HEARING ON REDUCED CARE FOR PATIENTS: FALLOUT FROM FLAWED IMPLEMENTATION OF SURPRISE MEDICAL BILLING PROTECTIONS

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

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United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
September 12, 2023
No. FC-14

CONTACT: 202-225-3625

Chairman Smith Announces Hearing on Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections

House Committee on Ways and Means Chairman Jason Smith (MO-08) announced today that the Committee will hold a hearing to examine the impact of the failure to fully implement the key patient protections from surprise medical bills contained in the No Suprises Act, signed into law on December 27, 2020. The hearing will take place on **Tuesday, September 19, 2023, at 10:00 AM in 1100 Longworth House Office Building.**

Members of the public may view the hearing via live webcast available at https://waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Tuesday, October 3, 2023**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee.

The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at http://www.waysandmeans.house.gov/.

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REDUCED CARE FOR PATIENTS: FALLOUT FROM FLAWED IMPLEMENTATION OF SURPRISE MEDICAL BILLING PROTECTIONS

TUESDAY, SEPTEMBER 19, 2023

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The committee met, pursuant to call, at 10:07 a.m., in room 1100, Longworth House Office Building, Hon. Jason T. Smith [chairman of the committee] presiding.

Chairman SMITH. The committee will come to order.

Three years ago, Congress passed the bipartisan No Surprises Act to end surprise medical bills for good. American patients were in desperate need of these protections, as too many had come face to face with medical bills from being treated without their knowledge by an out-of-network doctor. It left them on the hook for tens and even hundreds of thousands of dollars in surprise medical expenses.

This law has seen success in ending that crisis. Unfortunately, the new surprises for patients have come in the form of medical staff shortages, longer wait times, and fewer choices because of the Federal Government's flawed implementation of the law.

Three years ago, the Ways and Means Committee led the bipartisan effort to draft the No Surprises Act. But agency rulemaking has unfortunately ignored congressional intent. It has created a tilted dispute resolution process that has left medical providers paying more to participate in a process that often forces them to accept artificially low payments with no enforcement guarantee. It has also led to legal challenges that have resulted in significant backlogs and left the process clouded in uncertainty.

This law's implementation has made the very problem it intended to fix worse, resulting in more medical providers no longer covered under health insurance networks. This leaves Americans paying more to access fewer doctors than ever before. All of this makes it harder for patients to access quality care as health care facilities struggle to even keep their doors open, particularly in rural areas. Consequently, emergency room wait times have doubled since 2020.

The rules implementing the No Surprises Act have inflamed an existing staff shortage in an industry where having too few people can be a life-and-death matter. Right now, 600 rural hospitals are at risk of shutting down. Left unchanged, these Federal rules will continue to lead to less access to quality care. Patients are the ones

most impacted by closed hospitals and long wait times for critical services. Rural and urban areas both face a health care shortage.

At the same time, the agencies have not bothered to implement the advanced explanation of benefits, one of the key reforms that members of this committee fought to include in the No Surprises Act. Part of ending surprise billing is ensuring that people know the price of health care services before they walk in the door. Before a patient sees their doctor, patients should be told how much they will pay for the care they receive. And yet patients still have yet to benefit from this protection to which they are legally entitled.

While Congress made strides in stopping surprise medical bills, the fallout of this law's implementation demands our oversight. And I am encouraged that there is interest from both parties in seeing this bipartisan law fairly implemented. It is unacceptable that a major win for Americans can be turned into a scenario where medical providers struggle to keep their doors open, patients lose access to quality care, and the basic principle of knowing the price of the care they will receive has yet to be realized.

I look forward to working with my colleagues on both sides of the aisle to make the promise of the No Surprises Act a reality.

Chairman SMITH. And I am pleased to recognize Ranking Member Mr. Neal for his opening statement.

Mr. NEAL. Thank you, Mr. Chairman, and I am pleased that you have called this hearing this morning.

And I want to thank our witnesses for being here, as well, and I certainly look forward to hearing from all of you.

I know what Kevin Brady and I intended when we helped to write this law. And the implementation so far has been a disappointment, despite the fact that we continue to prevail in court decisions.

For too long, millions of Americans have struggled with unexpected out-of-pocket health costs that have caused anxiety and hardship for their families. When we wrote this law, we weren't targeting anybody, we weren't looking for a victim, and we weren't being punitive. In 2020, the Ways and Means Committee expanded a long legacy of patient-first policies, leading the charge to end the uncertainty of surprise medical billing. We brokered the No Surprises Act, putting an end to surprise medical billing while enhancing consumer protections and empowering patients with more information about the cost of their care. Unanimously, this committee put out the appropriate version of the legislation.

Ways and Means Democrats continue to want what is best for America's patients. That means an accessible, affordable, and transparent health care system with robust protections for consumers. The No Surprises Act builds on these priorities, providing for an impartial, structured process to settle payment disputes between insurers and providers with strong conflict-of-interest protections, timely decisions, and clear criteria for resolution.

Unfortunately, implementation of this law has strayed from Congress and its original intent, especially as it relates to the dispute resolution process. When drafting the law, we worked to ensure fairness between the parties involved in the payment disputes and

we carefully specified factors that should be considered during the Independent Dispute Resolution process.

The IDR process was developed through robust, extensive, congressional consideration in this committee for two years before the No Surprises Act took place. As written, this law carefully avoids any one single factor unduly influencing the dispute resolution process. Despite this consideration, the final rule for the No Surprises Act strays from the law as written in favor of an alternate approach that overwhelmingly favors one factor instead of the more balanced consideration that this committee and Congress fully intended.

Democrats have fought to bolster patient protections and build a healthier, stronger America. We delivered the historic Affordable Care Act, and now we are raising the first generation of Americans who didn't know a life without patient protections and the access that we provided and came through the Affordable Care Act. Now more Americans have health coverage than ever before, and Ways and Means Democrats are committed to building on the progress that we have made by continuing to lower health care costs and to promote price transparency. That is why we delivered the No Surprises Act—again, in a bipartisan manner—and we will continue to work closely with the Administration to ensure this law is implemented as this committee and as Congress intended.

It is time to get this back on track and ensure that one of the greatest consumer protection reforms in our country's history is fully implemented as the Ways and Means Committee intended.

Mr. NEAL. With that, Mr. Chairman, I yield back my time.

Chairman SMITH. Thank you, Mr. Neal. I will now introduce our witnesses.

Dr. Bleier is the vice president of finance at the Wake Emergency Physicians Professional Association.

We have Mr. Bobeck as the president of Federal Hearings and Appeals Services.

Ms. Spicer is the supervising attorney at Community Health Advocates.

And Ms. Thornton is the executive vice president of policy and strategy at America's Health Insurance Plans.

And Mr. Budzinski is the executive vice president and chief financial officer of Wellstar Health System.

Thank you all for joining us today. Your written statements will be made part of the hearing record, and you each have five minutes to deliver your opening remarks.

Dr. Bleier, you may begin when you are ready.

STATEMENT OF SETH BLEIER, MD, VICE PRESIDENT OF FINANCE, WAKE EMERGENCY PHYSICIANS PROFESSIONAL ASSOCIATION

Dr. BLEIER. Chairman Smith, Ranking Member Neal, and members of the committee, thank you for the opportunity to testify today in this hearing on the implementation of the No Surprises Act.

I am an emergency physician from Raleigh, North Carolina, and I currently serve as the vice president of finance for Wake Emergency Physicians PA, or WEPA. I am also a member and fellow of

the American College of Emergency Physicians, ACEP, which represents nearly 40,000 members as well as the North Carolina College of Emergency Physicians. On behalf of our practice and our specialty as a whole, we appreciate the committee's ongoing commitment to ensuring the law is implemented fairly and according to congressional intent.

Wake Emergency Physicians is an emergency medicine practice serving central North Carolina. Since our founding in 1992, we have always been physician-owned, and have never had any corporate or private equity backing or interests. Every owner regularly works in the emergency department. WEPA currently employs more than 200 dedicated emergency medicine specialists comprised of about 120 residency-trained, board-certified emergency physicians and 95 advanced practice providers. We serve in 11 different emergency departments across 4 different hospital systems in the region. Four of those emergency departments are located in rural communities. Our goal is and has always been to be in-network with every payer. And until the first regulations for the NSA were issued, we were in-network with all four major insurance carriers in our area of the state.

To be clear, the No Surprises Act is a critical bipartisan accomplishment that removes patients from the middle of billing disputes between physicians and insurers, and we strongly supported this goal. In an emergency where seconds and minutes are often a matter of life or death, patients should never have to think about their insurance coverage or whether they will receive a bill that they did not expect.

