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My Health Care Will Cost What? Advanced EOBs and Price Comparisons Coming in 2022

Starting in 2022, patients will know in advance what most health care services will cost. Enacted at the end of 2020 as part of the Consolidated Appropriations Act, 2021 (the CAA), the No Surprises Act requires that group health plans and insurers provide advance cost estimates, called advanced explanations of benefits (advanced EOBs), for scheduled services. The No Surprises Act also requires plans and insurers to provide price comparison guidance online and by phone, similar to what non-grandfathered plans and insurers already were required to do starting in 2023 under the Transparency in Coverage regulations. This article, part of our ongoing series on the group health plan changes in the CAA, covers these requirements.

Advanced EOBs

Starting with the 2022 plan year, both grandfathered and non-grandfathered plans under the Affordable Care Act will need to provide advanced EOBs to enrollees after receiving notice of scheduled services from providers or facilities. Timing for when the plan must provide the advanced EOB depends on when the patient schedules the service or requests the estimate:

- Patient schedules service three to nine days prior to the date of service: the plan must provide the advanced EOB within one business day after receiving the provider's or facility's notice.
- Patient schedules service at least 10 days prior to the date of service, or requests an advance EOB: plan must provide the advanced EOB within three business days after receiving the provider's or facility's notice.

The advanced EOBs will include the following:

- Whether the provider or facility is in- or out-of-network;
- If in-network, the contracted rate for the item or service;
- If out-of-network, a description of where to find information on in-network providers and facilities;
- The billed amount estimate from the provider or facility;

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- An estimate of the amount the plan will pay;
- An estimate of the person's cost-sharing responsibility for the item or service, as of the date of the notice;
- An estimate of the amount the person has incurred toward their cost-sharing limits, including deductibles and out-of-pocket maximums, as of the date of the notice;
- Whether the item or service is subject to medical management, including concurrent review, prior authorization, or step-therapy or fail-first protocols;
- A disclaimer that the advance cost estimate is only an estimate; and
- Any other information or disclaimers that are appropriate and consistent with the above.

Presumably, the plan's payment estimate for out-of-network services will be based on the billed amount estimate from the provider or facility, even though that estimate may not be the final amount the plan pays. This is the sort of information that plans might include as an additional disclosure, along with a general disclaimer that the advanced EOB is not a guarantee that the plan will cover the service.

Plans are required to provide the advanced EOBs by mail or electronic means, as requested by the covered person. However, it is not clear how individuals are to make that request. Providers and facilities do not need to ask a patient their preference when scheduling the services. Other open questions include how often a person will need to renew their request for mailed or electronic copies and whether a negative election is permissible (for example, if a covered person does not request mail or electronic delivery, he or she is deemed to have requested electronic). Further, if negative elections are impermissible and a person does not state a preference, would the electronic disclosure rules under the Employee Retirement Income Security Act (ERISA) apply? Further guidance from the Departments of Labor, Health and Human Services, and the Treasury would be appreciated, especially considering that advanced EOBs sent by mail inevitably will not arrive before the date of service if scheduled only three days in advance.

Price Comparisons

In addition to providing advanced EOBs, the No Surprises Act requires non-grandfathered plans to offer price comparison guidance by phone and via an online tool starting with the 2022 plan year. The tool will need to allow a covered person to compare the amount of cost-sharing that he or she would pay if an in-network provider furnished a specific item or service.

The requirement for an online price comparison tool is similar to a requirement under the Transparency in Coverage regulations, which the Departments of Labor, Health and Human Services, and the Treasury finalized in late 2020. Those regulations require the development of an online price comparison tool for an initial 500 items and services starting with plan years beginning on or after January 1, 2023, and for remaining covered items and services for plan years beginning on or after January 1, 2024.

Under the Transparency in Coverage regulations, which are much more detailed than the CAA, the online tool will need to provide real-time, individualized estimates of how much a covered person would pay for covered items or services. Users need to be able to search by description or billing code and by the name of an in-network provider, all in-network providers, or for an out-of-network allowed amount or other rate that reflects how much the plan would pay. The estimate that the plan generates will need to be based on in-network rates, out-of-network allowed amounts, and the specific individual's cost-sharing information, including progress toward a deductible or out-of-pocket maximum.

The No Surprises Act's one-year jump in the effective date for in-network price comparison guidance, when compared to the Transparency in Coverage regulations, may make it challenging for plans to comply on time. Plan sponsors will want to begin developing their approach as soon as possible in order to ensure they or their vendors have the necessary systems in place for the 2022 plan year, both for price comparison guidance and advanced EOBs.

The No Surprises Act will require a significant shift in how group health plans and insurers operate. The next alert in this series will focus on the requirements for identification cards, continuity of care, and provider directories. These changes will help make health care easier to navigate for patients, but require diligence by plans and insurers to implement.

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