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Advancing Health in America

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Xavier Becerra
Secretary
Department of Health and Human Services

Re: Requirements Related to Surprise Billing; Part II,
CMS–9908–IFC: RIN 0938–AU62, Vol. 86, No. 192 / Thursday, October 7, 2021

Dear Ms. Bodenheimer, Mr. O'Donnell, Mr. Mazur, Mr. Khawar, and Mr. Becerra:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for the opportunity to comment on the second set of interim final regulations (IFR) implementing the No Surprises Act. Hospitals and health systems strongly support protecting patients from gaps in their health care coverage that may result in unanticipated medical bills, and we look forward to working with you on implementation of these critical protections.

The IFR issued by the departments of Health and Human Services (HHS), Labor, and Treasury, along with the Office of Personnel Management (departments) address several provisions in the law, including the independent dispute resolution (IDR) process providers/facilities and plans/issuers may use to adjudicate reimbursement disputes, the good faith cost estimates providers must share with uninsured or self-pay patients for scheduled services, a process to resolve disputes between uninsured/self-

pay patients and providers about amounts charged, and an external review process as part of the oversight of health plan/issuer compliance.

The importance of these provisions and the patient protections that were addressed in earlier regulations implementing the No Surprises Act cannot be overstated. No patient should be fearful of receiving a bill for out-of-network care that they received during an emergency or when they reasonably could not have known the network status of the provider. In addition, hospitals and health systems are committed to helping patients access the financial information they need when scheduling or planning for care. We look forward to working with the departments to implement these patient protections.

Our priority comments request that the departments:

- **Restore the independence of the IDR entities by not distorting the process in a manner that negatively impacts patient access to care, undercompensates providers and has other consequences far beyond surprise medical bills.**
- Increase the efficiency of the IDR process by allowing for more flexibility in the batching of claims.
- Align the various price transparency policies to ensure patients do not receive conflicting estimates and to maximize efficiency in the health care system, including by allowing providers to utilize patient cost estimator tools, when available, for patients who are shopping for care.
- Work with all stakeholders to develop the necessary operational solutions, including transaction standards, to enable accurate, efficient implementation of both the surprise billing protections and good faith estimates.

Ensure that all rules and operational processes are in place and have been tested prior to Jan. 1, 2022 to ensure patient protections can be implemented on time.

INTRODUCTION AND OVERVIEW OF COMMENTS

Surprise medical bills are just one manifestation of a number of problematic payer policies affecting patients. For example, while surprise medical bills may result from gaps in provider networks, plans and issuers have implemented a number of policies that restrict patient access to care and create other forms of unexpected bills. Specifically, plans and issuers restrict access to care through unaffordable cost-sharing structures and confusing and burdensome utilization management requirements, such as prior authorization. When patients do receive care, plans and issuers frequently subject them to after-the-fact coverage denials, often for care that the plan authorized in advance. Indeed, the “surprise” medical bills that hospitals and health systems hear about most frequently from patients are not the ones that will end with implementation of the No Surprises Act; instead, they are the bills that arise from complicated cost-sharing structures that patients do not understand or coverage denials.

The following problematic policies have been documented in governmental studies, media reports, lawsuits and other research:

- Roadblocks to accessing medically necessary care, including for critical time-sensitive cancer care, behavioral health services, and care in the last year of life;[1, 2, 3, 4, 5]
- Failure to cover medically necessary services, in part as a result of inadequate provider networks;[6,7,8]
- Threatening to deny coverage for emergency services retrospectively;[9]
- Inappropriate prior authorization and coverage denials;[10]
- Inadequate spending by plans on medical services for Medicare Advantage beneficiaries;[11]
- False or misleading representation of the scope of coverage offered by a plan;[12]
- False or misleading representation of a plan's provider networks to consumers;[13] and
- Onerous administrative requirements contributing to clinician burnout.[14]

One factor that enables plans and issuers to implement such policies is that commercial health insurance markets are increasingly concentrated, and nearly every market is dominated by a single large commercial insurer. According to the American Medical Association, 46% of the country's metropolitan areas have one insurer that controls at least 50% of the market; and in 91% of metropolitan areas, at least one insurer held a commercial market share of 30% or more.[15] With such substantial market power, there is little risk to plans and issuers of blowback from the problematic policies described above.

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[1] https://www.gao.gov/assets/720/715370.pdf
[2] https://www.curetoday.com/view/prior-authorizations-for-oral-cancer-drugs-may-delay-time-patients-receive-therapy
[3] https://who13.com/news/special-reports/iowa-father-says-medicaid-failed-his-daughter-in-her-time-of-need-they-denied-her/
[4] https://www.floridapolicy.org/posts/floridas-medicaid-managed-care-program-falls-far-short-on-providing-quality-behavioral-health-care
[5] https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf
[6] https://www.dcmsonline.org/news/567274/State-hits-managed-care-plans-for-damages.htm
[7] https://www.wifr.com/2020/07/17/health-insurance-companies-fined-2m-for-violations/
[8] https://ohiocapitaljournal.com/2021/10/27/aetna-an-ohio-medicaid-contractor-accused-of-denying-kids-care-in-pennsylvania/
[9] https://www.nytimes.com/2021/06/10/health/united-health-insurance-emergency-care.html?smid=tw-share
[10] https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp
[11] https://www.startribune.com/feds-penalize-unitedhealthcare-plans-for-underspending-premiums-on-medical-care-for-seniors/600097385/
[12] https://www.gao.gov/assets/gao-20-634r.pdf
[13] https://www.sandiego.gov/sites/default/files/nr210625a.pdf
[14] https://nam.edu/systems-approaches-to-improve-patient-care-by-supporting-clinician-well-being/
[15] American Medical Association, "Competition in Health Insurance: A comprehensive study of U.S. markets," Sept. 28, 2021. Accessed at: https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf

Hospitals and health systems are therefore, profoundly concerned about the decision by the departments to distort the No Surprises Act IDR process in favor of plans and issuers at the expense of patients and providers. By directing arbiters to *presume* that the plan's or issuer's median contracted rate is the appropriate out-of-network reimbursement rate and creating a significantly higher bar for consideration of other factors means that the IDR process effectively will be unavailing for providers. Not only is this interpretation unlawful, as we describe in additional detail below, it is not sound public policy in light of the substantial plan and issuer abuses patients and providers experience today. What was supposed to be an independent check on both parties is now gone. In short, the departments have forfeited this important restraint with respect to plans and issuers, while creating a nearly insurmountable set of conditions for providers.

For both parties to know that there is essentially no way for a provider to prevail at arbitration means that payers and issuers will have greater ability to push their agendas to their benefit, not patients' benefit. Indeed, there is no guarantee that patients will see any of the savings as a result of this policy: nothing in law or regulation requires the plans or issuers to pass these savings onto patients, and the medical loss ratio requirements, which only apply to certain plans impacted by the law (i.e., those not regulated under the Employee Retirement Income Security Act (ERISA)), provide limited assurance given past gaming of this policy.[16, 17]

The impact will be a reduction in patient access to care. If a provider cannot agree to the terms the plan or issuer brings to a negotiation (which relate to far more than just rates), the plan or issuer can walk away with the expectation that the No Surprises Act protections will ensure enrollees' access to care (see Attachment A for real-world example). However, not all care is subject to these protections, and inadequate networks can have a profound impact on a patient's ability to access scheduled care. This is especially true for many of the ancillary services to which network adequacy rules generally do not apply, as well as self-funded plans regulated under ERISA for which there are no network adequacy requirements. Other particularly vulnerable providers include those who are highly specialized and which patients often access in emergency situations, like academic medical centers.

