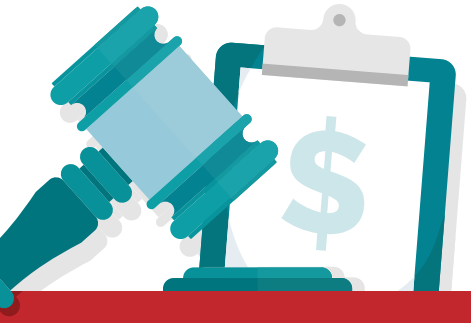

COALITION AGAINST

SURPRISE MEDICAL BILLING

The **Coalition Against Surprise Medical Billing (CASMB)** is an alliance of leading employer groups, labor unions, health insurance providers, and health organizations committed to meaningful solutions to end surprise medical billing. Congress took a first step to protect patients from these surprise bills with passage of the *No Surprises Act* in 2020. Now, it is more important than ever that implementation of the law adhere to the fundamental goals of making health care more affordable for patients and eliminating opportunities for abuse or misuse among out-of-network providers and private equity firms. The Biden Administration should prioritize the following patient-centered reforms in implementing the *No Surprises Act*:

Reduce health care costs by maintaining reasonable, market-based payments to out-of-network providers.

The Congressional Budget Office estimates that in most affected markets, smaller payments to some providers would reduce premiums by between 0.5-1 percent. The decline in premiums would occur because in facilities where surprise bills are likely, payment rates would move toward the median and insurers' payments to providers currently commanding in-network rates well above the median would drop to more typical amounts. The regulations should be drafted to achieve these cost reductions.

Allow health plans to make initial payments that reflect market conditions and keep consumers' costs low. Consistent with the legislation, regulations should not establish any standards or mandates regarding the initial payment amount.

Reinforce the qualifying payment amount (QPA) is based on contracted rates, not paid claim amounts. Health plans and employers negotiate contracted rates that encourage network participation while also delivering value for employers and consumers paying for health care. The *No Surprises Act* is clear that the QPA is based on median contracted rates, which should be distinguished from amounts actually paid for particular claims, which can exceed contracted rates when paying out-of-network providers. To reduce health care costs, regulations should define the "same or a similar item or service" as the same CPT code for purposes of calculating the QPA. No payment amount should prevent a health plan from applying the lowest possible cost-sharing for patients.

Explicitly prohibit use of certain third-party databases to arrive at QPAs. Third-party databases rely on billed charges that far exceed the actual cost of care and do not accurately reflect in-network rates for services. They should be explicitly prohibited as a basis or shortcut for arriving at a QPA unless required under the narrow circumstances described in the law and remain free from conflicts.

Allow calculation methodologies to account for non-Fee-for-Service arrangements. For decades, health plans and employers have worked to pay for quality, not quantities, of health care. Some value-based arrangements that do not pay providers on a fee-for-service basis may not directly align with a fee-for-service methodology for calculating the QPA. Regulations should account for these value-based payment arrangements when determining the QPA.

Ensure broad protections against unfair, surprise medical bills by establishing clear definitions around the scope of services affected by the law.

Establish clear prohibitions around 'balance billing' for the scope of services affected by the law. In order for consumers to be fully protected against out-of-network charges, regulators must clearly define the scope of services where balance billing is prohibited, including ancillary and diagnostic services. As new providers or services emerge, surprise billing protections should continue to apply so there are no loopholes in the system. Ambiguity in the scope of services could lead to providers intentionally avoiding network participation and abusing the arbitration process.

Implement consumer-friendly processes for advanced-care notifications from out-of-network providers. Out-of-network providers should provide clear and easily understood documentation to patients at least 72-hours in advance of a scheduled procedure, including information on network status and a cost estimate. Providers must receive acknowledgement of patient consent that is also shared with a patient's health plan. This is critically important for patients to understand the full extent of their personal cost responsibility and their rights when it comes to out-of-network care.

Avoid a cumbersome arbitration process that increases costs for patients, businesses and taxpayers.

Patients are best protected from surprise medical bills when more providers partner with health plans to deliver quality, affordable care as part of provider networks. Broad use of the independent dispute resolution (IDR) process runs counter to this goal and should only be considered as a 'last resort' as part of implementation of the *No Surprises Act*.

Prevent abuse of IDR by limiting the scope of claims eligible for 'batching'. To mitigate abuse and misuse of the IDR process among providers, regulations should define "provider" as an individual practitioner and "similar claim" as the same CPT code for purposes of batching disputes. Rules should also clarify that the dispute processes are limited to disagreement on the payment amount, rather than questions of coverage.

Certify IDR entities that are free of conflicts of interest and possess minimum qualifications. To make informed decisions on appropriate payment amounts, the IDR entity must have the requisite expertise to fully evaluate and understand health care market dynamics and economics, including requirements to demonstrate sufficient economic and health care pricing expertise to make informed determinations, and protect against unnecessarily inflating health care costs. Conflicts of interest should be broadly interpreted, so as to avoid unnecessary harms.

Reinforce the QPA as the primary criterion for choosing between two reimbursement offers. Regulations should reiterate that the QPA must be the primary consideration of IDR entities, as intended by Congress and scored by the Congressional Budget Office. Arbiters should be directed to choose the reimbursement offer closest to the QPA and demonstrate reasonable cause for deviation in limited extenuating circumstances. Further, as billed charges are expressly excluded from consideration, any rules should interpret that as excluding consideration of charge-based evidence.

Require transparency and reasonable fees from IDR entities. Regulations should look to harmonize administrative timelines and requirements for claims payment so arbiters are not being asked to render multiple decisions on a single claim should reduce costs and be addressed in proposed rules. How decisions are arrived at requires transparency into the IDR process, recordkeeping and a statement of rationale that demonstrates how the qualifying payment amount is reflected in the final decision. The agencies should randomly select a percentage of arbitration cases for audit and limit the fees that can be charged by certified IDR entities.