Beyond these important patient protections, the law established an equitable solution to resolve billing disagreements, at least in intent. Unfortunately, the implementation of the law to date has proven to be exceptionally challenging for smaller practices like ours. While we have so far been able to weather some of the impacts, if these challenges are not resolved we are deeply concerned that practice models like ours may not be viable in the near future, and access to lifesaving emergency care may be severely affected, especially for rural and underserved patients.

As I noted earlier, WEPA had historically been in-network with all major carriers in our region of North Carolina. Most of these contracts had been in place for at least a decade without any changes or updates. In November 2021, we and many other physician groups in the state received a letter from one of these insurers demanding significant cuts to our contracted rate. The letter explicitly cited the interim final rule on the NSA as justification for the reduction and stated that, if we did not agree to new payment terms, our contract would be terminated.

Thankfully, this did not come to pass, but we have since had two other payers unilaterally terminate a longstanding contract. These insurers are now paying at rates that are up to 70 percent less than our previous contracts for what are now out-of-network services. This is just not sustainable for a practice like ours. And, if these conditions persist, we may be forced to substantially reduce staffing hours, cut positions, or potentially even withdraw contracts at certain hospitals.

Adding to this burden is the fact that the IDR process has been virtually inaccessible for small practices once we are out of network. Many smaller practices have been advised by their billing contractors to avoid going through the IDR process altogether, as the costs outweigh any potential benefit. We cannot afford to challenge every underpayment when the non-refundable portion of the arbitration fee is $50, much less $350. Even though the government statistics show providers prevail the majority of the time over insurers in IDR, to date we have only submitted about 400 IDR claims. Batching rules, the IDR processing backlog, and cases where payers are simply not paying at all have also contributed to this substantial burden.

Now that at least some of these issues have been resolved due to recent court decisions and the resulting pending regulatory changes, we do hope to re-engage with the IDR process when the portal reopens. But all of this takes up valuable time and resources that we would much rather devote to patient care. We would rather not be forced to submit IDR claims. We want to go back to being in-network with every payer, and our long-lasting contracts in place prior to passage of the NSA show that we always did our best to be in-network.

WEPA is only one practice, but, sadly, we know our experience is not unique. We believe the No Surprises Act clearly struck a delicate balance as to not tip the scales too far in favor of any party, but the regulations have not been consistent with the law that Congress passed.

Thank you once again for your attention to these issues and for the opportunity to be here to share our experience. I look forward to any questions you may have.

[The statement of Dr. Bleier follows:]

Testimony of Seth Bleier, MD, FACEP

Vice President of Finance, Wake Emergency Physicians, PA (WEPPA)

House Committee on Ways and Means

Hearing on "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

September 19, 2023

Chairman Smith, Ranking Member Neal, and members of the Committee, thank you for the opportunity to testify during today's hearing, entitled "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections."

My name is Seth Bleier, MD, FACEP, and I am a board-certified emergency physician from Raleigh, North Carolina. I currently serve as the Vice President of Finance for Wake Emergency Physicians, PA (WEPPA), I am also a member and fellow of the American College of Emergency Physicians (ACEP) which represents nearly 40,000 members, and a member of the North Carolina College of Emergency Physicians. On behalf of our practice and the emergency medicine specialty as a whole, we appreciate the Committee's ongoing commitment to ensuring the No Surprises Act is implemented fairly and according to congressional intent.

Wake Emergency Physicians, PA is an emergency medicine practice serving central North Carolina. Since our founding in 1992, we have always been physician-owned, and have never had any corporate or private equity backing or interests. Every owner regularly works in our emergency departments. WEPPA currently employs more than 200 dedicated emergency medicine specialists, comprised of about 120 residency trained, board certified emergency physicians and 95 advanced practice providers. We serve in 11 different emergency departments across four different hospital systems in the region. Four of those emergency departments are located in rural communities. Our providers care for more than 450,000 patients every year. Our goal is and has always been to be in-network with every payer, and until the first regulations for the NSA were issued, we were in-network with all four major insurance carriers in our region of the state.

To be clear, the No Surprises Act is a critical bipartisan accomplishment that removes patients from the middle of billing disputes between physicians and insurers, and we strongly supported this goal. In an emergency where seconds and minutes are often a matter of life or death, patients should never have to think about their insurance coverage or whether they will receive a bill they did not expect.

Beyond these important patient protections, the law established an equitable solution to resolve billing disagreements - at least in intent. Unfortunately, the implementation of the law to date has proven to be exceptionally challenging for smaller practices like ours. While we have so far

been able to weather some of the impacts, if these challenges are not resolved, we are deeply concerned that practice models like ours may not be viable in the near future, and access to lifesaving emergency care may be severely affected, especially for rural and underserved patients.

As noted above, WEPPA had historically been in-network with all major carriers in our region of North Carolina. Most of those contracts had been in place for at least a decade without any changes or updates. Not only did our reimbursement rates not increase, they have actually significantly decreased due to factors such as inflation not being included in the contracts, as well as an increased patient burden due to high deductibles without the ability to pay.

In November 2021, WEPPA and many other physician groups in the state received letters from one of these insurers demanding significant cuts to our contract rates. The letters explicitly cited the Interim Final Rule on the NSA as justification for the reduction, and stated that if we did not agree to these new payment terms, our contract would be terminated. Thankfully this did not come to pass, but we have since had two other payers unilaterally terminate a long-standing contract. These insurers are now paying at rates that are up to 70 percent less than our previous contracts for what are now out of network services. These actions have pushed about 9 to 10 percent of our total patients out of network.

Our practice is a critical safety net for a substantial portion of our patients and for our communities. Approximately 44 percent of our patients are either uninsured or covered by Medicaid, which pays far less than the cost of care. 26 percent of our patients are covered by Medicare or TRICARE, and the remaining 30 percent are covered by commercial insurance. While these newly out-of-network patients only represent about 9 to 10 percent of our total patient population, it represents about **one-third** of our total commercial population and is a significant reduction in our practice's reimbursements.

Adding to this burden is the fact that the IDR process has been virtually inaccessible for small practices once we are out of network. Many smaller practices have been advised by their billing contractors to avoid going through IDR altogether as the costs outweigh any benefit. Most emergency department provider bills are less than $1,000. We cannot afford to challenge every underpayment when just the non-refundable portion of the arbitration fee is $50, much less $350. Even though the government's own statistics show providers prevail the majority of the time over insurers in IDR, to date we have only submitted about 200 IDR claims. Batching rules, the IDR processing backlog, and delay tactics by payers (for example, failing to abide by the arbitrators ruling and promptly remitting payment for cases won by the provider group, as has happened to WEPPA, or in some cases, not paying at all) have also contributed to this substantial burden. Now that at least some of these issues have been resolved due to recent court decisions and the resulting pending regulatory changes, we do hope to reengage with the IDR process when the portal reopens.

This increased focus on our collections and the rates being paid by insurers takes up valuable provider and staff time as well as resources that we would rather devote to patient care. We would rather not be forced to submit IDR claims. We WANT to go back to being in-network with every payer and our long-lasting contracts in place prior to passage of the NSA show that we always did our best to be in network. If these conditions persist, we may be forced to confront a financial reality where we must reduce salaries, reduce physician and advanced practice provider staffing hours, cut positions, or make difficult decisions about what areas we can realistically serve. The current climate not only threatens our ability to provide "everyday" emergency care, but it also significantly diminishes our readiness for a major disaster, mass casualty event, pandemic, or other significant event.

Frequently throughout the surprise billing debate at the federal level, emergency physicians as a profession were vilified by erroneous assertions that they purposely stay out of network so that they can charge higher rates. But our group and countless others are evidence of local, community-based emergency department (ED) practice groups who have been (or were) in long-term, stable contracts with the major insurers, and who would continue to be in network were it not for the regulatory implementation of the No Surprises Act – particularly the continued efforts to establish an artificially-low payment standard via the Qualifying Payment Amount (QPA).

Emergency physicians provide care under circumstances and laws that are unique among other physician and provider specialties. We provide more uncompensated care than any other physicians, as the federal Emergency Medical Treatment and Labor Act (EMTALA) requires that anyone coming to an emergency department must be stabilized and treated, regardless of their insurance status or ability to pay. The burden of uncompensated care only continues to grow, particularly in communities with high populations of uninsured patients. Additionally, in order to ensure 24/7/365 access to the emergency department, we work under stricter staffing and standby requirements than other types of medical providers so that we can meet the needs of patients who experience a wide range of emergencies every day, such as heart attacks, strokes, trauma, and mental health conditions, or as we have all experienced over the course of the last several years, the ravages of the global COVID-19 pandemic.

