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October 21, 2019

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development, Room C4–26–05,
7500 Security Boulevard, Baltimore, Maryland 21244–1850

Re: OMB control number 0938–0566

Dear CMS Desk Officer:

Anthem, Inc. (Anthem) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Advance Beneficiary Notice of Noncoverage (ABN) request for comment, as outlined by *Federal Register* notice dated August 20, 2019.

Through its affiliated companies, Anthem serves more than 78 million people, including more than 2 million Medicare beneficiaries, and is committed to providing access to high-quality, affordable healthcare services that help consumers improve their health and well-being. As one of the nation's leading health benefits companies, Anthem appreciates its partnership with CMS to serve Medicare beneficiaries.

Expand Medicare Fee-for-Service Financial Protections to Medicare Advantage Beneficiaries

We strongly encourage CMS to expand the current Medicare Fee-for-Service (FFS) ABN to Medicare Advantage (MA) to ensure beneficiaries are provided the same financial protections. Currently, when an MA beneficiary has a qualifying Out-of-Network (OON) event, but services the provider delivers are not medically necessary under FFS rules, the provider is able to bill the beneficiary directly for the cost of the service. In contracts, a Medicare provider treating a FFS enrollee is required to notify members if an item/service does not meet Medicare coverage criteria by providing an ABN to the beneficiary. If the beneficiary did not receive the ABN from the provider, then the provider is held accountable for the bill, not the beneficiary.

OON providers for MA plans have been specifically directed by CMS not to use the ABN, which would provide FFS and MA beneficiaries with the same billing protections. Through the Non-Contracted Provider Payment Dispute Process (NPPDP) in MA, beneficiaries may receive a "surprise bill" and become responsible for the payment of services because there is no CMS requirement to notify the beneficiary that the item/service did not meet Medicare coverage criteria. It is the MA beneficiary who

is then responsible, not the OON provider, for the services that were not medically necessary in accordance with Medicare guidelines. The current process disadvantages MA beneficiaries as providers are required to inform FFS beneficiaries when services are outside of Medicare coverage prior to the receipt of care.

The Different Notification Requirements Negatively Impact Medicare Advantage Beneficiaries

Under existing guidance, there is no requirement for providers who are OON to notify the MA beneficiary if an item or service does not meet Medicare coverage criteria. Therefore, when an MA beneficiary has a qualifying OON event, but some or all of the care is not medically necessary, under current rules, the provider can bill all or part of the cost of the services to the beneficiary. MA Organizations (MAOs) are liable for all of the Part A and B OON services, except cost-sharing, unless the services fall outside of what FFS would cover. MA beneficiaries only becomes aware the service was not covered when they receive a surprise bill, or the MA plan issues a denial following the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Ultimately, CMS' current guidance is putting MA beneficiaries in the middle and making them financially liable for surprise medical bills or allowing the Medicare program to cover non-covered services based on current MA guidance. While the current CMS process and guidance permits surprise bills being sent to beneficiaries by OON providers and MAOs cannot alter this process, MAOs are often the subject of the beneficiary complaints. Beneficiaries express their discontent by filing complaints with CMS and reporting frustrations through the Consumer Assessment of Healthcare Providers & Systems surveys, which negatively impact plan Star Ratings, and potentially lowers supplemental benefit funding for enrollees.

MA beneficiaries should have the same financial protections as FFS enrollees. By enabling the use of the ABN in MA, CMS can provide the same financial protections to all Medicare beneficiaries. We appreciate CMS' continued attention to this issue, and would like to work with the Agency to implement a solution to prevent additional beneficiaries from receiving "surprise bills" that can cause financial harm.

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Anthem appreciates this opportunity to provide comments on the ABN. We are committed to working with CMS to lower beneficiary costs, while their improving health outcomes. Should you have any questions or wish to discuss our comments further, please contact Amanda Hurley at (202) 508-7892 or amanda.hurley@anthem.com.

Sincerely,

Anthony Mader
Vice President, Public Policy

About Anthem, Inc.

Anthem is a leading health benefits company dedicated to improving lives and communities, and making healthcare simpler. Through its affiliated companies, Anthem serves more than 78 million people, including over 40 million within its family of health plans. We aim to be the most innovative, valuable and inclusive partner. For more information, please visit www.antheminc.com or follow @AnthemInc on Twitter.