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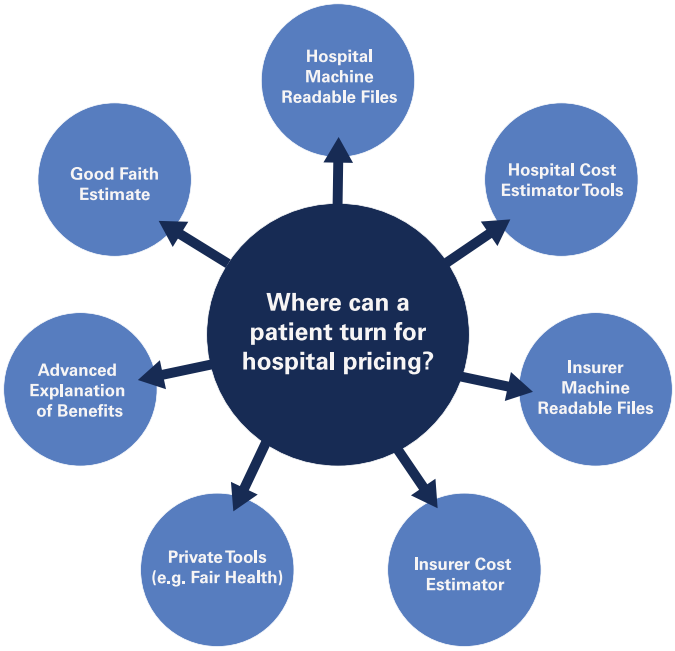
The Mock Claim Proposal:
A New Approach to Health Care Cost Transparency

For many patients, understanding the cost of a medical procedure before receiving care can feel like a guessing game, reflecting factors beyond the provider's role in delivering care. Even with insurance, it's often unclear how much care will be covered, what portion will be out-of-pocket, and whether additional providers involved in the service will bill separately. The No Surprises Act was designed to address this uncertainty by requiring health plans to provide patients with an Advanced Explanation of Benefits (AEOB) — a personalized estimate of their costs before care is delivered.

Implementing an AEOB is a complex undertaking that requires coordination among multiple providers, health plans and IT systems — many of which were not originally designed to communicate in real-time before care is delivered. This additional coordination has the potential to require additional time and resources for providers and plans.
To help address these challenges, the AHA and other stakeholders have proposed a practical and scalable solution: **the mock claim proposal.**[1]



What Is the Mock Claim Proposal?

The mock claim proposal is built from a simple, yet powerful, idea: **use the same electronic format that providers already use to submit insurance claims to transmit good faith estimates to health plans.** These estimates would be submitted as "mock claims" — mock versions of real claims not intended for payment, but to estimate the cost of care. This allows health plans to process the mock claims using their existing adjudication systems and generate a consolidated AEOB for the patient.

Here's how the process works:

When a patient schedules a medical service, the convening provider — the one responsible for coordinating the care — alerts any other providers who will be involved.

Each provider then submits a mock claim to the patient's health plan, detailing the expected services and charges.

The health plan uses these mock claims to calculate the patient's out-of-pocket costs based on their current coverage, deductibles and network status.

The result is a comprehensive AEOB that gives the patient a clear picture of what to expect financially.

1 https://www.cms.gov/files/document/progress-aeob-rulemaking-december-2024-update1pm.pdf

How the Current Claims Process Supports Accuracy

One of the key strengths of the mock claim proposal is its reliance on the existing claims infrastructure, specifically the X12 837 health care claim transaction format used for institutional (837I) and professional (837P) claims. These formats are standardized and widely adopted across the health care industry, allowing providers and health plans to exchange detailed information about services, charges and patient coverage.

When a provider submits a claim after care is delivered, the health plan uses its X12 adjudication system to determine how much of the charge is covered, what portion the patient owes, and whether any adjustments are needed based on network status, prior authorizations or benefit limits. This process is highly accurate because it draws on real-time data about the patient's insurance plan, including:

- Deductible and out-of-pocket maximum status.
- Coverage tiers and network participation.
- Service-specific benefit limits (e.g., number of covered visits).
- Coordination of benefits with other insurers.

By using mock claims to simulate this process before care is delivered, health plans can generate AEOBs that closely align with post-care claims. **This means patients receive estimates that are not just ballpark figures but rather grounded in the actual rules and data that govern their coverage.**

Benefits for Patients

For patients, the mock claim proposal offers several important advantages. By leveraging the same technology for both pre-service estimates and post-service claims, this method can deliver the most accurate pre-service estimate of a patient's out-of-pocket costs. It does this by incorporating current information on the insured patient's benefits, including network, coverage and accumulators (including deductible, maximum out-of-pocket and visit limits).

Implementation Made Easier

From a systems perspective, the mock claim proposal is designed to minimize disruption and reduce burden on providers. Providers can use their existing workflows to submit good-faith estimates, with only minor modifications to flag the transactions as mock claims. Health plans can process these submissions using their current X12 adjudication systems, avoiding the need to build new infrastructure or adopt untested technologies.

This approach also reduces the need for providers to share sensitive pricing information, which can be a barrier to collaboration. Instead, each provider submits their good-faith estimate directly to the health plan, which then creates a comprehensive AEOB for delivery to the patient.

Looking Ahead

The mock claim proposal represents a thoughtful, collaborative effort to bring price transparency to health care in a way that's practical, efficient and patient-centered. By leveraging systems that providers and insurers already use, it avoids costly delays and unnecessary complexity — while still delivering on the promise of the No Surprises Act.

For patients, it means clearer information and fewer surprises. For the health care system, it means a smoother path to implementation.

As the industry moves forward, proposals like this one show that meaningful change doesn't always require reinventing the wheel — sometimes, it just takes a smarter way to use what we already have.

Resources

- AHA letter to the Centers for Medicare & Medicaid Services on AEOB and good faith estimates
- Fact sheet: Hospital Price Transparency
- Fact sheet: Price Estimator Tools