AHIP Comments
Requirements Related to Surprise Billing; Part I (CMS-9909)

No American should worry that a trip to the emergency room or an unplanned treatment by an out-of-network physician will bankrupt them. The Consolidated Appropriations Act ("No Surprises Act") aims to guarantee that, and it is critical that this landmark law be implemented in an efficient, pro-consumer manner that achieves the goal of preventing surprise medical bills while lowering health care costs for Americans.

AHIP strongly supported Congressional efforts to protect American consumers from the financial hardship that too often results from receiving a surprise medical bill. While the inclusion of an independent dispute resolution option was not an ideal policy choice, the overall system can succeed at lowering health care costs if the regulatory framework is designed in a way that prioritizes consumer protections and correcting the market distortions that allowed for egregious billing practices. We are firmly committed to implementing this law to the benefit of patients and doing so in a way that can lower health care costs, as the Congressional Budget Office assumed this law would do.

Above all, any regulatory actions implementing the No Surprises Act must prioritize holding consumers harmless from balance bills and avoiding unnecessary administrative requirements that could confuse consumers, hinder medical care, and increase health care costs. We believe that regulations can protect consumers while restraining costs, namely by encouraging network participation among health care providers, leaving independent dispute resolution as a limited, last resort for failed negotiations, and predictably guiding arbitration decisions to reflect market rates for health care.

These comments do not represent the full extent of our recommendations on all sections of the No Surprises Act or the Consolidated Appropriations Act.

Craft rules for determining the qualifying payment amount such that it is keeps consumer out-of-pocket costs low and reflects local market rates for that service.

Under the No Surprises Act, the Qualifying Payment Amount (QPA) serves two critical purposes: as the metric for determining a patient's required cost-sharing and the primary consideration in the Independent Dispute Resolution (IDR) process. As a result, the QPA has an outsized impact on what an individual consumer will pay and on the overall impact of the Act on total health care spending. Health insurance providers have a vested interest in ensuring the QPA closely reflects local market rates and consumers have a vested interest in the QPA being a fair and accurate reflection of the market rates for the care. Health insurance providers benefit when non-participating providers and non-participating facilities have confidence that the QPA was determined according to the law and regulation, as well as assurance the amount reflects fair, negotiated market rates for the items or services provided. Before detailing recommendations for how to determine the QPA, it is important to highlight for the Departments the fact that for millions of Americans enrolled in health insurance coverage, particularly whose plans include co-insurance, their out-of-pocket costs will increase as the QPA increases. Therefore, it is in the public interest to prevent a QPA methodology that is inflationary.

Methodology for Calculating the Qualifying Payment Amount
AHIP recommends that the QPA be calculated as the median of all rates for an item or service as specified in each contract with a facility or provider group under contract the previous year in the same insurance market in a designated region, with one rate per contract being the input unit for arriving at the median rate for a given item or service. The same methodology is appropriate for the individual, small group, and large group markets. Further, we believe the statue is clear that the QPA must be derived from rates as contracted, rather than claims amounts.

To account for contracts that do not include a fee-for-service amount for a particular item or service, AHIP recommends a final rule allow for each plan or issuer to rely on an internal methodology to determine an amount that shall be treated as a contracted rate for purposes of deriving the median to calculate the QPA. The methodology must be actuarially sound and would be analogous to how federal regulations allow submission of enrollee-level claims data from capitated plans for purposes of HHS-administered risk adjustment and reinsurance programs. See 45 CFR 153.710(c). Value-based contracts are designed by health insurance providers and it is therefore health insurance providers who are best, perhaps solely, suited to determine what the equivalent contracted rate for an item or service would be under a value-based arrangement in order to include that rate in a QPA determination.

