COALITION AGAINST
SURPRISE MEDICAL BILLING

July 29, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue SW
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretaries Becerra, Yellen, and Walsh:

As organizations providing health benefits and coverage to millions of Americans and families across the country, we commend the Biden Administration for its work and commitment to protecting patients from surprise medical bills. Surprise medical bills have intensified alongside the rapid growth of private equity-owned provider practices and anticompetitive hospital consolidation across the country.[1] While surprise medical bills pose a direct financial harm for those who receive them, these charges are felt by all of us. Employers, American workers, families and taxpayers have absorbed more than $40 billion annually in unnecessary costs as a result of surprise medical billing.[2]

Addressing the root causes of surprise medical billing requires a comprehensive approach. We appreciate the important and foundational reforms that the Administration included as part of the first interim final rule (IFR) ("Requirements Related to Surprise Billing; Part 1) as well as the recent Executive Order taking action to counter anticompetitive hospital consolidation that contributes to higher costs and fewer choices for patients. While our members will submit more detailed comments as part of the forthcoming rulemaking process, we wanted to reinforce the vital groundwork laid to lower patients' costs through the initial IFR and the importance of protecting all health care consumers from unintended cost pressures related to the independent dispute resolution (IDR) process.

The recent IFR reflects sound, patient-centered market reforms that have broad support from

[1] Erin Duffy, Erin Trish and Loren Adler (October 2020). USC-Brookings Schaeffer on Health Policy. Surprise medical bills increase costs for everyone, not just for the people who get them. https://www.brookings.edu/opinions/surprise-medical-bills-increase-costs-for-everyone-not-just-for-the-people-who-get-them/

[2] Zack Cooper, Hao Nguyen, Nathan Shekita, Fiona Scott Morton (December 2019). Health Affairs. Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507

leading health policy experts, and importantly, ensures the qualifying payment amount (QPA) will protect patients.[3] Our members have consistently called for reforms that can deliver on the goal of improving health care access and affordability, and the IFR's requirement for the QPA to be calculated based on contracted rates should encourage greater network participation while also protecting patients from uncertainty in cost-sharing. Further, the IFR's approach in prioritizing geographic regions and insurance markets as part of the QPA methodology will ensure the QPA reflects the market conditions where care was provided. Together, these rules should help achieve the intent of Congress in protecting patients and simplifying health care services, while creating a pathway for implementation by January 1, 2022.

As the Administration moves forward with subsequent rulemaking as part of the *No Surprises Act*, we strongly urge the Departments take comprehensive action to prevent the IDR process from becoming the norm for determining payment for out-of-network services rather than a forum for disputes over outlier cases. Unfortunately, the experience in several states, including New York, Texas, and New Jersey, shows how easy it is for IDR to be abused by private equity firms and out-of-network providers at patients' expense.[4] Crafting consumer-centric rules that ensure an efficient, transparent and cost-effective IDR process is critical to achieving the cost-savings forecasted by the Congressional Budget Office. [5] We have outlined several critical recommendations for achieving that goal:

- **IDR should be limited and only used as a last resort for payment disputes.** By establishing an IDR process that is predictable and consistent, the regulations will provide an important incentive to expand access to in-network care – a benefit that will support patients and families across the country. In cases where the arbitration process is more expansive in scope and reach, as in New York, consumers have faced significantly higher costs as a result of out-of-network providers misusing the system to achieve higher reimbursement.[6] For each factor in the statute, regulations should clearly define what information may be presented as part of arbitration, as well as what constitutes sufficient proof for consideration.
- **The QPA should be the primary and overriding consideration for final payment determinations as part of the IDR process.** As outlined in the statute and scored by the non-partisan Congressional Budget Office, Congress clearly established the QPA as the primary consideration for arbitrators when determining the final payment for out-of-network care. Deviation from the QPA should be limited to extenuating circumstances that are not already reflected by calculation of prices for services in that market and merit additional consideration.
- **Exclude the use of any third-party database pricing information by the IDR entity.**

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[3] Matthew Fiedler, Loren Adler and Benedic Ippolito (March 2021). USC-Brookings Schaeffer on Health Policy. Recommendations for Implementing the No Surprises Act. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/03/16/recommendations-for-implementing-the-no-surprises-act/

[4] Jack Hoadley, Kevin Hart (April 2021). Georgetown University, Center on Health Insurance Reforms. Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending? https://www.commonwealthfund.org/blog/2021/are-surprise-billing-payments-likely-lead-inflation-health-spending

[5] Congressional Budget Office. Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260, Enacted on December 27, 2020. https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

[6] Rachel Bluth (November 2019). NPR. To End Surprise Medical Bills, New York Tried Arbitration. Health Care Costs Went Up. https://www.npr.org/sections/health-shots/2019/11/05/776185873/to-end-surprise-medical-bills-new-york-tried-arbitration-health-care-costs-went-

Many of these databases rely on allowed amounts and billed charges, values that are both excluded from plan and provider submissions, and parsing which of the databases is appropriate would be challenging. Furthermore, attempting to parse the appropriate pricing information for the IDR entity to use is unnecessary given that the IDR entity will already have the QPA value, which is representative of all of the plans' contracted rates for the item or service within the geographic region. Referencing this information would be redundant and could even be misleading as it would likely reflect payment rates of other payers not involved in the specific IDR case.