Those who support the approach that has been taken to date in implementing the No Surprises Act have suggested that cutting reimbursements to physicians and providers will enable insurers to lower premiums, allowing for more affordable and accessible coverage for Americans. Yet there is nothing in the law, or in its regulatory implementation, to ensure that happens. Several of our contracts were in place for a decade without any sort of increase to the negotiated reimbursement rates. If rising costs were "forcing" insurers to raise premiums year-over-year, it was not due to our contracts. In the meantime, insurers continue to see record profits, in no small part due to lower health care utilization during the height of the COVID-19 pandemic. Premiums for employer-sponsored family health coverage continue to grow, averaging $22,463 in 2022 and representing a 20 percent increase since 2017.[1] Meanwhile, UnitedHealth Group posted nearly $5 *billion* in quarterly profit in the final quarter of 2022, and more than $20 billion total over the

[1] https://www.kff.org/report-section/ehbs-2022-section-1-cost-of-health-insurance/

year – a more than 16 percent increase from 2021.[2] We remain skeptical that any savings, borne on the backs of providers under the implementation of the law to date, will ever be passed on to consumers.

Emergency departments throughout the country are already under immense strain due to the ongoing ED "boarding" crisis, where patients must wait hours, days, and even *months* for care or to be transferred to the appropriate setting they need and deserve. This has exacerbated physician stress and burnout – a persistent, pervasive issue for emergency physicians who consistently report the highest rates of burnout among any physician specialty (65 percent in 2021).[3] Continued cuts of this magnitude combined with growing frustrations in our attempts to negotiate in good faith for reasonable and fair contracts will have ripple effects throughout our practice, throughout the health care system in North Carolina, and throughout our country.

There is no doubt that these effects will be felt even more deeply in our rural and underserved communities, where the health care safety net is already under threat. Many emergency physician practices will be unable to afford to continue to operate in the areas where patients need them most, and millions of your constituents will have less access to the lifesaving emergency care they need and deserve. The growing trends of health care consolidation will only accelerate as practices are unable to endure the weight of these economic pressures.

WEPPA is only one practice, but sadly we know our experience is not unique. We believe the No Surprises Act clearly struck a delicate balance as to not tip the scales too far in favor of any party, but the regulations have not been consistent with the law that Congress passed. Thank you once again for your attention to these issues and for the opportunity to be here to share our experience. I look forward to any questions you may have.

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[2] https://www.fiercehealthcare.com/content/which-payer-raked-most-cash-last-year-answer-likely-wont-surprise-you

[3] https://www.prnewswire.com/news-releases/medscape-physician-burnout-and-depression-report-burnout-worsening-depression-increasing-301732504.html

Chairman SMITH. Thank you.
Mr. Bobeck, you are now recognized.

STATEMENT OF JAMES BOBECK, PRESIDENT, FEDERAL HEARINGS AND APPEALS SERVICES, INC.

Mr. BOBECK. Chairman Smith, Ranking Member Neal, and members of the committee, my name is James Bobeck, and I am the president of Federal Hearings and Appeals Services, a certified Independent Dispute Resolution Entity commonly known as an IDRE. Thank you for the opportunity to speak to the committee today regarding the implementation of the No Surprises Act and the Independent Dispute Resolution process.

FHAS is a certified, veteran-owned small business from Pennsylvania. We are an accredited, independent review organization possessing ISO certification. We are a leading provider of arbitration dispute services and health care reviews for Federal and state agencies. We have adjudicated over 100,000 health care disputes in the past year and over 3.1 million decisions in the past 27 years. FHAS was one of the first groups certified by CMS as an IDRE entity.

The No Surprises Act prohibits surprise medical billing in certain circumstances. Additionally, health plans must make an initial payment to providers based on the qualifying payment amount, which is the median rate for a particular service. If the provider feels that amount is too low, providers can avail themselves of the Independent Dispute Resolution process, and an IDRE will determine the final payment amount.

Over the past two years, the Department of Health and Human Services, Department of Labor, and the Department of Treasury, collectively known as the Departments, have promulgated Federal rules implementing various provisions of the No Surprises Act. Most notably, the Departments issued rules regarding how an IDRE should adjudicate payment disputes.

The program rules are determined solely by the Departments, and the IDREs are required to follow those rules in carrying out their designated functions. Most importantly, these functions include adjudicating payment determinations based upon the parties' submitted offers and supporting evidence.

Notably, the IDRE must choose either the provider or the payer-submitted offer, which is commonly known as a baseball-style arbitration.

The Departments published their latest statistics on the IDRE process on April 27, 2023. Those statistics cover the timeframe from the start of the process back on April 15, 2022 through March 31, 2023. In that time, disputing parties initiated 334,828 disputes. Entities rendered payment determinations in 42,158 of those disputes. FHAS alone issued 13,500 determinations in that timeframe, which represents about 32 percent of the overall payment determinations.

Additionally, 39,890 cases were ultimately determined ineligible for the IDRE process, and eligible cases primarily resulted from parties' non-compliance with the Departments' batching rules, which are rules regarding how parties can combine multiple cases into one dispute. IDR Entities also closed disputes for other rea-

sons, such as the parties may come to a settlement of the matter, or they simply withdraw their case.

Throughout the past year, Federal court rulings have vacated certain provisions of the Departments' rules. In response, we have made on several occasions a temporary suspension of the IDRE program, as CMS attempts to formulate new rules regarding that process. Currently, the dispute resolution process has been suspended since August 3, 2023, and during this suspension parties cannot submit new cases through the CMS portal and IDREs cannot adjudicate any payment determinations.

The dispute resolution portal must be opened immediately to allow dispute filing. Prior to the shutdown, parties routinely filed in excess of 40,000 cases per month. Providers and payers rely upon the portal's operation to finalize payment determinations. Without payment determinations, parties cannot resolve their disputes, providers cannot receive any payment for their services, and payers cannot render required payments to providers.

Thank you for the opportunity again to appear before the committee. FHAS is committed to providing timely arbitration services, and we look forward to continued engagement with the committee.

[The statement of Mr. Bobeck follows:]

Written Statement for the Record

of

James L. Bobeck, Esq.

President,

Federal Hearings and Appeals Services Inc.

for the

United States House Committee on Ways & Means

Hearing on

"Reduced Care for Patients:
Fallout From Flawed Implementation of Surprise Medical Billing Protections"

September 19, 2023

Chairman Smith, Ranking Member Neal, and Members of the Committee, my name is James Bobeck, and I am the President of Federal Hearings and Appeals Services, Inc. (FHAS), a certified Independent Dispute Resolution Entity (IDRE). Thank you for the opportunity to speak with you today regarding the implementation of the No Surprises Act and the Independent Dispute Resolution (IDR) Process.

FHAS is a certified veteran-owned small business (VOSB) founded in 1996. FHAS has full URAC Comprehensive Independent Review Organization (IRO) accreditation and ISO 9001:2015 certification. We are a leading provider of arbitration dispute services and healthcare external reviews for state and federal agencies. In the past year, FHAS adjudicated over 100,000 healthcare dispute decisions, and FHAS has adjudicated over 3.1 million healthcare decisions over the past twenty seven years. FHAS was one of the first groups certified by the Centers for Medicare & Medicaid Services (CMS) as an IDRE to adjudicate payment disputes.

Primer: Establishment of Independent Dispute Resolution Process

Effective January 1, 2022, the No Surprises Act prohibits surprise medical billing in certain circumstances. Prior to the No Surprises Act, patients would often be responsible for paying unanticipated medical bills. The No Surprises Act provides federal protection for patients against these bills, which are typically for out-of-network (OON) services. In certain situations covered by the No Surprises Act, patient bills are limited to no more than the in-network cost-sharing amount for these services. Health plans, issuers, and Federal Employees Health Benefits (FEHB) Program carriers must pay the OON provider, facility, or air ambulance provider for their services. In cases where payment disagreements arise, providers and payers can avail themselves of the IDR process whereby a certified IDRE will review the specifics of the case and the items or services received, and determine a final payment amount.

Over the past two years, the U.S. Department Health & Human Services, U.S. Department of Labor, and the U.S. Department of the Treasury (collectively, "the Departments") have promulgated federal regulations implementing various provisions of the No Surprises Act. Most notably, the Departments issued rules regarding IDRE payment determination arbitration. Throughout the past year, federal court rulings have vacated certain provisions of the Departments' rules, and the Departments are now implementing new rules to govern IDRE arbitration of payment determinations. During this time period, the Departments have periodically suspended the IDR program. During such suspensions, parties cannot submit new cases through the CMS portal, which is the first step to initiate a case dispute, and IDREs cannot adjudicate any payment determinations. Currently, the IDR process is suspended, and this suspension has been in place since August 3, 2023.