There is evidence that further constriction of networks, including their outright elimination, is already occurring. While once a more fringe offering, enrollment in no-network, referenced-based pricing plans is growing. For example, with UnitedHealth Group's acquisition of HealthSCOPE Benefits,[18] the largest commercial insurer in the United States now is promoting no-network, reference-based pricing plans to its self-funded employer clients.

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[16] https://www.startribune.com/feds-penalize-unitedhealthcare-plans-for-underspending-premiums-on-medical-care-for-seniors/600097385/
[17] https://www.modernhealthcare.com/insurance/medical-loss-ratios-mixed-record
[18] https://www.healthscopebenefits.com/careers/benefits/

We are deeply concerned that flawed interpretations of the impact of state surprise billing laws have misconstrued the potential effects of this policy decision. Specifically, several faulty commentaries on state surprise billing reports have been amplified through paid advertising that flooded a number of inside-the-Beltway publications over the past several months. The commentary and corresponding ads appear intended to sow doubt about the effectiveness of these state laws and, in particular, the states' dispute resolution processes. The problem with these assertions is that, in most cases, the state reports found exactly the opposite.

One such assertion: "Growing Reliance on Arbitration Risks Access to In-network Care: According to an analysis, the number of New York bills undergoing arbitration went from 115 in 2015 to 1,014 in 2018." These statements seem to suggest increased use of the arbitration process means that more providers have gone out-of-network. How else would the arbitration process put access to in-network care at risk? And yet, the state's own data says exactly the opposite. To quote the New York State Department of Financial Services: their law "reduced OON [out-of-network] billing in New York by 34%."[19] The ad fails to consider a much more likely scenario: it has taken some time for providers and payers to become familiar with using the arbitration process. Another possibility? Plans are increasingly paying remaining out-of-network providers inappropriately low rates, pushing providers to seek relief through the IDR process for a greater number of claims.

Another assertion: "Final Arbitration Decisions Often Lead to Inflated Charges, Higher Costs: A study found that the median arbitration award amount in New Jersey was 5.7 times higher than the median in-network price for the same service." This message suggests that arbitration increases spending on health care when the facts point to just the opposite. To create this narrative, the commentator compared the arbitration decisions to in-network rates versus what previously would have been paid out-of-network. The latter comparison is what shows the true impact of the law on spending, which is what the New Jersey Department of Banking and Insurance used in its evaluation. The state found a reduction in plans' out-of-network expenditures: "The total carrier spending on involuntary out-of-network services… was reduced by 22% for the individual health coverage market and 56% for the small employer health coverage market."[20]

Finally, the same ads claimed that "Private Equity Behind Majority of Arbitration Requests: 85% of arbitration requests in the first six months after the Texas law was implemented were from three entities, two of which were private equity-backed providers." While this may be factually accurate, it appears to suggest that private equity firms are the predominant providers that will be impacted by the federal IDR process. However, this information is irrelevant in the context of a national law that applies to the vast majority of providers regardless of ownership.

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[19] https://www.mag.org/wp-content/uploads/2020/08/NY-Report-on-the-IDR-Process.pdf
[20] https://www.state.nj.us/dobi/division_insurance/oonarbitration/data/200131report.html

The reality is that, according to the states themselves, these state laws have reduced surprise medical bills, have not contributed to health care inflation, and have encouraged network participation. They have done so without creating a de facto benchmark or disrupted network negotiations far beyond the limited issue of surprise medical billing.

Based on these findings, as well as demonstrated harmful actions by health plans and issuers, we strongly urge the departments to fix the IDR regulations to enable arbiters to consider all of the factors required by Congress, without prejudice, using their expertise and professional judgement.

Our detailed comments follow.

FEDERAL IDR PROCESS

IDR Factors for Consideration. The No Surprises Act establishes an IDR process to determine out-of-network rates to be paid to providers/facilities by plans/issuers for specified services when the two parties are unable to agree upon an appropriate payment amount after the plan/issuer has made an initial payment and the parties conclude a 30-day open negotiation period without resolution.[21] By statute, an IDR entity is required to choose between the offer submitted by the provider/facility and the one submitted by the plan/issuer.[22] The statute mandates that, in making its payment determination, the IDR entity "shall consider" a specified list of factors, including the following:

- the median in-network payment rate (the "qualifying payment amount" or "QPA");
- the level of training, experience, and quality and outcomes measurements of the provider or facility;
- market share of each party;
- acuity of the individual;
- teaching status, case mix and scope of services of the provider/facility;
- demonstration of good faith efforts by the parties to enter into network agreements over the previous four years; and
- any other factors that the parties may wish to submit for consideration with several explicit prohibitions.[23]

Rather than honoring this statutory requirement, the departments instead have chosen to make the QPA the presumptively appropriate payment amount, thus relegating all other factors to second-tier status and to be considered only as what the IFR preamble refers to as "rebuttal evidence" to demonstrate that the QPA is materially different from the appropriate out-of-network rate. The departments lack the authority to put their collective thumb on the scale in this manner. Congress expressly mandated that the

[21] Public Health Service Act (PHSA) § 2799A–1(c).
[22] *Id.* § 2799A–1(c)(5)(A).
[23] *Id.* § 2799A–1(c)(5)(C).

IDR entity consider ***all*** of the specified factors in rendering its decision. The statute does not contemplate the weighting of factors or the transformation of any of the factors to "rebuttal" status.

Because the IFR impermissibly limits the IDR entity's ability to consider fully all of the statutory factors, it fundamentally alters the statutory structure and guts the independence of the IDR entity. For these reasons, these provisions in the IFR are contrary to law, arbitrary and capricious, and otherwise violate the Administrative Procedure Act (APA).

Congress Did Not Delegate the Departments the Authority to Alter the Way an IDR Entity Determines the Appropriate Payment Amount

Both the statute and legislative history of the No Surprises Act establish that the IDR entity is vested with independent authority to evaluate all of the statutory considerations and relevant information, and then to choose between the provider's and payer's out-of-network payment offers. By establishing an ***independent*** review entity, Congress made clear that the payment determination itself is outside the purview of the departments.

The departments have essentially eviscerated the independence of the IDR entity by requiring it to presume that the QPA is the appropriate payment amount. Under the IFR, the IDR entity is independent in name only; its "determination" of the appropriate payment amount is essentially a foregone conclusion. In order to overcome the presumption that the QPA governs, the IDR entity must receive "credible information" that "clearly demonstrates" the QPA is "materially different" from the appropriate out-of-network payment rate. The statute simply cannot be interpreted to authorize the departments to erect significant barriers that distort the IDR entity's role.

The Chairman and Ranking Member of the House Ways and Means Committee made just this point in an Oct. 4, 2021 letter to the departments:

> Despite the careful balance Congress designed for the IDR process, the September 30, 2021 interim final rule with comment strays from the No Surprises Act in favor of an approach that Congress *did not* enact in the final law and does so in a very concerning manner. The rule crafts a process that essentially tips the scale for the median contracted rate being the default appropriate payment amount. Under the interim final rule, the IDR entity is only allowed to deviate from the median amount where the parties present "credible information about additional circumstances [that] clearly demonstrates that the [median in-network rate] is materially different from the appropriate out-of-network rate." Such a standard affronts the provisions enacted into law, and we are concerned that this approach biases the IDR entity toward one factor (a

> median rate) as opposed to evaluating all factors equally as Congress intended.[24]

An additional 152 U.S. Representatives reiterated this point in a Nov. 5, 2021 letter to the departments:

> The IFR directs IDR entities to begin with the assumption that the median in-network rate is the appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities.[25]

We share the view of Ways and Means Chairman Neal and Ranking Member Brady, as well as the additional 152 U.S. Representatives, and see nothing in the text or structure of the No Surprises Act that provides the departments with the authority they would need to make the QPA the presumptive appropriate payment amount or erect "materiality" or "credibility" barriers to considering the statutorily specified factors.

