E.O. 12866 MEETING: NO SURPRISES ACT RULEMAKING PART II

GLOBAL MEDICAL RESPONSE

August 19, 2021

Summary of Key Considerations for the No Surprises Act Rulemaking Part II

1. **No Special Weight to Qualifying Payment Amount (QPA) in Independent Dispute Resolution (IDR).** Congress elected not to assign any special weight to the QPA, and the Departments cannot override that election through rulemaking. Further, the QPA methodology established in Part I of the rulemaking will in many instances result in a QPA that is completely divorced from actual market conditions, leading to inconsistent and unpredictable results. For example, a payor with a national insurance network that only has rural provider in-network agreements in Oregon would be able to use its Oregon-only contracts to determine the QPA for flights for all its covered lives in Washington, California, Alaska, and Hawaii, and then would rely on a third-party database for all other states outside the Census Region. In some areas, we may see artificially high QPAs, and in others we may see artificially low QPAs—inconsistently raising or lowering the patient responsibility. Further, the less QPA reflects a true market rate, the less it will incentivize settlement agreements.

   We also note that Congress already made a statutory determination of the balance between the parties in IDR. The Departments should support the fair implementation of the IDR process and should not further tilt the scale towards insurance companies by forcing arbitrators to give the QPA more weight than Congress specified, or doing more work if they deviate from the QPA. Further, IDR will only drive in-network agreements if it produces fair and predictable results, providing an independent benchmark to realign the parties to a fair market rate.

   (a) *In Part II, the Departments should—consistent with Congress intent—ensure that IDR Entities have the discretion to consider all of the information required to be taken into consideration under the statute, and use their judgement to determine whether the QPA calculated by the insurer is a reasonable benchmark for a fair market rate.*

2. **Close the "Medical Necessity" Coverage Loophole.** Currently, many out-of-network emergency air ambulance transports are initially denied based on a supposed lack of "medical necessity," although the majority of those determinations are overturned after appeal. If medical necessity denials are treated as coverage-based denials, it is possible that such denials will not be eligible for IDR, leaving it up to the patient to challenge a coverage denial (*and the surprise bill that will result*) through the claims appeal process.

   Payors should not be allowed to "opt-out" of the IDR process for any emergency air ambulance claims merely by denying them for medical necessity, whether or not that is

later borne out by the facts, leaving the patient with the full financial responsibility for the billed charges.

(a) *In Part II, the Departments should protect patients from surprise medical bills due to these inappropriate denials of emergency air ambulance claims by clarifying that emergency air ambulance services are "emergency services" appropriate for treating an "emergency medical condition," which would explicitly require payors to evaluate the medical necessity of emergency air ambulance services under a "prudent layperson" standard prior to an initial denial.*

3. **Encourage Settlement in Open Negotiation through Transparency.** To encourage settlement during the open negotiation period (avoiding IDR), discourage parties from withholding relevant information during the open negotiation period.

(a) *The Part II regulations should provide that where a party introduces new information during IDR that had not previously been disclosed to the other party during the open negotiation period, the other party will be entitled to an additional five days and the ability to provide a response to the new information, on the grounds of extenuating circumstances.*