June 18, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretaries Becerra, Yellen, and Walsh,

As the Biden Administration moves forward with implementation of the *No Surprises Act*, we are providing additional recommendations on several key provisions of the law and upcoming regulatory guidance that are critical to achieving the comprehensive patient protections and cost containment intended by Congress.

Our coalition membership includes leading organizations representing the nation's employers, health insurance providers, unions, and health practitioners. These comments build on our bipartisan recommendations seeking to address the market failures that have allowed some out-of-network providers to charge consumers, employers, and health plans wildly inflated prices for their services that far exceed the actual cost of care.[1]

We are writing to provide specific guidance on a number of technical issues related to the *No Surprises Act*, including our recommendations regarding key patient protections pertaining to notice and consent as well as additional feedback on the independent dispute resolution process and prohibitions around third-party databases. Many of our members separately provided their own specific recommendations; this letter serves as a supplement.

- **Safeguard patients from unexpected surprise bills by limiting notice and consent provisions that waive surprise billing protections from out-of-network providers.**

The *No Surprises Act* establishes limited circumstances in which a patient could be provided a notice and then consent to receive a balance bill from a provider. These instances should be considered rare and only when a patient can meaningfully agree to be treated by a certain provider. As such, regulations must give clear guidance on the circumstances under which patients can give consent to out-of-network care and waive their protection from surprise billing.

It is critically important that notice and consent regulations uphold the full protections of the law and not be used as a loophole by out-of-network providers to balance bill unsuspecting patients. Patients receiving emergency care in an out-of-network hospital should not be forced to choose

[1] Zack Cooper, Hao Nguyen, Nathan Shekita, Fiona Scott Morton (December 2019). Health Affairs. Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507

between receiving a balance bill or transferring to a different hospital. To maximize these protections, the notice and consent regulations should adhere to the following:

- **Reinforcing that consumer consent to receive non-emergency, out-of-network care should be valid only when there is a reasonable and practical option** for consumers to choose an in-network provider or hospital.
- **In cases where a procedure or service is deemed medically necessary and the patient is incapacitated, then notice and consent is not feasible, and the patient should have blanket protection from balance bills.**
- Consistent with the statute, **notice and consent to waive balance billing protections should only apply when offered in advance of any services or treatment**. Any such notice and consent waiver of protections must be specific and should be provided when a service is first scheduled and at least 72 hours in advance.
- **To ensure the notice is sufficiently clear for all patients, the Departments of Treasury, Health and Human Services and Labor (the "Departments") should create model notices for providers;** one that applies in post-stabilization emergency situations and one that applies for non-emergency, non-ancillary out-of-network provider situations.
- The notice to the consumer **must also be clear that there is no obligation to accept the out-of-network charges. It should also contain a list of any in-network participating providers at the facility who are able to provide the designated treatment or care**. The notice should be provided separately to the patient from other in-take forms and include a reliable estimate of the cost for designated services.
- Out-of-network providers **should be required to notify the patient's health plan if the patient consents to out-of-network charges.** The Departments should develop efficient ways for providers and plans to communicate on this topic, including with electronic codes.

- **<u>Prevent the abuse and misuse of the independent dispute resolution process to ensure patients are protected from inflationary costs.</u>**

The *No Surprises Act* was intended to reduce overall health care costs by correcting a longstanding market failure. Achieving this goal will require that independent dispute resolution (IDR) is used as a limited, last resort for disputes that cannot be negotiated, rather than an avenue for inflating costs once the patient is taken out of the middle. Several states that have implemented IDR processes have found an overreliance on IDR by private equity-backed entities and out-of-network providers, which has led to higher health care costs for consumers.[2] To protect patients from these costs, regulations should ensure that IDR has sufficient guardrails that encourage health plans and providers to negotiate fair reimbursements and achieve in-network agreements. We have included a number of key recommendations in support of these goals below:

[2] Jack Hoadley, Kevin Hart (April 2021). Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending? https://www.commonwealthfund.org/blog/2021/are-surprise-billing-payments-likely-lead-inflation-health-spending

- To achieve the cost-savings projected by the Congressional Budget Office (CBO), **regulations should ensure the qualifying payment amount (QPA) is the presumptive consideration in IDR determinations.** This is consistent with the statute and Congressional intent, as well as the CBO score.[3]
- Guidelines should seek to achieve a professional, accountable, and transparent IDR process that prevents abuse by **certifying professional entities free of conflicts of interest (no prior affiliation with provider group or medical practitioner) who are knowledgeable about the provisions of the *No Surprises Act,* steeped in health economic expertise, and charge reasonable fees.**
- Encourage negotiations following timely and complete claims by **requiring providers to submit all claims for out-of-network services within 30 days of the date of service or date of discharge and clarifying that the 30-day window for health plan or issuer payment begins with receipt of a "clean claim."**
- Implementation guidance should **require that notification of initiation of the IDR process be sent electronically to appropriately designated responding parties**. There should be simultaneous submission of materials to the arbitrator.