Unable to point to anything in the law that gives them the needed authority, the departments state that, in their "view," making the QPA the presumptively appropriate payment amount is "the best interpretation of the" No Surprises Act.[26] They attempt to justify their "view" by saying that it is "consistent with" the statute's "emphasis on the QPA . . . as the basis of the surprise billing protections . . . and as the sole factor identified without any qualification."[27] This assertion is legally wanting as can readily be seen by looking at what the statute actually says. Congress mandated that, in rendering a payment determination, the IDR entity "shall consider" a long list of factors. The QPA was listed equally among all the other factors, with no special emphasis or weight assigned to it, let alone persuasive power. Whether Congress separately chose to make the QPA more central to *other* calculations such as patient cost-sharing is simply irrelevant. Moreover, it is unclear what the departments mean when they say the other

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[24] Letter from the Honorable Richard E. Neal, Chairman, Comm. on Ways and Means, and the Honorable Kevin Brady, Ranking Member, Committee on Ways and Means to the Honorable Xavier Becerra, Secretary, U.S. Dep't of Health & Human Servs., the Honorable Martin Walsh, Secretary, U.S. Dep't of Labor, and the Honorable Janet Yellen, Secretary, U.S. Dep't of Treasury 2 (Oct. 4, 2021) (Emphasis in original.)

[25] Letter from 152 Members of the U.S. House of Representatives to the Honorable Xavier Becerra, Secretary, U.S. Dep't of Health & Human Servs., the Honorable Martin Walsh, Secretary, U.S. Dep't of Labor, and the Honorable Janet Yellen, Secretary, U.S. Dep't of Treasury 1–2 (Nov. 5, 2021).

[26] 86 Fed. Reg. 55,980, 55,996 (Oct. 7, 2021).

[27] 86 Fed. Reg. at 55,985 .

factors are "qualified" while the QPA is not. But even if that were true, it would not mean the other factors could simply be ignored or relegated to "rebuttal" status.

The departments also point to the fact that the "statutory text lists the QPA as the first factor that the certified IDR entity must consider in determining which offer to select."[28] Maybe so, but this too is irrelevant. Listing one factor first in a long list of other factors does not mean (or even suggest) that it should play an outsized role in the payment determination. And it certainly does not suggest that the QPA should be the **presumptively** appropriate payment amount. If that had been Congress' intent, it would have been easy for it to say so. It notably did not. Instead, Congress mandated that the IDR entity "shall consider" the entire list of factors that was included in the No Surprises Act after a lengthy and contentious legislative process. In no way does the statute relegate the other factors to secondary status or establish hurdles like "materiality" in order for the IDR entity to rely on them to override choosing the offer closest to the QPA.

Nor is there anything in the statute suggesting that Congress somehow intended to delegate to the departments the power to override its command. When the No Surprise Act intended to delegate authority to the departments, it clearly did so. For example, the Act provided that "[u]nder the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for purposes of encouraging the efficiency (including minimizing costs) of the IDR process." 42 U.S.C. § 300gg-111(c)(3)(A). Similarly, the No Surprises Act specifically authorized the "Secretary [of Health and Human Services,] in consultation with the Secretary of Labor and Secretary of the Treasury, shall establish a process to certify . . . [IDR] entities under this paragraph." Id. at § 300gg-111(c)(4)(A). By contrast, the "Payment determination" provision assigns the departments no special implementation role. See id. § 300gg-111(c)(5) ("Not later than 30 days after the date of selection of the certified IDR entity . . . , the certified IDR entity shall" "taking into account the [Subchapter C Factors]" select one of the offers.). At most, the No Surprises Act generally delegates the authority to designing the process the parties must follow to obtain an IDR entity's determination when negotiations fail. But even that delegation is limited. It speaks to designing the procedures for IDR; it says nothing about the substance of the IDR entity's decision. To state the obvious, stacking the deck for payers by making the QPA the presumptively appropriate payment amount is not part of designing the "process" for independent dispute resolution. Indeed, the very section of the law that authorizes the departments to establish regulations governing the IDR process states that an "IDR entity . . . determines . . . the amount of payment . . . ." And, of course, Congress already mandated that the IDR entity considers the full panoply of factors spelled out in the statute. Nothing in the statute gives the departments the power to usurp the IDR entity's authority independently to determine the amount of payment.

[28] 86 Fed. Reg. at 55,996.

As Chairman Neal and Ranking Member Brady explained:

> The compromise reflected in the No Surprises Act balanced the various approaches alongside the significant political and economic considerations at issue. Multiple proposals that ultimately did not become law relied on the median in-network rate as the benchmark for payment, with baseball-style arbitration designed as a backstop to, at most, result in a mere adjustment to the benchmark rate. In contrast, the legislation reported out of the Committee on Ways and Means, which was adopted in the No Surprises Act, authorizes IDR but does not preference in-network rates to determine the payment amount. **The law Congress enacted directs the arbiter to consider all of the factors without giving preference or priority to any one factor** . . . .[29]

The IDR process created by the No Surprises Act is not Congress' first foray in charging a government agency with creating a health care dispute resolution process. In the Affordable Care Act (ACA), Congress provided the HHS Secretary broad authority to establish a dispute resolution process for the 340B Drug Pricing Program.[30] The ACA specifically directed HHS to establish, through regulation, an administrative dispute resolution (ADR) process to assist covered entities and manufacturers in resolving disputes regarding overcharging of 340B drugs, duplicate discounts between the 340B and the Medicaid rebate programs and 340B drug diversion (drugs for a non-eligible patient).[31] The implementing regulations describe in detail the timeline for the process, the information required and how the ADR entity is to adjudicate the dispute. They allow the ADR entity to seek further information from both disputing parties and require the ADR entity to adhere to the federal rules for civil procedure as well as the federal rules of evidence.[32]

Unlike in the ADR process in the ACA, in the No Surprises Act IDR process, Congress chose to be more prescriptive: Rather than deferring to the departments to establish the standards for the IDR entity's decision making, Congress directly set forth the specific information and factors the IDR entity must consider and not consider in adjudicating claims, as well as the timeline and process. The clear difference between the ADR process in the ACA and IDR process in the No Surprises Act shows that Congress knows how to delegate authority when it wants to do so. If Congress wanted the departments to exercise wide discretion regarding how the IDR entity makes its determination, Congress would have given the departments the authority to do so. It did not. The departments took matters into their own hands and put their collective thumb

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[29] Letter from the Honorable Richard E. Neal, Chairman, Comm. on Ways and Means, and the Honorable Kevin Brady, Ranking Member, Committee on Ways and Means to the Honorable Xavier Becerra, Secretary, U.S. Dep't of Health & Human Servs., the Honorable Martin Walsh, Secretary, U.S. Dep't of Labor, and the Honorable Janet Yellen, Secretary, U.S. Dep't of Treasury 2 (Emphasis added).
[30] https://www.hrsa.gov/sites/default/files/opa/programrequirements/phsactsection340b.pdf
[31] https://www.govinfo.gov/content/pkg/FR-2020-12-14/pdf/2020-27440.pdf
[32] https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-10 (See Sections. 10.22 Information Requests and 10.23 Conduct of the ADR Proceeding.

on the scale in favor of plans and issuers in resolving reimbursement disputes with providers and facilities.