For decades, health plans and health insurance issuers have increasingly offered products and contracts that do not reimburse at all or primarily based on a fee-for-service arrangement. More and more health plans have relied on "value-based payment models" to incentivize the delivery of more cost-effective, efficient, and higher quality care to patients. This trend is to be encouraged, as it generates savings for the American taxpayer, businesses, and individual consumers while financially rewarding high-quality health care providers and facilities and reducing incidence of harmful or unnecessary health care. Federal regulations should not create unnecessary administrative burdens or create roadblocks to utilizing value-based payment models that promote our shared goals of improving health care quality while reducing spending. Health plans that have developed these models should be given deference to be able to continue to utilize them and determine the best way to derive payment rates from them for purposes of out-of-network reimbursements. Further, as many of these models include incentive compensation for in-network providers, it would be fundamentally unfair to reimburse with an incentive or shared savings payment an out-of-network provider who does not participate in incentive-based or shared savings programs. The purpose of the QPA calculation is to determine what a prevailing market rate for reimbursement of a specified item or service would be, which would by definition not include extraneous elements of an incentive-based reimbursement contract.

In detailing a methodology for the QPA calculation, there is also the question of what constitutes a "provider in the same or similar specialty." Health plans routinely contract with providers of varying professional statuses – such as medical doctors, physician assistants, nurse practitioners, and others. We recommend the "same or similar specialty" be limited to contracted providers of the same practice level. The statute also includes reference to the "same or similar service." This definition should be limited to the same billing code – Current Procedural Terminology (CPT) codes for physician services and Diagnosis-Related Group (DRG) codes for facilities – which will be both administratively feasible and fair, as these numerous codes account for any variation in the nature of services. Anything else creates too much ambiguity and would leave providers without predictability and an uneven playing field that is avoided by using the same terminology – billing codes – that is already standard for health care reimbursements across networks.

Geographic Regions

AHIP believes it is important that the QPA closely reflect market rates for care in the local area where a non-participating provider or facility provided services to an enrollee and that the method to calculate the QPA is administratively feasible. We also want all parties involved in negotiation and any potential dispute resolution to have confidence that the QPA is a fair and accurate reimbursement amount. This requires using definitions of geographic regions that rely on structures that currently exist in federal law or regulation. It also requires further study, analysis, and experience-based input from stakeholders to determine which regions will best achieve the goals of reducing costs, instilling confidence, and reducing administrative burden.

Therefore, we recommend a phased approach to establishing geographic region definitions. As with the other aspects of determining the QPA, the health plan or issuer is solely tasked with making an accurate calculation based on its own contracted rates. For a minimum of the first two (2) calendar years following the effective date of the final rule implementing Section 102, the individual plan or issuer should have the discretion to determine which established geographic region from which it will analyze rates to determine the QPA. These established regions should be enumerated in federal regulation and a health plan or issuer would use the same geographic regions for calculating all QPAs within an insurance market. Examples of established regions would include QHP rating areas, Medicare Geographic Practice Cost Index (GPCI) regions, Metropolitan Statistical Areas (MSA) as determined by the Office of Management and Budget, or an entire State, district, commonwealth, or territory. Any of these are large enough to reduce the likelihood that a handful of outlier rates will distort the median, but narrowly tailored such that they reflect local markets, including when regions are rural or underserved by health care providers and facilities.

We recommend the Departments issue a Request for Information (RFI) in advance of future rulemaking to determine a more permanent approach to defining geographic regions. This will allow stakeholders, including health care facilities and providers, insurers, and employers, to provide the Departments with detailed insight from the first two years' experience with the processes required under the Act.

Treatment of Self-Insured Plans

The statute defines the health insurance market for self-insured group health plan to include other-self-insured health plans. It is unclear from the language whether an administrative services organization (ASO) or third-party administrator (TPA) is intended to calculate a QPA based on all self-insured plan contracts within a given geographic region, just as it does for coverage in the insured markets.

Requiring the calculation of a separate QPA for each group health plan sponsor would exponentially increase the operational complexity of the QPA, as each ASO or TPA would be required to calculate and maintain a vast number of QPAs for each client. Furthermore, ASOs or TPAs would likely find it impossible to calculate QPAs for any clients that they have added since January 31, 2019 without access to the proprietary contracts of the prior ASO or TPA upon which the QPA must be calculated. In the future, if a group health plan sponsor were to change their ASO or TPA (which happens routinely), the new administrator would not be able to calculate or substantiate the QPA without referencing proprietary contracts of a competitor.

Given this operational complexity, AHIP recommends that regulations establish that for items or services provided to an enrollee in a self-insured health plan by an out-of-network provider subject to the provisions of the Act, ASOs or TPAs are to calculate the QPA on behalf of all self-insured clients with whom they contract within a geographic region.