The Relationship between the Departments and IDREs: A Public-Private Partnership

Public-private partnerships involve collaboration between a government agency and a private-sector company. As it applies to the No Surprises Act, IDREs are private entities accredited by national accreditation bodies to perform independent reviews regarding certain health insurance disputes. The Departments, through an application process, approved certain private entities as IDREs under the No Surprises Act. While the Departments establish the rules of the program, IDREs are charged with performing certain functions under the No Surprises Act, namely, administering an adjudicative system in which new cases are received, offers and payments from providers and payers are collected, and payment determinations are made. Notably, the IDRE must choose either the provider or payer's submitted offer in making a determination (often referred to as a "baseball-style arbitration").

The No Surprises Act regulations are determined solely by the Departments, and IDREs are required to follow those regulations in carrying out their functions. IDREs are not funded through the government, but instead through fees collected from the parties.

No Surprises Act Arbitration Results over the Past Year

The Departments published their latest statistics on the IDR Process on April 27, 2023.[1] Between April 15, 2022 and March 31, 2023, disputing parties initiated 334,828 disputes. FHAS was assigned 16% of those disputes. Of the disputes closed during this period, 39,890 were ultimately determined ineligible for the federal IDR process. Most cases are determined ineligible due to non-compliance with the Departments' batching rules, which are rules regarding how parties can aggregate multiple cases into one dispute. IDREs entities rendered payment

[1] CMS released a partial report in April 2023. *See* CMS, "Federal Independent Dispute Resolution Process – Status Update" (April 27, 2028) available at https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf.

determinations in 42,158 disputes. FHAS issued 13,500 determinations in that timeframe, which represents 32% of all payment determinations.

IDRE entities also close disputes for reasons other than ineligibility or payment determinations. For example, disputes may be closed because the disputing parties withdraw their case, reach an outside settlement, or fail to pay required IDRE and/or government fees. Overall, IDRE entities have closed 106,615 disputes as of March 31,2023; FHAS closed 27,505 disputes during that timeframe, which represents 26% of case closures. The Departments have not released new statistics since April 27, 2023. However, as of July 31, 2023, FHAS has received 79,554 cases, issued 46,105 payment determinations, and closed 61,346 cases.

Path Forward

The IDR portal must be opened immediately to allow dispute filing and compliance with the No Surprises Act. Prior to the shutdown of the IDR portal, parties routinely filed in excess of 40,000 cases per month. As a result of the Departments' program shut down of the IDR portal, a significant backlog of cases has been created. Providers and payers rely upon the IDR portal's operation to settle and/or finalize payment determinations. Without payment determination finalization, parties cannot resolve disputes, providers cannot receive payment for services, and payers cannot render required payments to providers.

Conclusion

Thank you for this opportunity to appear before the Committee to discuss the No Surprises Act and the IDR process. FHAS is committed to providing timely arbitration dispute services and healthcare external reviews for state and federal agencies. We look forward to continued engagement with the Committee on these issues.

Chairman SMITH. Thank you.
Ms. Spicer, you are now recognized.

STATEMENT OF DIANE SPICER, SUPERVISING ATTORNEY, COMMUNITY HEALTH ADVOCATES, COMMUNITY SERVICES SOCIETY

Ms. SPICER. Chairman Smith, Ranking Member Neal, and distinguished members of the committee, thank you for holding today's hearing to examine the impact of the No Surprises Act.

My name is Diane Spicer. I work at the Community Service Society of New York, or CSS. CSS has been an unwavering voice for low-income New Yorkers for over 175 years. CSS administers the Community Health Advocates Program, New York State's Designated Health Insurance Consumer Assistance Program, through a live answer help line and in partnership with over 20 community-based organizations located throughout the state. Since 2010 Community Health Advocates has helped over half-a-million New Yorkers enroll in and use health insurance, negotiate medical bills, and otherwise access free or low-cost health care, saving them $180 million.

As the supervising attorney of Community Health Advocates, I have had the unique opportunity to view the implementation of both the New York State out-of-network surprise billing law and the Federal No Surprises Act.

In 2014, the State of New York passed the surprise billing ban, setting up a baseball-style arbitration that kept the patient out of the middle of payment disputes at the urging of CSS on behalf of a coalition of consumer advocates. CSS was encouraged to see Congress follow New York's model in 2020 and ban surprise medical bills for federally-regulated plans.

We are grateful for the work done in Congress and in our home state of New York to address surprise bills. Nevertheless, we still field over 20 calls per month from patients with questions. The health care system can be extremely complicated to navigate for even the most well-versed among us. Advocates spend a lot of time helping patients understand the complicated rules and processes necessary to determine whether they have received a surprise bill and how to appeal to be held harmless.

Prior to the passage of New York's law, CHA fielded hundreds of calls a year from consumers who faced surprise bills. A typical case involved the admission of a client to an emergency room for painful kidney stones. The emergency room transferred the client to the urology department, who performed surgery. All of their providers were in-network except the anesthesiologist, leaving the client with the classic surprise bill. New York's out-of-network surprise billing law addressed these classic cases for our state-regulated insurers.

We at CHA were delighted to see the enactment of the Federal No Surprises Act because it made additional improvements to what we had already achieved in New York, including providing protections against air ambulance bills, addressing network directory misinformation, affording protections to consumers in federally-regulated ERISA plans, and, importantly, covering the circumstances

of when a provider incorrectly tells a patient that they are in-network.

Claudia Knafo, a concert pianist who needed neurological surgery, is a classic example of this issue. Claudia did everything right. She found a hospital and a surgeon who were in-network, cleared everything with her insurance, and proceeded with her surgery. But her surgeon's office had misinformed her that he was in-network when he, in fact, was not. She was stranded with a $35,000 bill. Her situation is now covered by the NSA, which requires providers to issue notice and consent waiver forms in advance of treatment when they are out-of-network.

With that said, our clients still struggle every day with the implementation of our state law and the NSA. Specifically, the structure of the law leaves patients vulnerable to surprise bills in several ways.

The first, the process of determining which bills are covered and appealing a surprise bill, is too complicated for many consumers to understand.

Second, plans do not automatically hold consumers harmless for surprise bills, and many health care providers remain uneducated about the law and continue to balance-bill patients.

And third, providers may use the notice and consent form inappropriately. Loopholes also remain in the law. For example, there have been operational issues with the rollout of the notice and consent form waiver. We have seen instances where providers use the consent form inappropriately.

For example, in a recent case a consumer whose primary language was not English was told his varicose vein surgery would not be performed unless he signed the form. Because he needed surgery and did not understand the form, he signed the form shortly before surgery and paid a $6,000 deposit out of pocket. His plan's explanation of benefits later stated that his claim was reduced and, because of the protections of the NSA, he would owe only his in-network cost sharing of $18. However, the patient already signed the form, and thus it was incorrectly required to pay. It will be hard to reclaim this amount.

All of us sign numerous pages of forms when we go to the doctor and get procedures, sometimes on electric devices, and few of us have the capacity to understand the ramifications of signing the form.

I would like to close by saying we are deeply proud of the work we do. Patient confusion around health care costs continues to grow, despite Federal and state protections. We urge Congress to work together to restore funding to vital Health Insurance Consumer Assistance Program, so that together we can help improve the patient experience and help them through the very complicated processes of determining whether or not they have a surprise bill and appeal to be held harmless for that bill. Thank you.

[The statement of Ms. Spicer follows:]

Community Service Society

Powering a more equitable New York

Diane Spicer, Supervising Attorney
Community Health Advocates
Community Service Society
Testimony to the Ways and Means Committee
"Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections"

September 19, 2023

Chairman Smith, Ranking Member Neal, and distinguished members of the committee, thank you for holding today's hearing to examine the impact of the No Surprises Act (NSA). My name is Diane Spicer, and I work at the Community Service Society of New York (CSS). CSS has been an unwavering voice for low-income New Yorkers for over 175 years. CSS administers Community Health Advocates (CHA)—New York State's designated Consumer Assistance Program—through a live-answer helpline and in partnership with over 20 community-based organizations located throughout the state. Since 2010, CHA has helped over 550,000 New Yorkers enroll in and use health insurance, negotiate medical bills, and otherwise access free or low-cost health care, saving them $180 million.[1]

As the Supervising Attorney of Community Health Advocates, I have had the unique opportunity to view the implementation of both the New York State Out-of-Network/Surprise Billing Law and the federal No Surprises Act (NSA). In 2014, the State of New York passed its surprise billing ban, setting up a "baseball-style" arbitration that kept the patient out of the middle of payment disputes—at the urging of CSS on behalf of a coalition of consumer advocates. CSS was encouraged to see Congress follow New York's model in 2020 and ban surprise medical bills for federally regulated plans.