For all of the above reasons, the departments' decision to make the QPA the presumptively appropriate payment amount is unlawful. Simply put, if Congress had intended to permit the departments to take that step, it would have explicitly delegated that authority to them.

The Restrictions on the IDR Entity are Arbitrary and Capricious

As described above, the departments have failed to explain adequately why they possess authority to require the IDR entity to defer to the QPA, and why the other factors should be relegated to second-tier consideration. The departments' policy arguments are similarly wanting — they ignored information contrary to their preferred outcome and premised their decision-making on illogical assumptions. As a result, the restrictions spelled out in the IFR are arbitrary and capricious.

Perhaps the departments' greatest policy error is viewing the QPA to "be a reasonable out-of-network rate under most circumstances."[33] In fact, without reference to the other statutory factors, the median ***in-network*** payment does not rationally correlate to what an ***out-of-network*** provider should get paid. The QPA is effectively the health plan's median in-network rate, which will be wholly inappropriate in nearly any instance of out-of-network care as out-of-network providers receive none of the benefits of in-network status. Use of the health plan's median in-network rate for an out-of-network service inherently results in the health plan reimbursing an out-of-network provider at rates below rates the payer reimburses its in-network provider(s).

As would be expected, providers and payers consider many factors when deciding whether or not to enter into a contract. Factors that may be relevant to one provider may not be relevant to another, which means that the median contracted in-network rate may not be the appropriate payment level for all providers. Weighting the QPA also creates perverse incentives for payers: It is the responsibility of payers to maintain comprehensive provider networks, and making the QPA the presumptively appropriate payment amount removes incentives for payers to contract with providers or offer fair terms.

The departments also err in asserting that making the QPA the presumptively appropriate payment amount "will reduce the use of the Federal IDR process over time and the associated administrative fees born by the parties, while providing equitable and clear standards for when payment amounts may deviate from the QPA, as appropriate."[34] First, few out-of-network claims actually go through arbitration in the first place.[35] To the extent that establishing the QPA as the presumptively appropriate

[33] 86 Fed. Reg. at 55,996.
[34] 86 Fed. Reg. at 55,985.
[35] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Nickels-Surprise%20Billing%20Hearing_061219.pdf

payment amount would reduce the number further, that is only because the departments have tipped the scales unfairly in favor of payers. The statute requires the IDR entity to consider a number of unweighted factors in determining the payment amount. Dropping a number of the factors to "rebuttal" status, or making one presumptively dispositive, deters the use of arbitration at the expense of compliance with the statute. That is not a defensible goal. The same is true for the departments' tautological statement that requiring the IDR entities to presume that the QPA is the appropriate payment amount "will increase the likelihood that a certified IDR entity will generally select the offer closest to the QPA."[36] How could it not? But that does not make the outcome reasonable.

Finally, the departments' contention that the IDR entity's deference to the QPA will help limit increases in individuals' insurance premiums[37] also is misplaced. Arbitration itself has not been shown to increase health care premiums. New York State regulators report there has not been any indication to date of an inflationary effect on insurers' premiums.[38] If the out-of-network payment amounts resulting from arbitration without a thumb on the scale for payers have not increased premiums, then there is no need to put a thumb on the scale by making the QPA the presumptively appropriate payment amount.

The departments' simply ignored these facts in adopting the IFR and arbitrarily discriminated against providers.

The result will be a windfall to commercial insurance companies at the expense of patients, and the nation's hospitals and clinicians who serve them. First, as previously noted, there is nothing in the law or regulation that requires the plans or issuers to pass savings from this provision onto their enrollees, and we question any reliance on the medical loss ratio policy to instill some check on plan and issuer profits. Second, the departments fail to acknowledge how the resulting distortion to market leverage will impact in-network access to care. As evidenced in Attachment A, plans will use the law and regulations to strong-arm providers, including through false presentation of the facts. In this example, BlueCross BlueShield of North Carolina misrepresents the provisions of the No Surprises Act in an attempt to force in-network providers to reduce their rates. In what appears to be a form letter, the plan fails to define what constitutes an "outlier" or acknowledge any circumstances that may contribute to a provider receiving higher rates than the median. For example, there is no consideration of the challenge of recruiting clinicians to serve rural or historically marginalized communities or the higher overhead costs of academic medical centers and hospitals serving rural communities for which overhead costs are shared across a smaller patient population.

Arbitrarily reducing rates for these "outlier" providers could pose immediate access issues for patients. Prior to the COVID-19 public health emergency, 25% of hospitals

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[36] 86 Fed. Reg. at 55,996.
[37] *See id.* at 55,996–98.
[38] *https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/GU-CHIR_NY-Surprise-Billing_May-2019.pdf*

routinely operated in the red; since the pandemic struck, the hospitals and clinicians on the front lines have faced skyrocketing costs for personnel, personal protective equipment, construction to build new capacity, ventilators, and prescription drugs, all while facing substantial revenue losses from the cancellation of so-called elective care, as well as a reduction in emergencies.

During this time, the plans have shown their true colors. Despite requests from providers,[39] plans generally declined to use the premium dollars employers, the government, and individuals continued to pay to help providers secure the resources they needed to care for their communities. Indeed, the five largest commercial insurers earned $33 billion in profit in 2020,[40] including off of approximately $675 billion in federal and state contracts for the Medicare Advantage, Medicaid, Children's Health Insurance Program, and Health Insurance Marketplace contracts.[41]

The Departments Should Issue a Final Rule Requiring IDR Entities to Consider All the Factors Specified in the Act for Determining the Payment Amount and Eliminate the Presumption that the QPA Is the Appropriate Payment Amount

To quote again from Chairman and Ranking Member of the congressional committee that reported out the legislation ultimately adopted in the No Surprises Act:

> The IDR process was subject to extensive Congressional consideration for nearly two years prior to the enactment of the No Surprises Act. . . . [T]he law provides for an IDR process overseen by an independent and neutral arbiter who must consider a number of factors equally in deciding whether to select the provider or payer's offer. . . . **Congress deliberately crafted the law to avoid any one factor tipping the scales during the IDR process.[42]**

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[39] See Attachment B

[40] UnitedHealth Group earned $13.8 billion, a 15.5% increase over the prior year (Source: https://fortune.com/company/unitedhealth-group/fortune500/); Aetna/CVSHealth earned $6.6 billion (Source: https://fortune.com/company/cvs-health/fortune500/); Anthem earn earned $4.8 billion, a 28.2% increase over the prior year (Source: https://fortune.com/company/anthem/fortune500/); Cigna earned $5.1 billion, an increase of 93.6% over the prior year (Source: https://fortune.com/company/cigna/fortune500/); Humana earned $2.7 billion, a 60.8% increase over the prior year (Source: https://fortune.com/company/humana/fortune500/).

[41] Medicare Advantage: $315 billion in 2020 (Source: https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf#page=161); Medicaid Managed Care/CHIP: $296 billion in 2018 (Source: https://www.medicaid.gov/state-overviews/scorecard/annual-medicaid-chip-expenditures/index.html); and Health Insurance Marketplace: $62 billion in 2019 (Source: https://www.cbo.gov/publication/55085). These numbers reflect the latest publicly available estimates we could locate. However, we expect they are comparable, if not lower, than spending in 2020.