- **Prohibit the use of third-party databases that rely on billed charges and inflationary allowed amounts as part of the QPA methodology.**

Third-party databases that rely on billed charges and inflationary (or above market) allowed amounts should be explicitly prohibited as a basis or shortcut for deriving the QPA. As we understand, currently many third-party databases, including FAIR Health, reflect or include providers' billed charges – the invented list price unilaterally set by the provider and separate from any negotiated, in-network contract determined by the health plan or the provider. According to a recent Brookings analysis, these billed charges often far exceed Medicare payment rates, especially for specialties where surprise billing is most common (emergency medicine and anesthesiology).[4] In cases where insufficient information exists for developing the QPA, we would recommend the following:

- Regulations should **clearly specify when a health plan or issuer is considered to have sufficient information to base the QPA on the median contracted rate**. We suggest that a plan with at least three contracted rates for an item or service is sufficient information to determine the QPA. In situations where there are fewer than three contracted rates, the Departments should use the state or contiguous states as the relevant geographic area.
- In the case of new items or services that did not exist or did not have applicable billing codes in a prior year, **CMS should provide a timely list of billing codes the agency deems are similar to items or services that existed in the prior year at issue to allow the health plan or issuer to calculate a QPA based on the similar items or services.**

[3] Congressional Budget Office. Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260, Enacted on December 27, 2020. https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

[4] Kathleen Hannick, Loren Adler (May 2021). Brookings. Provider charges relative to Medicare rates, 2012-2018. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/05/03/provider-charges-relative-to-medicare-rates-2012-2018/

- **<u>Ensure IDR outcomes are fully transparent to all parties, including the justification for final determination of payment.</u>**

Regulations should establish clear guidelines for arbitrators to ensure a predictable, consistent result from payment disputes – providing an incentive for providers and health plans to reach network agreements, thus using IDR less frequently. Transparency around these decisions is critically important to mitigating abuse of the process overall.[5] For example, submitting a high percentage of claims to IDR – either as a share of a particular service line or as a share of that clinician's work – should be regarded as *prima facie* evidence that a provider has not negotiated in good faith. Ensuring a transparent and consistent IDR process would require:

- **Clear documentation on the justification and methodology used for arbiters' decision-making,** particularly when the arbiter favors a reimbursement offer that deviates from the QPA and relies on subjective "additional circumstances."
- **Transparent data on past decisions by arbiters to be used by the Departments to determine "default" entities.** The *No Surprises Act* provides the parties four days to select a certified IDR entity and if they fail to agree, a "default" entity is selected. The process for selecting the "default" entity should be completely transparent for both parties to review and those entities should have a record of making IDR determinations close to the QPA, with determinations both below and above the QPA.
- **States to report on a standardized set of data points (such as data on IDR outcomes)** to allow federal regulators to assess the impact of the law over time, including any effect on premiums and provider access, the frequency of violations by provider type, and any other information that would inform future rulemaking.

We appreciate your continued collaboration and attention to protecting American families and patients from surprise medical billing. It is of the utmost importance the *No Surprises Act* be implemented in a way that protects patients by significantly limiting the instances in which patients may inadvertently consent to receiving a balance bill – especially after being stabilized at an out-of-network facility after an emergency. It is also critical the regulations achieve Congressional intent to decrease health care costs, including premiums and patient cost-sharing by reigning in inflated charges from certain providers exploiting a market failure. We look forward to continuing to work with you as you implement this historic law.

Sincerely,

The Coalition Against Surprise Medical Billing

Cc:

Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services
Shalanda Young, Deputy Director, Office of Management and Budget

[5] Sara Hansard (November 2020). Bloomberg. Texas 'Surprise' Billing Ban Points to Capitol Hill Clash. https://news.bloomberglaw.com/health-law-and-business/texas-surprise-hospital-bill-ban-points-to-capitol-hill-clash