

August 20, 2021

Implementation of Section 103 of the No Surprises Act and Developing Regulations Establishing an Independent Dispute Resolution Process - AHIP Comments

AHIP¹ offers the recommendations below in advance of rulemaking required under the No Surprises Act (“the Act”), enacted as part of the Consolidated Appropriations Act signed into law December 27, 2020. In particular, the recommendations in this letter focus on how to best implement section 103 of the Act and establish an independent dispute resolution (IDR) process for when negotiations fail to resolve out-of-network payment disputes in situations that would have previously resulted in a surprise medical bill.

Given the first surprise billing interim final rule is under OMB review, we are submitting these technical and preliminary comments to inform the Departments thinking on IDR. When the Departments release any forthcoming IFRs for comment we expect to carefully review and submit official written comments for the docket.

Protecting Americans from surprise medical bills has been a top priority for AHIP and health insurance providers for over a decade. We are pleased Congress took action and remain eager to work with the Administration to ensure patients are not only protected from surprise medical bills, but that the underlying market failure may be corrected, consumer costs reduced, and health insurance provider networks grow. These goals can be achieved with final rules that establish an IDR process that is efficient, predictable, transparent, and cost-effective – intended to be used in limited circumstances where plan offers or negotiations fail. To achieve that, we urge the Departments of Health and Human Services, Labor, and the Treasury (“the Departments”) to consider the following recommendations on how to best craft consumer-centric rules establishing an IDR process.

Determination through Open Negotiation

The Act establishes the IDR process to be activated only in circumstances where open negotiations between health plans and providers or facilities fail to achieve mutual resolution. Regulations should be crafted in a way that encourages negotiations as a substantive discussion intended to reach mutual agreement without accessing independent dispute resolution.

Separately from the general policy approach to open negotiations, we request clarity on the following matters in rulemaking:

- AHIP recommends the Departments clarify providers have thirty (30) calendar days to initiate a thirty (30) calendar day negotiation period that shall begin with a written, electronic transmission, made in a manner specified by the health plan, notifying it that they seek to proceed with negotiations.
- As we have articulated before, we ask the Departments clarify through rulemaking that the “clock” begins with receipt of a “clean claim.” The Act provides that health plans and health insurance issuers are to send an initial payment or denial of payment to the provider or facility within 30 days after the bill for services is sent to the plan or health insurance issuer. Our membership anticipates substantial confusion should the rules not clarify that these timeframes begin with receipt of a “clean claim,” that is, one that is not missing essential information for

¹ AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

claims processing. It is common for plans and issuers to have to send claims back to the provider or facility for additional information. The statutory scheme would not make sense should the 30-day requirement begin prior to a plan or issuer possessing a processable claim. We also ask that the Departments provide a definition for a clean claim that applies uniformly in the absence of the application of a state law.

- AHIP recommends that the Departments establish guidance on how to maintain any information received from the other party during open negotiation, including strict confidentiality and patient privacy requirements and a requirement that any records or transmittals be retained until at least the conclusion of the IDR process.
- We do not believe the rules need to mandate that parties share information received during Open Negotiations with the IDR entity. Any communications exchanged in the course of Open Negotiations should be inadmissible in the IDR process to encourage robust negotiations that are not merely a prelude and discovery phase of the IDR process.
- There is an overlap between the option to access IDR and the additional statutory option to provide patients with written notice and seek informed consent for care that could result in a balance bill. We ask the Departments to consider the possible abuse some providers may engage in and scrutinize notice and consent form utilization. The Departments should closely review all received consent notices to determine if providers or provider groups are utilizing signed consent forms to avoid the reimbursement requirements of the No Surprises Act.

Independent Dispute Resolution - Establishment through Rulemaking

The IDR process would ideally be designed in such a way that it is seldom used. We particularly urge the Departments to consider whether the rules governing the IDR process, the certification and contracting process that must take place, and the stakeholder infrastructure adjustments that must be implemented can be fully completed in the time between a final rule and the effective date.

- The Departments should continue to hold patients harmless, but delay enforcement of the IDR process established under section 103 until at least 6 months following the publication of a final rule that details how the process is to run and how entities will be certified. During this time, there must be interim rules governing payments by health plans and issuers to out-of-network providers and facilities providing items or services within the scope of the No Surprises Act. As rulemaking establishing how to determine the Qualifying Payment Amount (QPA) will be final well in advance of January 1, 2022, we recommend the Departments permit plans and issuers to pay out-of-network providers an amount equal to the QPA should the initial payment be declined. These interim rules would be just that – interim for a brief period until the full process is properly set up and stakeholders have acclimated.
- The final rules should clearly delineate when an item or service is subject to the federal IDR process versus state payment resolution rules, such as if an item or service as part of a treatment is covered by the No Surprises Act but not state laws. We recommend in scenarios where there are mixed claims as part of a single episode of care, the No Surprises Act apply when state law does not apply to all underlying claims.
- During the IDR process the parties should relay information solely to the certified IDR entity, rather than to each other. Some information will be competitive, sensitive, or proprietary in nature and releasing it to the other party could jeopardize future contract negotiations or other business activities.
- A provider should be precluded from further challenging claims as part of the same episode of care once the federal IDR process is initiated. The process must ensure there are no duplicative

administrative burdens or legal pre-emption that might allow a provider to challenge other aspects of the same claim.

- We urge the Departments to consider clear rules that detail who shall be the responding party to a dispute claim should there be multiple, applicable insurance coverages that enroll the patient at issue.