We are grateful for the work done in Congress and in our home state of New York to address surprise bills. Nonetheless, we still field over 20 to 30 calls per month from patients with questions. The health care system can be complicated to navigate for even the most well-versed among us. Advocates spend a lot of time helping patients understand the complicated rules and processes to determine whether they have received a surprise bill and how to appeal to be held harmless.

Prior to the passage of New York's law, CHA fielded hundreds of calls a year from consumers who faced exorbitant surprise medical bills. A typical case involved the admission of a client to the emergency room for painful kidney stones. The emergency room transferred the client to their urology department who performed surgery. All of the providers were in-network,

[1] https://communityhealthadvocates.org/who-we-are/our-impact/

except the anesthesiologist—leaving our client with the classic "surprise bill." New York's Out-of-Network/Surprise Bill law addressed these classic cases for our state regulated insurers.

We at CHA were delighted to see the enactment of the federal No Surprises Act (NSA) because it made additional improvements to what we had already achieved in New York, including: providing protections against air ambulance bills; addressing network directory misinformation; affording protections to consumers in federally-regulated (ERISA) plans; and, importantly, covering the circumstance of when a provider incorrectly tells a patient they are in-network. Claudia Knafo, a concert pianist who needed neurological surgery, is a classic example of this last issue. Claudia did everything right. She found a hospital and a surgeon who were in-network, cleared everything with her insurance and proceeded with the surgery. But her surgeon's office had misinformed her that he was in-network, when, in fact, he was not—stranding Claudia with a $35,000 bill.[2] Her situation is now covered by the NSA which requires providers to issue a notice and consent waiver form in advance of treatment when they are out-of-network.

That said, our clients still struggle with the implementation of our state law and the NSA. Specifically, the structure of the law leaves patients vulnerable to surprise bills in several ways: (1) the process of determining which bills are covered and appealing a surprise bill is too complicated for many consumers to understand; (2) plans do not automatically hold consumers harmless for surprise bills, and many health care providers remain uneducated about the law and continue to balance bill patients; (3) providers may use the notice and consent form inappropriately; and (4) loopholes remain in the law.

1. **The process of determining which bills are covered by the NSA and appealing them is too complicated for many consumers to understand.**

Patients whose bills should be covered by the NSA may have difficulty exercising their rights. In some cases, patients receive bills that they should be protected from, and it is my job, along with my team, to determine if they should be protected and guide them through complicated appeal processes to ensure they are not responsible for more than their in-network cost-sharing.

In these cases, CHA advocates call health plans and providers to determine the reason why claims are denied and patients are billed. Often, we spend many hours on the phone to understand the circumstances that arose during the episode of care that led to the bill, and the actions the consumer and provider took at that time. These are complicated situations in which consumers are rarely able to determine on their own if their billing situation fits within the letter of the law. For consumers who actually received surprise bills and did not sign the notice and consent waiver, we file appeals and, sometimes, complaints with the regulator.

2. **Plans do not automatically hold consumers harmless for surprise bills, and many health care providers remain uneducated about the law and continue to balance bill patients.**

[2] https://www.vox.com/health-care/2019/3/19/18233051/surprise-medical-bills-arbitration-new-york

CHA Advocates have noticed that health insurance plans and providers do not automatically hold patients harmless for surprise bills when our clients come to us with their billing problems. The patients we assist are often billed and must file an appeal so that they are only responsible for the in-network cost-sharing. From our perspective, some health care providers are not educated about NSA protections and continue to balance bill consumers. While we are there to help them, not every patient will know they can turn to us for help – or that they do not have to pay the bill to begin with.

For example, one consumer CHA assisted was seen by an in-network provider for abdominal pain. The provider ordered labs, which were done at an in-network facility, but read by an out-of-network radiologist. The consumer was billed $563, when his in-network cost sharing should have been $62. He appealed and complained, asking for relief under the NSA. Both his plan and the NSA helpdesk responded that the NSA did not apply since the services he received were neither emergency nor inpatient. These determinations were patently incorrect: the NSA applies to both non-emergent and outpatient care. This consumer's billing issue has taken more than six months to resolve and will likely go to external appeal. He is still being billed for the out-of-network services of the radiologist.

3. Providers may use the notice and consent form inappropriately.

The NSA also includes a requirement that providers issue patients a notice and consent form to make them aware of their network status and unexpected charges which may result from an out-of-network service. This is an important consumer protection for patients who were misinformed by providers and stuck with the bills (like Claudia Knafo).

But there have been operational issues with the roll-out of this requirement, and many cases we see include instances in which providers use the consent form inappropriately. For example, in one recent case, a consumer whose primary language is not English was told that his varicose vein surgery would not be performed unless he signed the consent form. Because he needed the surgery and did not understand the form, he signed the form shortly before surgery and paid a $6,000 deposit (50% of the surgery's cost) out of pocket. His plan's Explanation of Benefits notice later stated that the claim was reduced and, because it was protected by the NSA, he would owe only the in-network cost-sharing of $18. But the patient had signed the consent form and was thus incorrectly required to pay the $6,000 – which will be nearly impossible to reclaim.

All of us sign numerous pages of forms when we go to the doctor and get procedures—sometimes on an electronic device that fails to adequately display the documents. Few of us have the capacity to understand the ramifications of signing a notice of consent form.

4. Loopholes remain in the NSA.

Even with all the NSA's improvements, loopholes remain.

The federal protections do not apply to consumers who receive a "surprise" medical bill from out-of-network ambulances or out-of-network urgent care facilities. In addition, while NSA

covers ancillary care such as pathology and labs, it only does so in the hospital or ambulatory care setting. Similarly, patients are not protected for post-ER follow-up care with out-of-network providers. For example, one of our CHA clients had emergency kidney stone surgery. She was in a lot of pain when she got to the emergency room and did not know that her surgeon was out-of-network with her plan. The doctor placed a stent. That bill was covered. Unfortunately, she remains responsible for the bill to see the same out-of-network surgeon to remove it.

Another common outstanding loophole is the failure to address ground ambulance cases.

When patients bring these claims to us, we often spend countless hours confirming that consumers are not protected, negotiating discounts and filing financial assistance applications with the ambulance and other service providers. Sometimes, these attempts fail, and we must resort to turning to private health care charities. But these charities quickly run out of funds and not all consumers are able to access them.

Generally, CSS has seen a 64 percent increase in outreach to our office about medical bills since 2019. Many of these consumers are protected by the New York State Surprise Billing Law and the NSA but are unaware that they are being balanced billed. Our New York program handled about 500 cases regarding similar out-of-network bills since the start of the NSA in January of 2022.

We urge Congress and the Administration to work together to improve consumer protections in our health care system offered under the NSA and other laws.

I would like to close by saying, we are deeply proud of the work we do as New York's designated Consumer Assistance Program. Like New York, a dozen states continue to operate these programs—despite lack of federal appropriation. Patient confusion around their health care costs continues to grow, despite federal and state law protections. We also urge Congress to work together to restore funding for these vital Consumer Assistance Programs so that together we can work to improve the patient experience in the health care system.

Chairman Smith, Ranking Member Neal, again thank you both for holding this hearing and including the patient voice as part of this important conversation. I look forward to answering any questions you may have.

Chairman SMITH. Thank you.
Ms. Thornton, you are now recognized.

STATEMENT OF JEANETTE THORNTON, EXECUTIVE VICE PRESIDENT OF POLICY AND STRATEGY, AMERICA'S HEALTH INSURANCE PLANS

Ms. THORNTON. Good morning, Chairman Smith, Ranking Member Neal, and distinguished members of the committee. I am Jeanette Thornton, executive vice president for policy and strategy at AHIP.

I testified here in May 2019 as this committee and others in the House and Senate were debating legislation to end the practice of surprise medical billing. As I said then, every American deserves affordable, high-quality coverage and care, and surprise medical billing was a barrier to that goal. At that time, approximately one in five emergency department visits resulted in a surprise bill. Going to the emergency department or being treated at the hospital meant uncertainty and worry not only about your health, but also that you would get an unexpected bill that you couldn't afford.

