (e.g. FHIR or some other architecture).* ***Again, we strongly recommend the creation of and reliance on a single, federally funded clearinghouse through which GFE and AEOB information passes between providers to payers.*** While we currently engage in other types of data exchange, our organization does not have existing standards-based APIs that could be repurposed for this use case, nor is there an existing industry standard defining the data elements to exchange. For health care organizations that do have reusable API technology, this new type of information exchange will still not be possible without an industry standard defining specific data

element requirements. The clearinghouse approach would allay concerns over the lack of an industry standard, as a single pass through would define a single standard for the exchange of relevant data elements.

Further, we do not have existing workflows for this new type of exchange. All cost and administrative burden to comply with GFE requirements for covered individuals will be new. More broadly, these new requirements will increase the volume of GFE production by orders of magnitude and deeply impact existing GFE workflows.

2. **Purchasing and Implementing a Standards-based API**
   Overall, Nemours believes it is more likely that we would purchase a standards-based API for AEOB and GFE exchange rather than build it ourselves. This is especially true if we are required to establish connections to multiple endpoints. However, purchasing and implementing a third-party product comes with its own set of challenges.

   First, we must rely on technology vendors to create, test and validate certified products, and adopt standards produced via industry consensus or by a federally funded clearinghouse. These standards are a prerequisite for scalability.

   Second, the cost of purchasing such technology is significant and could be cost-prohibitive for smaller providers. In our experience, there are two dominant licensing models, and each is expensive. Some vendors charge a lump sum for the product and some charge a per-exchange subscription fee. Our estimate for the lump sum product is a minimum of $10,000 for each point-to-point connection. Subscription-based models can vary significantly in cost, but our closest current analogous subscription product costs $.25 per exchange with a single claims clearinghouse, **totaling $46,500 per month**. Actual estimates Nemours has received for other types of exchange (e.g. authorizations, e-DocuSign) have ranged from to $3.50 to $6 per exchange.

   Third, these significant costs can affect the price of insurance premiums, as payers pass them on to their members. Higher premiums can impact insurance and health care affordability and lead to higher rates of uninsured Americans. While this is not a cost-shifting practice we support, we are also concerned that providers do not have the ability to pass along these costs and must absorb them completely. Our only potential recourse is to renegotiate contracted rates with payers, which ultimately impacts premium costs as well, and is likely to increase overall health care expenditures.

3. **Factors Impacting Burden and Cost of Providing GFEs for Covered Individuals**
   The cost estimates outlined above would likely be cost prohibitive for small and/or rural providers, especially if multiple point-to-point connections are required. In our view, the single most cost-efficient approach would be for the federal government to establish (or contract with) a single entity through which all payers and providers exchange GFE and AEOB information, similar to how Medicare and several other payer claims are submitted. This approach would not eliminate all cost burden, but it would significantly reduce it.

   Further, including the development of this technology as a requirement for product certification through the Health IT Certification Program would also help reduce the cost to providers.

   Finally, limiting the number of items or services for which GFEs and AEOBs are required during the first two years of implementation would help to reduce cost and burden for providers and payers.

4. **Other Information to Consider**

We caution the Departments to consider that the industry has not yet analyzed or quantified the impact of related requirements under other price transparency rules or the first two NSA regulations. We don't yet know what has been most helpful to patients, what needs improvement, or how the new information and tools have impacted the overall cost of care.

While the thrust of these past, present and future rulemaking activities has been to increase transparency and lower cost, the Departments must also consider the financial impact of these regulations on providers. Each of these rules has resulted in increased operating costs to comply, and we anticipate that this future GFE/AEOB regulation would increase our costs as well. As stated above, higher operating costs can impact future contract rates, as providers attempt to offset these new costs.

We are also concerned that these regulations, while well-intentioned, over-emphasize cost as a primary driver of health care decisions, and de-emphasize clinical considerations such as quality, complexity and specialization. This shift could lead to worse health outcomes.

Finally, we encourage the Departments to devise strategies for educating Americans on how health insurance works, how to understand their plans and benefit structures, and the differences between premiums, copayments, coinsurance, and deductibles, among other things. Part of the challenge facing patients is the lack of transparency and understanding about how health insurance companies and health care providers work together to determine the cost of their care.

CONCLUSION

Nemours stands ready to leverage our expertise and relevant experiences to assist the Departments in crafting the next phase of NSA regulatory requirements. We are encouraged by the Departments' interest in early input and appreciated the opportunity to partner with you in this process. Thank you for your consideration of our recommendations, and we look forward to continued collaboration. Please do not hesitate to reach out to Katie Boyer, Senior Advisor of Legislative and Regulatory Affairs at katie.boyer@nemours.org with questions or requests for additional information.

Sincerely,

Rodney A. McKendree
EVP, Chief Financial and Business Services Officer