Authority to Continue Negotiations

The ability to continue negotiations is an important part of an overall approach that prioritizes agreements between plans and providers while disincentivizing IDR. To help facilitate that, based on open questions from a reading of the statute, we recommend:

- When an agreement is reached prior to the conclusion of IDR, the rules should require the IDR entity be compensated 75% by the party that elected to access IDR, 25% by the other party. In all circumstances, including completed IDR proceedings, the fees paid to the IDR entity should be regarded as regulatory fees for calculating the Medical Loss Ratio.
- When a party elects to access IDR, we recommend the regulations establish an administrative process whereby a third-party entity will be tasked with reviewing the dispute request for timeliness and appropriateness before proceeding. The rules should permit the responding party(ies) to challenge timeliness and eligibility within five days of receipt of a notice of demand.

Batching of Items and Services

Batching of claims is permitted under the statute for the express purpose of “encouraging efficiency.” Independent Dispute Resolution is intended to be an efficient, limited process available in the event of failed open negotiations for decisions about reimbursement that are so similar as to not justify separate consideration. Batching rules must be constructed in a way that minimize administrative costs but do not incentivize providers to routinely pursue IDR as a standard business procedure. There is a balance that must be struck by encouraging batching and IDR rules that look at each provider and each code, with administrative cost and burden. It will also be critical to discourage overutilization and abuse of the IDR process by private equity and the largest provider entities in the markets that left patients most vulnerable to a surprise medical bill prior to enactment of the No Surprises Act.

- AHIP recommends that for purposes of batching, the “same provider or facility” be the same exact health care provider or facility, as identified by both the same NPI number and Taxpayer Identification Number (TIN). The Administration should promote efficiency and reduction of administrative costs over the long term by allowing batching for physician claims only by the National Provider Identifier (NPI) type 1, by individual physician provider, rather than NPI type 2. Overuse of batching is likely to encourage the use of surprise billing practices in order to maximize reimbursement at the expense of consumers, plans and taxpayers.
- We recommend that the “same party” be treated as each health insurance issuer or group health plan sponsor. Each plan sponsor (employer) is unique and should be allowed to approach IDR as their own entity, rather than bound by choices of other plan sponsors with the same third-party administrator.
- For purposes of batching claims, items and services “related to the treatment of a similar condition” should be regarded as items or services where the batched claims use exactly the same CPT or DRG code(s) for each patient in the batch and all other items or services fall within a common clinical domain within the CPT or DRG code(s).

- Any alternative period for batching as identified by the Secretary that exceeds the 30 days following the furnishment of the first item or service should be limited to no more than 60 days and should be limited to situations where the items or services are so similar as to include the same CPT or DRG codes.
- The rules could also clarify whether batching claims during open negotiation has any impact on the ability to batch for purposes of IDR, as the statute is silent on batching during negotiation.
- We do not believe that emergency medical care should be grouped together for purposes of batching, but rather similar emergency medical treatments, including of the same severity level, furnished for similar conditions be batched together. “Emergency medical care” is not a condition and codes 99281-99285 should not all be treated as alike for batching purposes. Batching within a given CPT code in this series will not result in batching treatment of similar conditions. For each set of claims batched by CPT code, any claims batched should also share the same primary ICD-10 diagnosis code in addition to the same CPT code.
- The Departments should consider ways to monitor and subsequently enforce limits on overuse of IDR, including manipulation or abuse of the 90-day waiting period by certain providers, facilities, or their associates.

Certification and Selection of IDR Entities

The entities considering these disputes is of similar importance to what they can consider. Professional, expert, ethical, efficient IDR entities will lead to a process that earns the trust of the public and of health care stakeholders.

- We recommend HHS contract with between three (3) and five (5) entities nationwide deemed suitable for adjudicating payment disputes. The same process, including the same rules, forms, and standard procedures should apply to any contracted IDR entity, and the arbitrators themselves should annually complete an HHS-approved training course. We recommend the entities demonstrate a sufficient level of expertise in medical claims and billing, as well as an understanding of the No Surprises Act, health care economics, and professional ethics. For States with surprise billing laws that include the option to access IDR for fully-insured plans, we recommend the Departments provide a pathway for state-certified entities to be certified by HHS should they meet the same standards, so that there are not dueling IDR entity processes in certain states.
- The federal process should establish an electronic proceeding whereby information submitted by the parties is entered into a database form for review. Each party should be permitted to submit a narrative statement, not to exceed 1500 words, summarizing the party’s position. All notices of demand under the process should be sent to responding parties electronically and all correspondence to and between parties must be via electronic means. The electronic dispute system should allow submission of materials to arbitrator via the electronic portal and allow parties to view and track the status of the IDR process.
- We recommend “conflicts of interest” be defined broadly by the Secretary to include past professional employment experience or familial relationships with parties at issue in IDR proceedings, including health care providers, hospitals and facilities, and health insurance plans and issuers. There should be a strong firewall – including financial relationships, communications, oversight, and administration – between the certified entity and any affiliate or subsidiary businesses that may be associated with the entity or the entity’s parent corporation.

- Each party should be entitled to a unilateral strike of a potential certified entity in each dispute. When the two parties accessing IDR are unable to mutually agree upon a certified entity, HHS should select a contracted entity based on a random drawing.
- We recommend all certified IDR entities are required to implement and follow identical policies and procedures to promote administrative efficiency and consistency.
- The certified IDR entity should be subject to HIPAA privacy rules, treated as a business associate.
- Certified IDR entity fees should be capped at no more than \$300 per dispute and \$500 per batched dispute.

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. As we have articulated prior, we believe 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.

- 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.

- We recommend the final rules allow for explanations as to how health plans and issuers arrive at rates that include comprehensive discussion of rate-setting processes and negotiations, which would include reference to the role of Medicare rates in determining private, commercial rates.