Enacted with strong bipartisan support in Congress, the No Surprises Act had—has resulted in peace of mind and financial security. But the promise of the No Surprises Act remains—has not been completely fulfilled. Work remains to improve the dispute process, lower health care costs, and grow the number of in-network providers.

It is first worth reflecting on how far we have come since the No Surprises Act was passed. The No Surprises Act has prevented one million surprise bills per month. To put it simply, that is 20 million bills since January 2022. Patients in every state are protected from most surprise medical bills. Bill charges, often exorbitant amounts, no longer dominate as the payment demand for out-of-network care. Patients see lower and more predictable out-of-pocket costs because of the Qualifying Payment Amount, or QPA, is based on the median of market rates.

There is more good news. For nearly 9 in 10 out-of-network claims subject to the law, the No Surprises Act works without issue. An initial payment is made by the health plan to a provider or hospital, typically based on the QPA, and this amount is accepted without any dispute.

The dispute process was meant to be a backstop, a recourse for providers and hospitals to utilize in limited instances where market rates for health care items and services may not be applicable. But today this process is costly, inefficient, and heavily weighted in favor of initiating parties, with them prevailing in 71 percent of disputes.

We share your frustration in how the dispute resolution process has rolled out. More cases have gone to IDR than were ever contemplated, 14 times more, highly concentrated in just 5 states. Providers are submitting claims that are ineligible. The overwhelming majority of claims are from a small subset of physician staffing and billing companies and one air ambulance company. Repeated litigation from the Texas Medical Association and others has created uncertainty and caused repeated starts and stops and hindered the regulators in developing a process that works.

Our goal is to have more health care providers, particularly facility-based providers, join plan networks so that this IDR process is rarely used. The success of our business model depends on having large networks of high-quality, high-value health care providers.

A lack of sufficient information has at times delayed payments. But despite claims to the contrary, this is not intentional on the part of health insurance providers. In fact, withholding payments really works against our business model.

We encourage the regulatory agencies to continue their work to ensure the Federal process is efficient, reduces ineligible claims, and facilitates on-time and accurate payments. It is critical that unbiased IDR Entities are evaluating factors in a uniform and transparent manner that aligns with the intent of the law.

Thankfully, today patients no longer have to worry about receiving a surprise medical bill when they return home from the hospital or emergency department. And for when this does happen, we believe there is a path forward to make this dispute process work as intended in a way that reduces health care spending if all stakeholders work together.

Thank you for the opportunity to testify. AHIP and our members appreciate the continued bipartisan commitment to protecting patients from surprise medical billing and lowering health care costs.

[The statement of Ms. Thornton follows:]

Jeanette Thornton, AHIP
before the
U.S. House Committee on Ways & Means
Hearing on Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections

Good morning, Chairman Smith, Ranking Member Neal, and distinguished members of the Committee. My name is Jeanette Thornton, and I am Executive Vice President for Policy & Strategy at AHIP, the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, our members improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, and access to care. AHIP is committed to improving the health and well-being of all Americans.

On behalf of AHIP and our member companies, I appreciate the opportunity to testify today on a topic of tremendous significance to American patients, consumers, health care providers, employers, labor unions, health insurance providers, and our economy. I sat at this witness table in May 2019 as this committee, and others in the House and Senate, were considering legislation to end the practice of surprise medical billing. As I said then, every American deserves affordable, high-quality coverage and care and the practice of surprise medical billing was a barrier to that goal. At that time, approximately 1 in 5 emergency department visits in the U.S. resulted in a patient receiving a surprise medical bill.[1] Additionally, each year millions of patients receiving care at hospitals or other facilities that participated in their health insurance network received a surprise medical bill because a specific health care provider who treated them was out-of-network. In many cases, patients did not actively choose that particular provider or were not aware the provider was out-of-network. Indeed, in many instances, hospital-based providers would not participate in any health plan network.

Protecting Patients
Today, the worry and uncertainty of an emergency or hospital stay resulting in the financial harm of a surprise medical bill has been greatly reduced for America's patients, thanks to the No Surprises Act. Enacted with strong bipartisan support in Congress, the No Surprises Act largely has been a success in providing peace of mind and financial security to the AHIP and health plans across the country. Much work remains to make the No Surprises Act work not only for patients, but for all health care stakeholders so that affordable, high-quality health care, especially in an emergency, is accessible for everyone. Much work also remains to achieve the promise of the No Surprises Act – lower health care costs and more in-network providers.

With that important work ahead, it is worth reflecting on how far we have come since the No Surprises Act was passed in late 2020.

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[1] Pollitz K, Lopes L, Kearney A, et al. US Statistics on Surprise Medical Billing. *JAMA*.2020;323(6):498. doi:10.1001/jama.2020.0065

Before the No Surprises Act, going to the emergency department or being treated at the hospital meant uncertainty and worry, not only about the procedure or health emergency, but also uncertainty and worry that your specialist or another provider would send you a bill. These costs could range from several hundred dollars to thousands or even tens of thousands of dollars.[2] Families across America were routinely burdened with the high costs of surprise medical bills and some were financially devastating.[3]

Before the No Surprises Act, a 9-year-old hiking at her summer camp could be bitten by a venomous snake, receive immediate and excellent care and be discharged from the hospital less than 24 hours later, only for her parents to receive a bill for $143,000.[4] Before the Act, two hours in an emergency room for a rabies shot and antibiotic after a cat bite could mean a bill of more than $48,000,[5] and a 27-mile air ambulance transport could result in a $51,000 bill[6] - just under $1,900 per mile cost to the patient in a time of emergency. Even a routine throat swab for a cough and sore throat could mean a $28,000 bill from an out-of-network lab.[7]

Before Congress thoughtfully acted to end the practice, billed charges – often exorbitant amounts – dominated as the payment demand for out-of-network care. Those high costs I listed are unrepresentative of the actual cost of care and bear no resemblance to either negotiated, contracted rates, or the rates paid by programs like Medicare. Health insurance providers negotiate lower payments on behalf of their members and would work to settle the out-of-network bill, aiming to protect their members from having to pay the full cost of those billed charges. Health insurers and employers would find themselves paying billed charges or amounts close to billed charges to take the patient out of the middle, which could increase health insurance premiums for everyone. The practice of surprise medical billing was not only costly for patients, but also costly for everyone, including taxpayers.[8]

What's Working

Today, patients in every state are protected from most surprise medical bills. Research conducted by AHIP last year repeatedly found that the No Surprises Act was preventing approximately 1 million claims per month from reaching consumers in the form of a surprise bill.[9] That's 20 million claims since January of last year that did not become surprise bills. Whether or not patients realize it, the No Surprises Act is protecting them from these costly and unnecessary out-of-network bills. Today, patients are seeing lower and more predictable out-of-pocket costs when they receive out-of-network care at an in-network hospital or in an emergency, and that's because

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[2] Office of the Assistance Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (2001). *Evidence on Surprise Billing: Protecting Consumers with the No Surprises Act*.
[3] American Heart Association. (2020). *Poll: Surprise medical bills pose significant financial burden*.
[4] Carmen Heredia Rodriguez. Kaiser Family Foundation Health News. (2019). Summer Bummer: A Young Camper's $142,938 Snakebite.
[5] Julie Appleby. Kaiser Family Foundation Health News. (2019). Meow-ch! The $48,512 Cat Bite.
[6] Anna Almendrala. Kaiser Family Foundation Health News. (2019). The Air Ambulance Billed More Than His Surgeon Did For A Lung Transplant.
[7] Richard Harris. Kaiser Family Foundation Health News. (2019). For Her Head Cold, Insurer Coughed Up $25,865.
[8] Duffy, Erin, Erin Trish, Loren Adler. Brookings Institute. (2020). Surprise medical bills increase costs for everyone, not just for the people who get them.
[9] AHIP. (2022). New Study: No Surprises Act Protects 9 Million Americans from Surprise Medical Bills.

of the Qualifying Payment Amount – or QPA – that Congress wrote into law as a centerpiece of the No Surprises Act, including as the basis for determining cost-sharing.

Operations Are Not Working as Intended
Patient protections took effect for plan years beginning January 1, 2022, just one year after the law was enacted. Less than four months later, the Administration opened the federal IDR portal to begin processing disputes for out-of-network payments. AHIP and our members have worked in good faith from the day the No Surprises Act became law to be reliable partners in implementing the many provisions of this far-reaching law. Standing up sweeping new regulations and developing the infrastructure and staffing technology required to process disputes – and to do so in just over a year – has been a daunting process filled with many challenges and lessons learned. We share many of the frustrations of other health care stakeholders and members of this committee regarding the technical aspects of implementation and dispute resolution process.