- **Arbitrators should be required to provide substantive written justifications on final payment decisions if the decision deviates from the QPA.** Written decisions should reflect the considerations used to determine a final decision and sufficient justification for deviating from the QPA if done so.
- **The IDR process should not be used to address clinical, coverage, or plan administration denials.** Participants and beneficiaries should utilize the plan's existing claims procedures to exhaust appeal rights for a clinical, coverage or plan administration decision and denial of benefits, including external review. If the denial of benefits is overturned, then the surprise billing protections would apply. If benefits are denied and the denial is upheld, then the surprise billing provisions should not apply and the IDR process would not be triggered. The IDR process should only apply if the clinical, coverage and administration denials have been completely resolved to overturn the denial.
- **IDR rules should prevent automation of disputes while allowing limited, efficient "batching" of claims to minimize administrative costs and prevent misuse of the process.** Batching of claims is permitted under the statute for the express purpose of "encouraging efficiency" and the rules must be constructed in a way that discourages providers from pursuing IDR as a standard or automated business procedure or disputing reimbursements en masse. Even when batched together for purposes of reducing administrative costs, the certified IDR entity should be required to consider each claim individually and determine its likeness to other claims in a batch, i.e., items or services with the same CPT, DRG, E/M code for a same or similar condition. Given the uniqueness of each patient, claim and service, only a faulty IDR system would permit high-volume batching and high-volume payment decisions.
- **Only in-network agreements demonstrate good faith efforts by nonparticipating providers and facilities over the four-year IDR look-back period.** In making its payment determinations, an IDR entity should only consider in-network agreements and associated contracted rates as additional considerations as demonstrations of good faith efforts. Out-of-network and single case agreement contracts should not be considered demonstrations of good faith efforts by the nonparticipating provider or facility to enter into network agreements. Such out-of-network and single case contracts are frequently developed as a last resort with providers and facilities when there has been no true good faith efforts to enter into in-network agreements. To allow rates under such contracts to be considered would reward providers and facilities that have not made good faith efforts to enter into in-network agreements.
- **IDR outcomes should not serve as precedent.** Regulations should prevent IDR outcomes from being used as a precedent for decisions involving the same or other plans. IDR should not be used to drive pricing for either party as a result of adjustments made based on arbitrated claims. Arbitration should not be a process that allows extrapolation from one arbitration case to another. The IDR process itself should not drive pricing.

- **Arbitrators should meet established qualification standards, including knowledge of health care economics, be free of conflicts, and charge reasonable fees.** HHS should certify a sufficient number of entities (i.e., at least three) to be able to address variations in volume of IDR, help mitigate the impact of outlier entities that favor either party, accommodate potential decertification of some IDR entities and encourage competition for purposes of managing IDR fees. The same process, including the same rules, forms, and standard procedures should apply to any IDR entity with which HHS contracts, and the arbitrators themselves should annually complete an HHS-approved training course. HHS should require annual submissions of financial interests and conflict of interest disclosures from IDR entities, including individual arbitrators within each entity, and ad hoc submissions from entities in the event of significant changes. 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, market dynamics, 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.
- **IDR regulations must prevent abuse of the notice and consent process that can lead to forced patient consent under duress.** The Departments should closely review all received consent notices to determine if providers or provider groups are over utilizing signed consent forms to avoid the cost-sharing protections of the *No Surprises Act*.
- **IDR regulations should clearly delineate when an item or service is subject to federal IDR versus state payment resolutions rules.** For plans subject to state insurance law, in cases where there are mixed claims as part of a single episode of care – specifically related to an item or service that is covered by the *No Surprises Act* but not state laws, subsequent rules should clearly define when the *No Surprises Act* standards apply and where state law does not apply to all underlying claims.
- **Subsequent regulations should prevent delayed challenges to claims once IDR has been initiated.** 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 appreciate all the work your departments have done to protect patients from surprise medical bills. We look forward to continuing to work with you to safeguard patients from surprise medical billing and the exorbitant costs from out-of-network providers.

Sincerely,

The Coalition Against Surprise Medical Billing

Cc:

Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services
Shalanda Young, Deputy Director, Office of Management and Budget