New Plans and Insufficient Information

Calculating the QPA presents unique challenges when a consumer is insured by a new health plan or an out-of-network provider or facility treats a patient in a geographic region where a health plan lacks sufficient plan information to derive a meaningful median rate. The health plan or health insurance issuer remains the entity best suited to determine a rate that most closely reflects market rates for covered services in that region.

For new plans, we urge caution when determining a suitable database free of conflicts of interest. Congress was clear that billed charges are not to be a consideration in IDR proceedings and we interpret this as billed charges cannot factor in the QPA. Any third-party database that includes source data from provider billed charges should be expressly excluded.

We recommend that the Departments apply rules for insufficient information to scenarios where, for a given year, there are fewer than three (3) provider group or facility contracts for an item or service in a market in a geographic region. Under such circumstances, the health plan or issuer should be permitted to either (a) incorporate contracted rates from a different insurance market in the same geographic region (such as large group rates when analyzing an individual market case) or (b) incorporate contracted rates from one neighboring geographic region that directly borders the region where services were provided.

A different procedure would be necessary in the case of new items or services that did not exist or did not have applicable billing codes in a prior year. In these circumstances, we recommend that the Departments issue timely guidance that lists related billing codes that existed in the prior year at issue. For each in-network claim in the database, health plans and issuers would calculate the ratio of the actual payment amount to the amount Medicare would have paid for that service. The plan would then calculate the median of those ratios and multiply by the Medicare rate for the new service to obtain the QPA for that service.

We note the substantial regulation of health plans and health insurance issuers throughout the process and the statutory requirement for complaint processes to challenge the determination of the QPA. Congress gave the health plan or health insurance issuer the charge of calculating the QPA and also provided an avenue to challenge that calculation – either through a formal complaint or during the IDR process. Therefore, deferring to the internal methodology and expertise of a health plan in these circumstances is supported by the overall legislative scheme established by the No Surprises Act.

Encourage provider network participation and open negotiations by establishing a predictable, transparent IDR process that anchors decisions to the Qualifying Payment Amount

Considerations in IDR Determination

Independent Dispute Resolution under the No Surprises Act should be limited and predictable. Congress spent considerable statutory text establishing the Qualifying Payment Amount in order to drive predictability in outcomes. The attention Congress gave to the QPA, coupled with the legislative history that led to passage of the Act, demonstrate that the QPA is meant to be the overriding consideration for certified IDR entities. It is the only required consideration before an entity that will have but three monetary amounts before it: the reimbursement request from a facility or provider, reimbursement offer from a health plan or issuer, and the Qualifying Payment Amount. Rulemaking that prioritizes the QPA in the IDR process will be rulemaking that reflects the text of the statute and Congressional intent while crafting good public policy. The IDR entities should begin their inquiry into which of the two offers to accept with a rebuttal presumption that the offer amount closest to the QPA shall prevail.

Instruct Certified IDR Entities to Consider the Amount Closest to the QPA as the Presumptive Award Amount

As part of the training process for certified IDR entities and included in written guidance provided to each certified entity, the arbitrator should be instructed that the inquiry as to which of the two offers presented should prevail should begin with the only numeric amount required to be considered as part of the process, the QPA. The amount closest to the QPA should prevail, as a matter of policy, unless there are extenuating circumstances demonstrated through submissions offered as additional considerations that it would be counter to the public interest to award the reimbursement closest to the qualifying payment amount. The QPA should at all times be the guiding consideration, creating a rebuttal presumption in favor of the amount submission closest to it, from which the arbitrator may deviate only when evidence presented is compelling to permit overcoming the presumption.

The QPA amount itself is established based on a searching inquiry that Congress took significant pains to ensure is both objective and consistent and it considers factors that are similar to the "Additional

Circumstances" included in the IDR determination. Thus, the Additional Circumstances retread the same ground that has already been considered in setting the QPA, as each of those are accounted for in determining contracted rates. It would be redundant to consider them twice, absent cause or an anomaly. Certified IDR entities should be instructed that additional considerations already accounted for in the qualifying payment amount calculation should be disregarded for additional weighting in the determination.