Today, it is what patients *do not* see that requires improvements if we want the No Surprises Act to protect patients for generations to come. The Independent Dispute Resolution, or IDR, process established by the No Surprises Act was meant to be a backstop – a recourse for providers and hospitals to utilize in limited instances where market rates for health care items or services may not be applicable to the circumstances of a unique case or a payment amount could not be resolved through good-faith open negotiation. For nearly 9 in 10 out-of-network claims subject to the patient protections of the No Surprises Act, the law works without issue. In 9 out of 10 claims, an initial payment is made by a health plan to a provider or hospital, typically based on the QPA, and this amount is accepted without any dispute.

Our view as Congress was debating this legislation – a view shared by employers, labor unions, patient and consumer groups – was that any proposal that would use arbitration to determine payments to out-of-network providers would be costly to the health care system and fail to address the root cause of surprise medical billing. Today, we have an arbitration process – the federal IDR process – that is costly, inefficient, and heavily weighted in favor of initiating parties.

Our goal should be a balanced IDR process that works in tandem with the other provisions of the law – including the patient protections, limits on cost-sharing, and calculation of the QPA based on negotiated, market rates – in a way that reduces health care spending. That requires the law to be implemented in a way that encourages broader participation in health plan networks while discouraging commonplace use of IDR. In the No Surprises Act, Congress placed the QPA at the center of the two pillars that make the entire Act work – limiting consumer cost sharing and establishing a process for resolving payment disputes when an initial payment was deemed insufficient. Limited use of IDR, where the payment determinations are most likely to reflect reasonable market rates for a health care item or service, is necessary for this law to achieve the intended cost savings.

Just as the overwhelming majority of surprise bills originated with a subset of health care providers or hospitals, the overwhelming majority of claims that go to IDR are from a small

subset of physician staffing and billing companies.[10] One company alone is responsible for nearly 1 out of 3 non-air ambulance disputes. More than half of all the emergency and non-emergency items or services disputed under the No Surprises Act are claims from 1 of 3 companies. Just as some provider staffing firms disproportionately relied on surprise billing as a business strategy, there is a small, but active number of physician groups disproportionately using – and misusing – the IDR process:

- 17,000- the initial estimate by the Administration were of disputes initiated during the first year of IDR.[11]
- 334,828 – the actual number of disputes initiated by a small number of physician staffing and billing firms during the first year the IDR portal was open – 14 times what was predicted.[12]
- 60% of all disputes initiated in Q4 of 2022 came from 5 states.
- For more than a third of those disputes, there were eligibility questions and tens of thousands closed after being deemed ineligible.[13]
- CMS reports that the primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the federal IDR process.[14]

Between an overwhelming number of disputes and repeated litigation from the Texas Medical Association that has created regulatory uncertainty and repeated starts and stops, the Departments have been hindered in developing an IDR process that works.[15] The IDR process should be fair to all parties, with consistent rules, transparency into decisions, and ultimately used rarely. At present, CMS estimates the IDR process overwhelmingly favors health care providers and air ambulance suppliers, with initiating parties prevailing in 71% of disputes that reached a final determination.

While use of IDR to resolve surprise bills was not our preference, AHIP has been unwavering in our commitment to taking patients out of the middle and making sure the No Surprises Act succeeds in lowering health care costs for the American people. With regulatory certainty and improvements to the federal IDR portal, we are confident the approach laid out in the No Surprises Act can work for all parties involved.

Part of our commitment to protecting patients and lowering costs through the success of the No Surprises Act is our goal of having more health care providers, particularly facility-based providers, enter into network agreements so that IDR is rarely used. The success of our business model largely depends on having large networks of high-quality, high-value health care

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[10] Cooper, Zack, Fiona Scott Morton, Nathan Shekita. National Bureau of Economic Research. (2018). Surprise! Out-of-Network Billing for Emergency Care in the United States.
[11] Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (October 7, 2021). https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf.
[12] Centers for Medicare and Medicaid Services. (2023). Federal Independent Dispute Resolution Process – Status Update.
[13] U.S Departments of Health and Human Services, Labor, and the Treasury. (2022). Partial Report on the Independent Dispute Resolution (IDR) Process.
[14] Centers for Medicare and Medicaid Services. (2023). Federal Independent Dispute Resolution Process – Status Update.
[15] O'Neill Institute, Georgetown University. Health Care Litigation Tracker. No Surprises Act.

providers. As an industry, we must be good faith partners with health care providers, which includes collegial communication and timely, accurate payments to health care providers. Timely payments require sufficient information from an IDR entity to make proper payments, for correct claims, to the right provider. Presently, in too many disputes, particularly batched disputes, IDR entities are not supplying sufficient information about payment determinations, and this has at times delayed payments. The idea that health insurance providers are intentionally withholding required payments to health care providers defies our fundamental business model. While we advocate for a regulatory structure that incentivizes network participation over IDR, when a provider is owed additional amounts after IDR, because we aim to bring more providers in-network, we have every incentive to view that provider as a potential partner and make timely payments. We have asked that IDR entities are required to furnish health plans with necessary and complete information to facilitate timely payment.

AHIP has repeatedly come to the table with recommendations for improving the federal IDR process and there are reasonable changes that can be made to the benefit of all disputing parties. We continue to believe the tri-Departments must ensure the federal IDR process is efficient, reduces ineligible claims, facilitates on-time and accurate payments, and provides direct communication that ensures unbiased IDR entities are evaluating factors in a uniform and transparent manner that aligns with Congress' intent and direction.

AHIP and our members view the No Surprises Act as an important landmark law that has already significantly and noticeably improved the lives of millions of Americans. Today, as the bipartisan law intended, patients no longer have to worry about receiving a surprise medical bill when they return home from a hospital or emergency department. We believe there is a path forward to making the open negotiation and IDR processes work as intended and, this is important, do so in a way that reduces health care spending.

Thank you for the opportunity to testify. AHIP and our members appreciate the continued bipartisan commitment to protecting patients from surprise medical billing and to lowering consumer health care costs. We remain ready to work with this Administration and Congress and future Administrations to implement the No Surprises Act and make health care more affordable. By working together and putting the best interests of patients first, we can strengthen our health care system and reduce costs for all Americans.

Chairman SMITH. Thank you.

Mr. Budzinski, you are now recognized.

STATEMENT OF JIM BUDZINSKI, EXECUTIVE VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, WELLSTAR HEALTH SYSTEM

Mr. BUDZINSKI. Thank you, Mr. Chairman, Ranking Member Neal, distinguished members of this committee.

Consistent with the introduction, my name is Jim Budzinski. I am the chief financial officer of the Wellstar Health System from the great State of Georgia.

The Wellstar Health System is a not-for-profit, community-based, 11-hospital system serving 1.5 million Georgians. The Wellstar Health System operates——

Chairman SMITH. Could you just pull the mic a little bit closer?

Mr. BUDZINSKI. Yes, sir, thank you.

The Wellstar Health System operates 6 of the state's 20 busiest emergency departments. We provide more uncompensated care than any other system in Georgia, totaling nearly $1 billion in our last fiscal year alone.

Wellstar supports the No Surprises Act, which protects patients from surprise emergency room bills. However, we appreciate the opportunity to share with you the unintended consequences of implementation of the Act, which have negatively affected the people and communities whom we serve.

Health plans have been able to narrow their networks such that their enrollees often no longer have access to in-network emergency care in many of our communities and rely on a broken system to lower reimburse—to hospitals below sustainable levels.

One of our biggest problems with the implementation is the broken Independent Dispute Resolution process, which significantly disadvantages hospitals and health systems. The problems are the result of regulatory interpretations that have biased the process in favor of health plans, and bogged it down such that there is a long wait time for adjudication of submissions.

For Wellstar, the IDR entities have resolved only 7 percent of our roughly 8,000 requests for determination. The estimated reimbursement on our requests exceeds $40 million, funds owed to us by some of the largest health insurance companies in America. At this rate, it will take over 20 years to resolve all of our outstanding requests.

We are also concerned that the implementation of the Act has also encouraged bad insurer behavior. Now, without consequence, insurers are able to sell insurance in counties in which they have no in-network hospital emergency departments. While the Act intended for hospitals and insurers to work together for appropriate reimbursement, health plans are ignoring this provision of the law and regulations.

For example, one national insurer with whom we are out of network reduced our reimbursement by nearly 50 percent immediately after following the implementation of both Federal and state surprise billing laws. This change represented a $50 million reduction in reimbursement to our organization.