[42] Letter from the Honorable Richard E. Neal, Chairman, Comm. on Ways and Means, and the Honorable Kevin Brady, Ranking Member, Committee on Ways and Means to the Honorable Xavier Becerra, Secretary, U.S. Dep't of Health & Human Servs., the Honorable Martin Walsh, Secretary, U.S. Dep't of Labor, and the Honorable Janet Yellen, Secretary, U.S. Dep't of Treasury Page 2. (Emphasis added.)

The departments should issue a final rule that revises the regulation governing the "*Payment determination for a qualified IDR item or service"* to reflect what the No Surprises Act actually says: The IDR entity is to choose between the offer submitted by the provider and the one submitted by the payer after considering a list of specified, unweighted factors as well as any additional information submitted by either party. The QPA is not presumptively correct, the other factors may not be downgraded to "rebuttal" factors, and the regulations must be changed to be consistent with the statute.

Batching of Claims. The statute permits parties to batch claims under certain conditions "for purposes of encouraging the efficiency (including minimizing costs) of the IDR process."[43] We have shared in previous comments to the departments that achieving such efficiencies will require flexibility in defining which claims can be combined in a single batch. The regulations, however, limit batching to those claims that, among other requirements, are for the same items or services as defined as being billed using the same service code or a comparable code under a different procedural code system. This limitation on the batching of claims will substantially reduce the potential efficiencies gained from batching.

The AHA encourages the departments to allow for broader discretion in the batching of claims, which will benefit all parties in several ways. First, more comprehensive batching will significantly reduce the number of requests brought before the IDR process. It also may help disincentivize plans and issuers from adopting inappropriate out-of-network payment methodologies that would trigger IDR in the first place. Finally, by implicating a larger number of claims in a single IDR decision, providers and facilities are not incentivized to batch unless they have strong evidence to support their position.

Examples of why such flexibility may be needed to reduce burden on the system and create the right incentives for both plans, issuers, and providers and facilities include:

- The plan or issuer and the provider or facility have a dispute about a specific case, such as a complex trauma patient. This case may benefit from the ability to bring a single episode to the IDR process.
- The plan or issuer uses the same payment methodology for all out-of-network care, such as a percentage of the Medicare allowed amount. In this instance, providers and facilities should have the option to batch all claims paid under the same methodology as it is the fundamental methodology that is being challenged, not reimbursement for a single service.
- The plan or issuer uses various reimbursement methodologies that result in inappropriate overall reimbursement for all out-of-network care. Examples may be when the plan or issuer pays a certain percentage of the Medicare allowed amount generally but then removes underlying components of the payment for certain cases and unilaterally changes the services on other claims (such as "downcoding" an emergency visit). In this instance, the provider or facility should

[43] PHSAct § 2799A–1(c)(3)(A).

be permitted to batch all claims from the plan or issuer under a dispute around the "totality of payment."

All of these scenarios can be easily handled by experienced and knowledgeable arbiters. Such arbiters would have no problem assessing a case on its merits whether the case relates to an individual service or a collection of claims all paid under the same methodology.

Cooling Off Period. The statute and implementing regulations require a "cooling off period" of 90 days during which neither party can bring a claim for a same or similar service to IDR. Any claims that occur during this period can be brought to IDR once the 90-day period has concluded. **In order to increase the efficiency of the process, the AHA strongly encourages the departments to allow parties to incorporate any claims that occur during this period that would otherwise be eligible for batching as part of an existing petition to be incorporated into that petition.** Doing so will increase the efficiency of the process.

FEDERAL IDR PROCESS – OPERATIONAL CONSIDERATIONS

Central to the efficiency and efficacy of the federal IDR process is the functionality of the process, including the federal IDR portal. The departments have created the web-based federal IDR portal to serve many functions: It is where interested organizations apply for IDR entity certification, where disputing parties initiate the IDR process, where the IDR entity communicates to the disputing parties and requests further information, where the IDR entity relays payment determinations, and where final fees are to be paid. The departments unveiled the federal IDR portal through this IFR and began the application and selection process for IDR entities; however, much of the IDR portal remains unpopulated.

In general, we recognize the need for and value of such a portal. We agree with the intent to have single "one stop shop" for both information about the IDR process, as well as to complete the various steps in the process. We are concerned, however, about the ability to stand up a fully functional portal by Jan. 1, 2022. The federal government has used similar web-based portals to manage other federal programs. Most recently the web-based Provider Relief Fund, administered by HHS, provides COVID-19-related financial assistance to health care providers. Nearly a decade ago, Healthcare.gov, was launched using a web-based portal to connect individuals to the ACA coverage programs. Both of these federal portals were beset initially by problems. While ultimately resolved, experience with these portals demonstrates the risk of short ramp-up times, technology challenges for back-end and front-end functions, and inadequate staff to provide support.

Many of these very same challenges face the federal IDR portal: numerous requirements to implement through a single technology interface, many stakeholders with different roles and needs, a short timeframe to execute required functions, and heavy reliance on electronic communication and data exchange. **The AHA strongly**

recommends that the departments ensure the functionality of the IDR portal prior to launch, including through upfront testing with the stakeholders that will ultimately rely on the portal, as well as through establishing a continuous learning process that incorporates stakeholder input. The following are recommendations to improve the IDR process and the functionality of the portal.

Timeline for the IDR Process. The No Surprises Act specifies the timeline for the IDR process from its initiation to its resolution. In the IFR, the departments chose to base the timeline on business days (instead of calendar days) for most purposes, which the AHA early this year had urged the departments to adopt.[44] Moreover, the departments provided a process for either party to request an extension of the timeline. However, the circumstances for granting extensions seem to be limited to matters beyond the control of the parties, such as natural disasters. In addition, the disputing parties must initiate such a request after completing the required form and submitting it to the federal IDR portal without regard to any logistical problems they may be facing. **The AHA recommends that the departments grant the IDR entity greater discretion regarding meeting the tight specified timeframes, particularly at the beginning of this untested IDR process. In addition, the departments should establish a contingency plan in case the federal IDR portal malfunctions or other unforeseen challenges facing the IDR entity or the disputing parties.**

Initiating the IDR Process and Selection of the IDR Entity. If the 30-day open negotiation period ends without resolution, either party may initiate the IDR process. That clock starts on the 31st business day after the start of the open negotiation period. The disputing entities must communicate their positions, complete the appropriate IDR forms, and select the IDR entity all within a very short time period. Much of these communications must take place through the federal IDR portal. For the IDR process to work effectively, electronic forms of communication and data sharing will be necessary. **The AHA recommends that the departments establish a "mailbox" system within the federal IDR portal. This would allow the disputing parties and the IDR entity to communicate more effectively and minimize the risk of undelivered postal or email communications or data transmission challenges over email.**

The disputing parties also are required to mutually agree upon the IDR entity and, if no agreement can be reached, the departments will select the entity using a random method. Again, this process must be conducted through the federal IDR portal. Because either the IDR portal is not yet complete, or because of design, it is unclear to us how the disputing parties will be able to access information regarding the certified IDR entity for the selection purpose. **The AHA recommends that the departments ensure that the information regarding the certified IDR entities is easily accessible to the disputing parties along with sufficient information to allow the parties to confidently attest that there is no potential for conflict of interest. In addition, the AHA recommends that the public also should have access to the list of certified IDR entities, including all necessary information.**

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[44] AHA Letter Re: No Surprises Act – Implementation Guidance | AHA

Certification of the IDR Entity and Petition to Revoke IDR Entity Certification. The departments have highlighted in the IFR the standards IDR entities must meet to be certified. In general, the AHA supports the requirements that IDR entities are accredited by a nationally recognized organization such as URAC, that the entity personnel have appropriate and relevant training such as that conducted by the American Arbitration Association, and that such IDR entity personnel have the requisite expertise to arbitrate payment disputes. **The AHA recommends that the departments ensure that the accreditation and personnel training and proficiency be monitored throughout the 5-year period for which the IDR entity is certified.** Any organization over a 5-year period could undergo significant leadership and staff changes that could affect their accreditation and proficiency and, as a result, impact their ability to effectively and fairly arbitrate disputes.