Regulations should direct certified arbitrators to discard the presumption in favor of the qualifying payment amount only if a party presents clear evidence that the services or circumstances at issue in a specific case materially differ from those in the historical data used to calculate the qualifying payment amount with respect to patient acuity or the characteristics of the provider delivering the service. The final rules or any implementing guidance should generally require the parties to present direct evidence of the differences between the presumptive or historical rates and their instant case.

Protect patients from "Loophole Surprise Bills" by ensuring unambiguous notice of possible charges when consenting to out-of-network care.

Implement Consumer-friendly Processes for Advance-care Notifications from Out-of-Network Providers and In Post-Stabilization Emergency Settings

In care scenarios subject to the provisions of the Act, out-of-network providers should provide, explain, and receive acknowledgement of clear and easily understood documentation to patients 72-hours in advance of a scheduled procedure, including information on network status and their billed charge amount, for patients to understand the full extent of their personal cost responsibility. This notice document should be provided to the patient as a standalone document, rather than in conjunction with other paperwork. The health care provider or a designated representative should be required to orally explain the contents of the notice prior to requesting consent from the patient. While still needing clear and easily understood documentation, these notices should differ from the notice required in post-stabilization emergency care scenarios.

Content of the Notice

We recommend the Departments require the notice from providers to include clear language that voluntarily accepting out-of-network care through the notice exemption will result in acceptance of costs will exceed in-network cost-sharing. The notice and consent procedures must not become a loophole for circumventing the consumer protections of the No Surprises Act. To accomplish this, notices to patients must include clear, visible and easily understood language that the patient is not obligated to accept the out-of-network charges and that the costs will exceed what they would pay if services were administered by an in-network provider of their choosing or their in-network cost sharing as limited under the No Surprises Act.

Patient Informed Consent

The Departments should develop information sharing requirements for providers when patients consent to be balance billed. The notice and consent exemption should not be an open door to providers to misuse information obtained from health insurance plans. Information sharing protocols and oversight mechanisms must be established. Among these, health plans must promptly be provided an electronic copy of the consent document when a provider obtains it so the plan can determine the enrollee's financial obligation. In addition, oversight mechanisms should include processes for resolving any disputes between providers and patients on whether notice was sufficient and/or consent was given, including a mechanism for notifying health plans of the final resolution of disputes.

We note the overlap between this requirement under Section 104 of the Act and mandates imposed on health plans and health insurance issuers by Sections 111 and 116 of the Act, regulating Advance

Explanation of Benefits (EOB) and provider directories. We ask the Departments to carefully consider the timing of these three overlapping requirements and the new technology infrastructure that must be designed, stood up, and tested to ensure accuracy at each phase of communicating provider network status or cost estimates to enrollees. For example, among the requirements of Section 104 Notices are that the health care facility or provider furnish the patient with a list of any participating providers at the same facility who are capable of providing the same health care services. Efficient administration of these overlapping or complementary provisions will require additional time beyond January 1, 2022 to facilitate information sharing. There must also be good faith safe harbors and *de minimis* exceptions for inadvertent inaccuracies in information presented.

Establish a Good Faith Compliance Safe Harbor for 2022.

While January 1, 2022 is a reasonable date by which patients can be held harmless from surprise medical bills, there are many administrative functions that must be in place to operationalize the law that require regulatory direction well prior to then, often with state-mandated filing deadlines approaching in the coming weeks and months. We have a real concern that systems will not be in place prior to January 1, 2022 to ensure that patients receive accurate information at the point of care or that provider payments meet any requirements laid out in regulations specifying how health plans and insurers must determine the qualifying payment amount. Smooth transitions are also needed for new policy years that start later in the year (July 1, October 1).

In order to guarantee accurate consumer information and accurate provider payments, we urge the Departments to consider means by which good faith compliance may suffice for certain aspects of implementation of the No Surprises Act prior to January 1, 2023. Health insurance providers will be subject to significant changes within a brief period, including many after state-mandated deadlines have passed. We also encourage the agencies to include safe harbors following the good faith compliance period where if a health plan is applying the methodology as outlined in the final regulations, the health plan is deemed compliant.