BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

August 17, 2021

Recommendations for the Surprise Billing IDR Process

The Blue Cross and Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the surprise billing requirements established by the No Surprises Act in the Consolidated Appropriations Act of 2021 (CAA). BCBSA is a national federation of 35 independent, community-based and locally operated Blue Cross and Blue Shield companies (BCBS Plans) that collectively provide health care coverage for 110 million – one in three – Americans. BCBS Plans offer coverage in every market and every ZIP code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

The thoughtful design and implementation of the IDR process is critical to meeting Congress' dual intent of protecting consumers from surprise medical bills and preventing healthcare cost increases. BCBSA's most important priorities are as follows.

Factors for the Arbiter's Consideration

- **Confirm that the QPA is the primary reference point for the arbiter.** The statute includes several factors that the arbitrator may consider in IDR. However, it is clear from the statutory structure and the non-partisan Congressional Budget Office scoring that the QPA should be the primary reference point for consideration. First, the contracted rates on which the QPA is based already account for the additional circumstances outlined in the statute. Because of the market-based nature of negotiated rates they already reflect the provider's level of training, experience, quality and outcomes, market share, complexity of treatment, case mix, and scope of services. *See* PHSA § 2799A-1(c)(4)(C).

  Second, the statutory structure mandates (with limited exception) the use of the QPA for determining the cost sharing for individuals and plan participants *for the very same claims payments that are then subject to IDR*. *See, e.g.,* PHSA § 2799A-1(a)(1)(C)(ii); PHSA § 2799A-1(a)(3)(H). It would make no sense under the statute's structure to use the QPA for the critical purpose of establishing cost sharing, but relegate the QPA to just one of many factors for the arbitrator to consider in the context of payment disputes.

  Finally, reliance on the QPA would promote predictability in the process and outcomes for plans and providers and encourage less game playing in the IDR process, while also maintaining incentives for providers to participate in provider networks. It is important to note that even if the QPA amount is confirmed by the agencies to be the key factor for the arbitrator's consideration, health plans will still have strong incentives to bring providers into their networks because of state network adequacy laws, the reduction of costs

associated with the IDR and other regulatory requirements, the reduction of provider conflict and abrasion, the quality and other standards associated with network agreements, and strong desire to maintain satisfaction of employers and individual customers.

- **Clarify that providers may only pursue IDR for disputes related to payment amount (not, for example, eligibility, medical necessity or whether an item/service is covered under the plan/certificate).** The Interim Final Rules on Surprise Billing, Part I ("IFR Part I") makes clear that a dispute over the initial payment amount is not an "adverse benefit determination" subject to the claims and appeals regulations. *See, e.g.,* 45 CFR 149.30. The agencies should confirm this point again in the IDR rule.

- **Exclude the use of any third-party database pricing information by the IDR entity.** The statute already prohibited the use of usual and customary charges. *See* PHSA § 2799A-1(c)(4)(D). Similarly, any third party database should be excluded from use by the arbiter. Many of these databases rely on allowed amounts and billed charges, values that are both excluded from plan and provider IDR submissions. The databases would also encompass rates from other health plans and would conflict with the use of the QPA as the primary factor for the arbiter to consider.

IDR Entity Requirements

- **Conduct a competitive bidding process every 5 years to identify 5-7 companies that meaningfully reflects regional dynamics.** In order to "certify" a "sufficient number of entities" capable of providing IDR services, *see* PHSA § 2799A-1(c)(4), a competitive bidding process should be adopted to ensure that qualified companies are selected. This process should be repeated every 5 years to ensure that IDR entities have incentives to continue to improve their processes over time.

  In selecting IDR entities, the agencies should balance the efficiency of selecting entities with national coverage with the statute's requirement that regional dynamics are considered. Contracting with 5-7 companies would strike a balance where there is a manageable number of entities for the agencies to oversee and certify while also ensuring that the continued participation of any one IDR company is not essential to the functioning of the IDR system. This latter point is critical in case there are unanticipated spikes in volume and/or if an entity needs to be decertified for any reason. Finally, the competitive bidding process should meticulously ensure that the statute's standards for IDR entities are met, including expertise, cost efficiency and timeliness, confidentiality, and disclosure of financial interests.

Batching of Claims

- **Standards must be established to determine what claims can be batched.** An expansive definition could encourage abuse by allowing aggregation of unrelated claims and issues, imposing burdens on the arbitrator to sort different claims types, and encouraging providers to engage in a class action arbitration type process with low barriers to entry to move thousands of disparate claims to arbitration.
- **To address these clear concerns, the IDR rule should align the definition for what can be batched with the QPA definitions of services and providers:**

- **Items or services with the same CPT, DRG, E/M code for a same or similar condition.** This approach will support the IDR entity in reviewing cases with similar QPA values and case specifics, consistent with the intent of batching to combine similar cases to promote efficiency for all parties. This efficiency would not be realized by allowing all items and services for the same or similar condition to be batched together as each item or service itself would be distinct interms of the QPA value, how the service is usually paid (*e.g.*, bundled, per unit) and additional nuances on how the item or service is determined to be neededand/or rendered. Moreover, this approach is consistent with the IFR Part I which defines same or similar item or service based on service codes. *See, e.g.*, 86 Fed. Reg. 36872, 36891 (Sept. 13, 2021).

- **Provider defined at the group level to align with how providers are grouped under the QPA methodology within a geographic region.** To reduce complexity for all parties, it is appropriate to allow batching at the provider group level rather than each individual provider with in a group of providers. However, to maintain alignment with the QPA methodology, and to maintain the economies intended for batching, providers with in a group must be in the same geographic region.

Cooling-off period and timely filing

- **Enforce the cooling-off period.** The statute clearly provides a cooling off period where a plan or provider may not submit a case for the same or similar service within 90 days of the original case. *See* PHSA § 2799A-1(c)(4)(E)(ii). This provision encourages parties to be judicious in their use of the IDR process and we urge the agencies to reinforce this requirement in the IDR rule.