The departments also have included a petition process as an oversight tool that allows any member of the public to petition for the denial of certification of an IDR entity applicant or the revocation of a certified IDR entity. **The AHA supports the opportunity to petition for such revocation to ensure greater oversight of the IDR process. As part of this process, we recommend that the departments adopt standards for the immediate revocation of an IDR entity's certification for cause and that a process be established to reassign pending payment determinations to other certified entities with the approval of the disputing parties.**

Administration of IDR Fees. Participating in the IDR process requires two types of fees: an administrative fee charged by the federal government for use of the IDR process and an IDR fee that the IDR entity can charge for its services. Both fees are to be paid directly to the IDR entity, and the entity will remit the administrative fee to the federal government. At the time the interim final rule was published, the Centers for Medicare & Medicaid Services (CMS) issued guidance for the administrative fees for calendar year 2022. For 2022, the administrative fee will be a flat $50, and the IDR entity can set their fee within the range of $200 to $500 for a single determination and $268 to $670 for batched determinations. Again, it is important to reiterate that the federal IDR portal will play a key role in the administration of the fees, which underscores how important it is that the federal IDR portal functionality be continually tested and monitored. **While the AHA does not have a specific recommendation on the set fee amounts for calendar year 2022, we recommend that the departments use the experience during 2022 to evaluate whether the administrative flat fee and the IDR fee range are fair and appropriate. In addition, we recommend that there is an ongoing evaluation process regarding the fees that allows input from all stakeholders.**

GOOD FAITH ESTIMATES AND PATIENT-PROVIDER DISPUTE RESOLUTION COMMENTS

Through this IFR, HHS implements the good faith estimate requirements for uninsured and self-pay patients scheduling or shopping for care, as well as the patient-provider

dispute resolution process. **The AHA continues to support policies that help patients access the information they need when making decisions about their care, including information about their potential costs.** Hospitals have long been committed to providing patients access to this information, particularly for uninsured and self-pay patients. While we are supportive of the goals of this policy, we have a number of operational concerns that we request to be addressed through further guidance in order to reduce inefficient and impractical processes. We also continue to urge HHS to assess the numerous price transparency policies together and make the necessary changes to avoid duplication of effort that will introduce unnecessary costs into the health care system and confusion for patients. This last point is particularly of concern as the myriad policies will very likely result in different estimates, and it is far from certain that patients will get only one. Additional policymaking in this space will help ensure that providers and facilities are meeting patients' financial transparency needs efficiently and in a manner that maximizes staffing and technology resources and eliminates excess and unnecessary added cost to the health care system.

Our detailed comments on the uninsured and self-pay good faith estimates and the patient-provider dispute resolution process follow.

Price Transparency Policy Alignment. HHS seeks comment on opportunities to leverage the hospital price transparency rule requirements to more efficiently meet the uninsured and self-pay good faith estimate requirements. We appreciate HHS' interest in finding ways to connect these two policies. However, the AHA urges the department to go further to assess the policy changes needed to remove duplication and fully align the federal price transparency requirements. The departments began the work of reducing duplication and aligning *insurer* price transparency policies in their recent FAQs,[45] which addressed overlaps in the No Surprises Act and transparency in coverage rule requirements. As we have commented previously,[46] more is needed to also align the *provider* requirements**. As the regulations stand today, the hospital price transparency rule and the good faith estimate requirements are operationally distinct, requiring separate workflows and resulting in discrete outputs. In addition, as currently designed, neither policy offers much implementation support to the other and therefore cannot be leveraged to help achieve consistency or efficiencies.**

The purpose of the first hospital price transparency requirement, the creation of machine-readable files, is to provide researchers and other non-patient stakeholders' access to hospitals' negotiated, self-pay, and chargemaster rates. In this IFR, HHS asks

[45] Departments of Health and Human Services, Labor, and Treasury. FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49. August 20, 2021. Available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FAQs%20About%20ACA%20%26%20CAA%20Implementation%20Part%2049_MM%20508_08-20-21.pdf

[46] AHA Comments on the CMS' Hospital OPPS and Ambulatory Surgical Center Payment System Proposed Rule for CY 2022. September 17, 2021. Available at: https://www.aha.org/lettercomment/2021-09-17-aha-comments-cms-hospital-opps-and-ambulatory-surgical-center-payment

whether these files can be used by a convening provider or facility to collect co-provider or co-facility estimated charges. We continue to question the value of such files generally, and, in particular, disagree with HHS' suggestion that they could have any utility in meeting the uninsured and self-pay patient good faith estimate requirements.

First, not all provider or facility rates exist in the machine-readable files since only hospitals are required to publish these files. Therefore, this data would only be available for some co-facility items or services. Even in instances when the convening provider or facility needs information on items or services included on a co-facility's machine-readable file, the files do not contain the needed information, as they only include the generic self-pay rate, while the good faith estimates, as we understand them, require individualized self-pay rates that are reflective of any available discounts for the patient.

Moreover, without contacting the co-facility directly from the start, the convening provider or facility would not necessarily know which items or services will be delivered during the course of care. Therefore, using these files would not remove a step in the process but instead would add an unnecessary one. Ultimately, while we agree with the objective of automating as much of this process as possible, this simply cannot be done today absent new technological advances discussed below and cannot be served by utilizing the machine-readable files.

The second hospital price transparency requirement, often referred to as the shoppable service requirement, better aligns in purpose with the uninsured and self-pay good faith estimates but differs slightly in expected output and delivery method. Most hospitals are choosing to fulfill the shoppable service requirement through the use of an online patient cost estimator tool. Like the good faith estimates, the output of these tools needs to be an individualized estimate of what a patient should expect to pay for a pre-planned health care visit. However, the cost estimator tools typically do not reflect self-pay discounts, such as financial assistance. They also do not always include co-provider or co-facility information, as it is not required by the hospital price transparency rule and, as discussed in more detail below, no standard exists currently to easily share this information between providers/facilities.[47] In many cases, only integrated delivery systems that have existing connections between facility and provider financial systems will have the capabilities to integrate information from all providers and facilities. Finally, these tools typically deliver estimates directly to the patient through an online interface, rather than through email, portal message, or standard mail as required by the uninsured and self-pay good faith estimates. While both requirements can be meaningful to patients, maintaining both as currently written is inefficient and introduces excess cost into the health care system. Instead, the two policies should be evaluated together and revised to remove duplication. **The AHA recommends utilizing patient cost estimator tools, when available, for all instances when a patient is shopping for care and only requiring the delivery of good faith estimates when a service is scheduled or a cost estimator tool is not available. Specifically, we encourage HHS to deem hospitals with hospital price transparency rule-compliant patient**

[47] The uninsured and self-pay good faith estimates will also not include this information for the first year.

estimator tools to also be in compliance with the good faith estimate requirements for patients shopping for care.

