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AFL-CIO

AMERICA'S UNIONS

Implementation of the *No Surprises Act:*
The IDR Process

August 23, 2021

Attending the meeting on behalf of AFL-CIO and affiliated unions:

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We strongly support the objectives of the *No Surprises Act*. Consumers that seek care at an in-network facility should not pay higher cost-sharing to a provider who, unbeknownst to them, is out-of-network.

But as important as it is to shield consumers from these unfair bills, this issue is bigger than the one-time bill an individual gets for a particular procedure. It is also about stopping a business model that has already increased the premiums for everyone. We believe that controlling health care costs is the best protection for consumers in the long-run.

The *No Surprises Act* mandates the use of arbitration to settle payment disputes. We believe that, if it is structured appropriately, the IDR process actually should increase reimbursement for those rare patients that require extraordinary resources or expertise not ordinarily available in the community. But IDR should be a last resort, not tool to allow providers to avoid networks or increase leverage in negotiations.

I want to talk briefly about the role of the qualified payment amount and the reasons why this should be the primary factor that arbiters should consider.

- There is the structure of statute. Congress purposely listed the qualified payment as the first factor that arbitrators should consider; other criteria were listed in a separate, subsequent section of the statute, to be used as necessary.

- Second, there is the legislative history. There were sharp disagreements on how to resolve payment disputes, but support for the final legislation was based largely on the $17B savings forecast by the CBO. The press release put out by the leadership of authorizing committees announcing the legislative compromise made it clear that those savings would offset the reauthorization of expiring public health programs (Community Health Centers, National Health Service Corps, Teaching Health Centers, and Special Diabetes Programs).

- Third, there is the nature of the other criteria. The *No Surprises Act* lists five factors for arbiters to consider, but most of these are either fairly subjective (things like patient acuity or experience and training of the provider) or ambiguous in their application (things like market share of the parties). The QPA is in fact the only factor that offered CBO enough objectivity and concreteness to enable it to forecast savings. The other four factors are mushier and less predictable. They are also more likely to result in higher reimbursement, so they must have a secondary role if the legislation is going to have the overall fiscal effect sought by lawmakers and predicted by CBO.

- Indeed, the other criteria mentioned in the statute, are not unimportant but they are, to a certain extent, already baked-in to the QPA. The typical acuity of a patient effects the median contracted rate for a particular procedure. For rare and particularly difficult procedures, reimbursement is high in part because of the extraordinary training of a physician and her likely training. To allow these factors to have a major impact on an arbiter's decisionmaking is to double-count their influence.

The role of the QPA is critical. We can see from states that have tried to tackle this issue that the criteria an arbiters use matters in terms of overall healthcare spending. State laws in NY, NJ, and TX directed arbiters to consider the 80th percentile of billed charges. The result has been a flood of arbitration cases and awards that have increased reimbursement. The *No Surprises Act* bars the use of billed charges, but there is still an important lesson here: Arbitration can only limit health care costs if arbiters focus primarily on market conditions and network rates. Focusing on criteria that can be taken out of context or manipulated by providers will only exacerbate the problem.

The other criteria, while secondary, need to be further defined.

- Patient acuity should be viewed in the context of a facility's patient population and infrastructure. The acuity of a patient should not by itself justify a higher reimbursement for a level I trauma center that routinely treats high-acuity patients. On the other hand,

patient acuity may get greater weight for a level V facility that typically transfers such patients as soon as possible.

- A provider's training and experience should be compared to his or her peers in the community, *e.g.*, similarly situated in-network clinicians who care for patients with similar medical needs. The fact that a physician or a specialist has extensive training and experience should not be relevant to whether reimbursement should be above the median commercial rate if such training or experience is standard in the profession or the community.

- The market share of a non-participating facility should be a proxy for its ability to seek payment rates greater than would be necessary for an efficient provider to cover the cost of care. There is ample evidence that dominant hospitals use their market power to increase prices and support a higher cost structure; high prices often bear little relation to these providers' cost of care.

- Recent changes in staffing practices should be considered when evaluating whether a provider has entered into good-faith negotiations. There are numerous examples of hospitals contracting with private equity-backed staffing firms to outsource entire departments as part of a long-term strategy to increase in-network rates.

- Submitting a high percentage of claims to arbitration – 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. Arbitration should be reserved for cases that are true outliers in terms of resource requirements, not as a tool to avoid networks or supplant commercial negotiations.

- The statute bars arbitrators from looking at "billed charges." This should include not only claims based on billed charges but also claims based on a percentage of billed charges. Moreover, providers should not be able to submit charges based on what a provider would bill were he or she seeking the consent of the patient to out-of-network care. The charges described in a provider's notice of consent are fictional, without any cost-basis or market discipline and thus are akin to billed charges.

Other Issues Related to Arbitration

- There must be clear criteria for disqualifying an arbiter that exhibits a "pattern or practice of noncompliance" with the statute. HHS is responsible for creating a certification process. Guidance is also necessary to ensure that stakeholders understand the grounds for and method of disqualification, either of a particular arbiter or an entity employing an arbiter.

- Any use of data from state or national databases to determine the qualified payment must be limited to actual claims. While such databases may shed light on negotiated

rates, such databases too often include billed charges – something that Congress explicitly did not intend to be part of the arbitration process. Data based on billed charges should be excluded from any calculation of market rates or payments.

- HHS, DOL, and Treasury should set clear expectations for the fees charged by arbiters and the frequency in which the proposed payment amount favored by the arbiter exceeds the qualifying payment amount. While individual cases may justify awards above the median contracted rate, the aggregate results of IDR should produce awards at or near the median contracted rate.

- The federal government should strongly encourage arbiters to explain the methodology for their decision-making, particularly when the arbiter favors a proposal that relies on optional criteria. Understanding why arbiters accept one proposal over another will allow for more effective negotiations between plans and providers, reducing the need for arbitration over time.

Worker Protections

- The Secretary should use his or her authority to expand the list of "ancillary services" that are not subject to balance billing when a provider has fulfilled the notice and consent requirements. For example, the list should include providers of mental and physical health care services provided on an emergency basis; it should also include communities where provider shortages prevent consumers from accessing in-network care.

- Consumers should have access to a transparent complaint process that does not require an understanding of which government agency has jurisdiction. For example, consumers should not need to know whether their health plan is subject to state or federal laws governing surprise billing. The federal government should work with states to set up a "no wrong door" approach to receiving consumer concerns; no consumer complaints fail because of a lack of agency jurisdiction.