The good faith estimates are much more labor intensive than the online tools, as they require additional layers of specificity (e.g., accounting for how health status may alter the course of care, financial assistance eligibility) and, therefore, will need to be completed manually in most, if not all, instances. The additional information required is more likely to be known for scheduled services, though collecting and applying it prior to scheduling may prove challenging. For example, a patient scheduling a knee replacement with their surgeon is likely to have had prior visits that would inform the surgeon about the types of ancillary items or services that are most likely to be needed and the expected complexity of the procedure based on the patient's other health conditions. In addition, it is more likely that the specific ancillary providers will be known when a service gets scheduled rather than merely requested, though this can prove challenging even for scheduled services in some instances. Requiring this level of specificity for the good faith estimates for scheduled services may be reasonable given the availability of additional details and the role that these good faith estimates play in the patient-provider dispute resolution process. However, attempting this level of specificity with the limited information available about a patient shopping for care is not workable and is duplicative when the patient can instead access equally reliable cost estimates through the automated online cost estimator tools. **The AHA urges HHS to remove the uninsured and self-pay good faith estimate requirement for patients shopping for care if a patient cost estimator tool is available, given the availability of an equally reliable estimate created through a more automated and efficient process.**

Financial Assistance Screening. HHS requires the uninsured and self-pay good faith estimates to reflect any discounts, including financial assistance discounts, for which a patient is eligible. This poses an operational challenge if the financial assistance eligibility must be determined prior to the development of the good faith estimate. Similar to determining eligibility for means-tested government programs (e.g., Medicaid, Marketplace tax credit subsidies), determining a patient's eligibility for a hospital's financial assistance program can take time, as each application is specific to the patient. It is a manual process for the patient to secure and provide supporting evidence to the hospital and for the hospital staff to assess the materials. In hospitals, this process typically occurs following an initial screening by hospital staff or when a patient self-identifies. It is unclear in the regulations whether HHS now expects providers to conduct a financial assistance application on every patient scheduling and whether providers are limited from completing such an assessment after the fact if new information is learned about the patient after care is delivered (or their circumstances change). **We urge HHS to confirm that the good faith estimates are only intended to reflect a patient's known financial assistance eligibility at the time of scheduling or request for an estimate and that this regulation does not require providers/facilities to conduct an assessment for every patient prior to scheduling or within the short good faith estimate timeline.** In addition, we ask that you clarify that nothing in these regulations prohibits providers or facilities from assessing financial assistance eligibility after a

service is rendered if they learn additional information about a patient's financial situation.

If the assessment and adjudication of financial assistance eligibility is expected to occur before delivery of the good faith estimates, care will be delayed. Providers and facilities will need to require patients to file all of the necessary financial assistance paperwork prior to scheduling and verify that information in order to apply the appropriate financial assistance discount to the estimate. Completing these steps takes time and will require hospitals to hire additional financial assistance counselors and other finance staff to assist the patients in compiling the necessary documents, verify the documents through third-party sources, and apply the appropriate financial assistance to the cost estimates. In total, each application can take several hours to complete, with necessary pauses between each step while staff solicits and waits for additional information. Doing so for all scheduled patients would simply be impossible given resource constraints (and, we anticipate, a lack of sufficient available workforce).

Good Faith Estimate Delivery Timelines. The IFR requires convening providers and facilities to deliver good faith estimates to patients within one business day for services scheduled between three and nine days in advance and within three business days for services scheduled at least 10 days in advance or in instances when an estimate is requested prior to scheduling. In order to create a compliant good faith estimate, a convening provider or facility will need to gather a significant amount of information, often from multiple sources such as from any co-provider or facility. This would include information on the expected items and services to be delivered and their charges reflective of any available discount for the specific patient. The convening provider or facility also must compile information on all providers/facilities involved in the period of care, such as National Provider Identifier (NPI) numbers and Taxpayer Identification Numbers (TIN). Completing this task in three days while also completing all existing administrative functions will require significant planning and workflow adjustments, as well as the hiring of new staff as this level of workload cannot be borne by the existing workforce.

Delivering good faith estimates in these timeframes is unrealistic, if not impossible, and will result in providers needing to delay scheduling until they are able to complete the estimate. **In order to avoid delays in patient care, we urge HHS to streamline these requirements by allowing patients who are shopping to use online cost estimator tools and clarifying that financial assistance eligibility checks must only be done for those patients who request it or may be reasonably expected to meet the criteria, as well as assist in the development of tools to automate these process.**

Co-provider/Co-facility Compliance Date. HHS indicates in the IFR that it will utilize enforcement discretion regarding the collection of good faith estimates from co-providers and co-facilities until Jan. 1, 2023. Although we appreciate this delay in enforcement, we encourage CMS to use the development and implementation of a technical solution to enable this collection to occur before enforcing these regulations. To ensure the efficient delivery of timely, accurate, and comprehensive good faith

estimates, administrative/billing systems need a standard method of sharing this information. Otherwise, this process will remain manual, which is both inefficient and unable to meet the short statutory timeframes for delivering good faith estimates to the patients.

There is currently no method for unaffiliated providers or facilities to share good faith estimates with a convening provider or facility in an automated manner. In order to share this information, billing systems would need to be able to request and transmit billing rates, discounts, and other necessary information for the good faith estimates between providers/facilities. This is not something that practice management systems can generally do, since billing information is traditionally sent to health insurers and clearinghouses, not other providers/facilities. Practice management systems utilize standard electronic transactions to send information to other stakeholders, many of which are codified under the Health Insurance Portability and Accountability Act. This allows providers and facilities to utilize the same transaction across all health insurers and clearinghouses, eliminating the administrative burden of adhering to idiosyncratic technology platforms. The current administrative transactions do not allow for provider-to-provider communications though, so would not be usable for development of the good faith estimates. **To ensure that co-provider and co-facility information can be accurately and efficiently collected, HHS should identify a standard technology or transaction that would enable convening providers and facilities to automate the creation of comprehensive good faith estimates.**

Upon establishing a new standard method of collecting various provider/facility information, HHS should allow sufficient time for providers and facilities to complete the technology upgrades, operational updates, and staff training necessary to comply with the standard. We recommend that HHS allow 24 months from the establishment of the new standard for providers and facilities to comply with the requirement, consistent with how other transaction standards, such as the ASC X12 5010 standards, were implemented.[48] This would ensure that good faith estimates could be inclusive of all provider and facility information and delivered in a timely manner.

Co-provider/Co-facility Estimate Delivery Timelines. Beginning Jan. 1, 2023, HHS will require convening providers and facilities to deliver good faith estimates inclusive of items and services provided by co-providers/co-facilities within the allotted one or three day timeframes. This expectation is unrealistic given the procedural complexities discussed above. The most concerning aspect of the good faith estimate delivery timeline is the incorporation of the co-provider and co-facility information. In order to create a comprehensive good faith estimate, a convening provider or facility will need to request good faith estimates from each co-provider/co-facility (mostly likely via a phone call, which may not be immediately answered), await delivery (similarly likely to be done manually via the phone), and then incorporate all of the information across providers and facilities into the comprehensive estimate. The delivery of this information in three

[48] https://www.federalregister.gov/documents/2009/01/16/E9-740/health-insurance-reform-modifications-to-the-health-insurance-portability-and-accountability-act

days would require significant technology investment, staff-time, and cooperation across unaffiliated providers and facilities, many of whom may not have the resources, such as staff, available to provide the immediate attention necessary to comply. To deliver this information in one day is infeasible. **We urge HHS to reassess the timeline for estimates inclusive of co-provider or co-facility information once a technical solution for exchanging this information is developed.** This will allow an accurate and appropriate assessment as to what is most feasible for providers and facilities and most useful for the patient.

Good Faith Estimate Delivery Methods. The interim final rule allows patients to elect to receive their good faith estimates via electronic method or sent via U.S. postal service.

Utilization of postal service mail raises significant concerns about the usefulness of the information provided in the good faith estimate, as the time elapsed during the delivery process may render the estimate unusable. For example, if a patient whose service is in three to nine days elects to receive an estimate via postal service, a good faith estimate produced within one day may be delayed due to postal service logistics and not be delivered until after the service date. **We encourage HHS to permit electronic delivery of estimates for all patients or determine a timelier alternative in order to ensure that patients receive their good faith estimates without delivery delays**.

Amount of Variation to Trigger Eligibility for Dispute Resolution. The IFR provides a framework for addressing instances when a good faith estimate is lower than the patient's final bill. These provisions specify that when a patient's bill for a particular provider or facility's services is $400 or higher in excess of that provider or facility's good faith estimate, the patient is eligible to initiate the select dispute resolution process. Although we agree with efforts to ensure that patients do not receive unexpectedly high medical bills, the $400 barometer will likely create inordinate amount of disputes for legitimate, medically necessary reasons, especially for uninsured and self-pay patients who are not sharing costs with an insurer.

The delivery of first-rate medical care and procedures can be expensive, particularly for complex care involving costly drugs or innovative technologies. The AHA has long supported the idea that all Americans should have access to affordable, comprehensive health insurance coverage as it enables patients to undergo necessary medical procedures and incur the associated costs without experiencing debilitating financial peril. Without insurance, slight changes in medically necessary care can increase the overall cost, leaving even the most diligent patients and transparent providers with unexpected changes in the cost of care.

A $400 threshold to trigger a dispute resolution process is impractical. Slight changes during complex medical treatments would frequently trigger a $400 cost increase, which could lead to an excessive number of disputes going before the select dispute entities. For example, a patient who is under anesthesia for surgery for 135 minutes instead of 120 would quickly surpass this figure, despite the $400 being only a minor amount of

the overall bill. **In order to ensure that the dispute resolution process is reserved for instances in which good faith estimates are substantially inaccurate, we encourage HHS to instead require a final bill to be at least 10% in excess of the good faith estimate for it to be eligible for the dispute resolution process.**

CONCLUSION

Protecting patients from surprise medical billing is of utmost importance, and we are pleased to work with the departments on implementation of this important law. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, AHA's group vice president for policy, at mollysmith@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President

BlueCross BlueShield
of North Carolina

Re: Necessity to amend rate agreement, response needed before November 21, 2021.

Dear Provider:

_____ is likely aware of the passage of the federal "No Surprises Act" in December of 2020, with an impending effective date of January 1, 2021. Under this law, payments from health plans to out-of-network providers in many circumstances will be set at the "Qualifying Payment Amount" (QPA) which is generally calculated at the median in-network contracted rate for the same or similar specialty within the applicable geographic area. The law applies with respect to out-of-network emergency services, out-of-network professional services at a visit to an in-network facility, and air ambulance services. It applies to our commercial networks (non-Medicare Advantage, non-Medicaid). The QPA paid by health plan to the out-of-network provider constitutes payment in full unless certain limited exceptions apply for a given QPA. These exceptions include express prior patient disclosure and consent, or successful challenge in arbitration.

This new federal law allows a significant change to Blue Cross and Blue Shield of North Carolina's contracting approach with emergency service providers, hospital-based providers, and air ambulance services. Where previous state law could result in an obligation to pay at full charges if no contract is in place, the new law sets reasonable limits on payment at the median in-network rate. Where Blue Cross NC may have previously contracted at what we deemed an inflated rate that is at least somewhat lower than charges in order to avoid paying at full charge, we are now able to seek to contract at a rate more in line with what we consider to be a reasonable, market rate.

We have identified _____ as one of our outlier in-network providers with respect to rates. While the exact, final QPAs are not yet available pending upcoming finalization of the Rules to the No Surprises Act, the Interim Final Rules provide enough clarity to warrant a significant reduction in your contracted rate with Blue Cross NC. If we are unable to establish in-network rates more in line with a reasonable, market rate, our plan is to terminate agreements where the resulting out-of-network QPA would reduce medical expenses to the benefit of our customers' overall premiums.

Our ask of you at this point is as follows. We are seeking an immediate reduction in rates under our commercial agreement, as in interim step to the January 1, 2022 effective date of the No Surprises Act. This interim reduction will buy us breathing room to negotiate the final rates in light of the QPA amounts established in accordance with the upcoming Rules. With the interim reduction in place, we will not need to quickly terminate outlier contracts as a means of avoiding

payment levels after January 1, 2022 that are significantly higher than the default out-of-network QPA. Our reduction proposal, for a **December 15, 2021 effective date**, is [redacted]. We ask that you respond to this letter indicating your intention to agree, or providing a specific, comparable counterproposal. If we are able to reach agreement on the rate reduction we will quickly provide a simple rate amendment for your execution. If we are unable to reach agreement on the reduction, our intention is to proceed with identifying and executing on terminations of outlier contracts where the out-of-network QPA will result in significant savings to the benefit of our customers.

Thank you for your prompt attention to this request and your response before November 21, 2021. We hope and trust that we can update and maintain our ongoing partnership for January 1, 2022 and well beyond. If you have any questions, please contact Sr. Contract Manager, Sherrie Miller, Sherrie.Miller@bcbsnc.com at (919) 287-7439.

Sincerely,

Mark Werner
Vice President, Provider Networks

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

April 1, 2020

Matthew Eyles
President & Chief Executive Officer
America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Dear Matt:

The COVID-19 public health emergency is putting incalculable stress on individuals and families, the economy and the health care system. Addressing this global pandemic requires unprecedented action by everyone. That is why citizens are asked to stay in their homes, businesses are temporarily closed, and health care providers are asked to staff the frontlines despite many challenges. Following up on our previous conversation, America's hospitals and health systems today are asking that your member organizations join us as we meet this historic challenge to ensure that the health care system is there for anyone who needs care.

This crisis has had an immediate and dramatic impact on health care providers. Elective care is being delayed at the same time that costs are skyrocketing for certain supplies, extra staffing is becoming a critical issue, and hospitals are building surge capacity like never before. This challenge is true for both those hospitals and health systems treating high numbers of COVID-19 patients and those that are not. Inadequate financial resources and cash flow threaten hospitals' ability to remain staffed and open. While Congress and the Administration have taken a number of steps to address these issues, their actions alone cannot fill the gap resulting from reduced revenue from private insurance.

Insurers could make a significant difference in whether a hospital or health system keeps their doors open during this critical time. The federal government has already taken a number of steps to provide critical resources, such as by providing a bump in reimbursement through the Medicare program for COVID-19 cases and enabling Medicare providers to opt for accelerated payments. However, these actions alone are not enough. We urge you to work with your member organizations to commit to similar actions.

Specifically, we ask that insurers support stable cash flow by allowing providers to opt into periodic interim payments and/or accelerated payments for the duration of the public health emergency, much like what is available through the Medicare program. We also ask that

insurers eliminate administrative processes that cause delays in payment, such as prior authorization and certain payment edits, and provide adequate coverage and reimbursement of services in hospitals and alternative sites of care, including by covering cost-sharing for COVID-19 treatment. In addition, we urge insurers to expedite processing of outstanding claims that have resulted in billions of dollars in accounts receivables.

This crisis is challenging for all of us, and everyone has a role to play. The courage and dedication of our front line health care workers who show up every day to care for their communities are an inspiration to us all. We owe them the same kind of dedication by showing up for them. Our patients, our communities and our health care workers deserve nothing less than our best.

Sincerely,

/s/

Richard J. Pollack
President & Chief Executive Officer