Further, another national insurer recently threatened to terminate our 20-year-plus contract unless we agreed to a 20 percent de-

crease in payment. This demand would represent a reimbursement loss of over $4 billion over the next 10 years at a time when our cost of care has increased because of the pandemic over 25 percent due to workforce shortages and increases in supply and drug costs.

While we were able to resolve this matter with only a $1 billion cut over the next 10 years, this emboldened behavior by insurers is not unique to Wellstar, and it is one of the reasons for the median health system operating margins being negative, as reported by Standard and Poor's just last month. For Wellstar, these cuts in emergency reimbursement jeopardize the services we provide to our communities, including those sole community hospitals in our system, some of which now operate at deficits of 14 to $19 million annually. This result was not the intent of Congress when it passed the Act.

Mr. Chairman, Ranking Member Neal, members of this committee, we have appreciated the opportunity to share our thoughts with you today. Our time together here is limited, so I would refer to our written testimony for more information.

This concludes my remarks, and I would be happy to take any questions. Thank you.

[The statement of Mr. Budzinski follows:]

Testimony for the Record
Submitted to the
House Committee on Ways and Means
For the Hearing
"Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

September 19, 2023

Jim Budzinski, MBA, MHA
Executive Vice President and Chief Financial Officer
Wellstar Health System

About Wellstar

Wellstar Health System is a not-for-profit, community-based health system, serving more than 1.5 million Georgians. Wellstar operates 11 hospitals, 9 emergency departments, 9 cancer centers and more than 300 medical office locations. Wellstar operates 6 of the top 20 busiest emergency departments in Georgia and operates Georgia's largest trauma network. We employ over 30,000 team members and have over 3,000 physicians on our medical staff. We provide more uncompensated care than any other provider in Georgia – totaling nearly $1 billion last fiscal year alone.

We are also expanding and investing in robust efforts to train and educate the next generation of healthcare providers. Examples include: our Graduate Medical Education program, our nursing school at Kennesaw State University, our relationship with Augusta University and the Medical College of Georgia, and our partnership with Georgia State University. We are working with these institutions to help them grow the number of their clinical graduates.

Nearly one in every six Georgians, or over 1.5 million people from diverse communities, depends on Wellstar for care annually. As a mission-driven, non-profit system, we reinvest in the healthcare needs of the communities we serve. We provide care well beyond the walls of

Wellstar facilities and directly into our communities through unique partnerships and collaborations, including initiatives focused on combating the opioid epidemic, addressing food insecurity, behavioral health, and the maternal health crisis, to name a few.

Effects of the Implementation of the No Surprises Act on Wellstar

Wellstar supports the No Surprises Act, which protects patients from surprise emergency services and certain other bills. Americans have undoubtedly benefited from the protections against surprise medical billing granted by the No Surprises Act. However, the unintended negative consequences of the way the Act has been implemented, specifically with respect to the independent dispute resolution (IDR) process, are already noticeable and have significantly disadvantaged hospitals and health systems, presenting long-term implications for patient access to care.

The U.S. District Court for the Eastern District of Texas has several times set aside certain regulations implementing the No Surprises Act. In particular, the Court ruled against the Administration's overemphasis on the qualifying payment amount (QPA) in the IDR/arbitration process, which significantly tilted the process in insurers' favor. The Court also found the methodology for calculating the QPA unlawful, as it depresses insurers' payments to hospitals and health systems. While we agree with these rulings, they are evidence of the implementation challenges hospitals and health systems face, and they do not resolve all the problems with implementation of the law.

The law was never intended to pick winners and losers. Unfortunately, the way the No Surprises Act has been implemented has done just that – and the health insurers are winning – further increasing their profits at the expense of community not-for-profit hospitals and health

systems that are facing significant financial challenges that threaten their ability to continue to meet their community needs.

The IDR rules have been written and rewritten several times and are still problematic. The process is inefficient, and the results, when there are results, are arbitrary. The lack of timely, fair and equitable determinations through the IDR process benefits the health insurers at the expense of those, like Wellstar, that provide medical care. A study conducted by the Centers for Medicare and Medicaid Services (CMS) found that a payment determination was reached in only 15 percent of cases. For Wellstar, the results have been even worse – Wellstar has 8,000 claims that we are attempting to resolve through the IDR process, and only 7 percent have been heard and closed to-date. At this rate, it will take 20 years to resolve our pending claims.

In addition to throughput issues, there are numerous other problems with the administrative processes of the Act, including:

- Batching rules that are based upon the physician reimbursement model, which effectively makes batching of hospital claims impossible,
- Bundling rules, which ignores the way hospitals are actually reimbursed and require multiple appeals for a single episode of care for a single patient,
- Inconsistent and seemingly arbitrary findings between IDR entities and within IDR entities on cases that present the same issues,
- IDR entities and payers that ignore the timelines required by the Act without consequence, while providers are required to comply, and,
- Duplication of work required by providers, causing increased administrative cost burdens.

The problems with the IDR administrative processes are not the only unintended consequences of the Act. The Act has unintentionally encouraged bad payer behavior. Now, without consequence, payers are able to sell health insurance in counties in which they have no in-network hospital emergency departments. The Act and its administrative process have allowed those insurers to receive in-network level discounts from hospitals without the need for good faith negotiations, and some take discounts below even in-network rates. The consequence for patients is that their access to high-quality healthcare will suffer. Already, health systems are forced to make difficult decisions about where and how to spend limited resources. As payors reduce reimbursement below fair and reasonable levels, those limited resources will be further challenged. A report from Gibbons Advisors indicates the number of healthcare bankruptcies increased by 84 percent from 2021 to 2022, driven by rising costs, workforce shortages, and high interest rates.[1] Though not explicitly named, the No Surprises Act has likely contributed to this statistic.

Wellstar is directly impacted by the No Surprises Act, perhaps more than other systems, because we operate some of the busiest emergency departments in the State of Georgia in a region of a higher concentration of "narrow network" health plans. Narrow network health plans limit the choice of patients, as they only have a limited number of providers from which to choose. This is one reason that Wellstar has been relying on both hospitals' responsibilities under the *Emergency Treatment and Active Labor Act (EMTALA)*, as well as the reimbursement policies of the No Surprises Act, to ensure access to this care.

The estimated reimbursement due to Wellstar on our requests exceeds $40 million – funds owed to us by some of the largest health insurance companies in the country. And, despite

[1] https://gibbinsadvisors.com/healthcare-sector-bankruptcy-filings-increased-by-84-from-2021-to-2022/

all the administrative processes tilting in insurers' favor, IDRs have found in Wellstar's favor 53 percent of the time. Unfortunately, despite determinations in favor of Wellstar, we have only been reimbursed on a timely basis for one-third of these, with insurers failing to pay what they owe for the care provided to their enrollees.

In addition, as stated above, payers are relying on the NSA to be able to sell health insurance in counties in which they have no in-network hospital emergency departments. For example, one national insurer with whom we are out-of-network reduced our reimbursement by nearly 50 percent immediately following the implementation of Federal and State surprise billing laws and indicated the cut was made because of the enactment of recent legislation. This change represented a $50 million annual reduction in reimbursement to us. Further, another national insurer recently threatened to terminate our twenty-plus year contract unless we agreed to a 20 percent decrease in payment. This demand represented a reimbursement loss of over $4 billion over the next ten years, at a time when our pandemic-induced cost of care has increased by over 25 percent. While we were able to resolve this matter with "only" $1 billion in cuts over the next ten years, this emboldened behavior by insurers is not unique to Wellstar, and it is one of the reasons for the negative median health system operating margin, as reported by Standard and Poor's last month.

The $40 million in outstanding reimbursement for these out-of-network claims represent a significant sum for a health system working in an environment nationally that has seen negative margins for the last several years and margins that typically are very low. This is an additional financial pressure that hospitals and health systems in our country can ill afford right now as they face the worst financial situation in decades.

Further, Wellstar has had to adapt to the changing administrative rules of the No Surprises Act. This is in addition to challenges from bundling and batches, which restricts what types of similar claims can be bundled for resolution.

Lack of Feedback Following the Review Process

When a decision is made in the independent dispute resolution process, Wellstar receives no feedback about why they ruled the way that they did. Consequently, there is no "learning" to be had, and our teams are unable to become more effective and efficient in filing relevant claims to alleviate backlogs. In our experience, the same facts receive different outcomes from case to case.

Insurers Refusing to Negotiate

Furthermore, the No Surprises Act disincentivizes health insurance companies from maintaining robust networks. By prioritizing the QPA, the details of which insurance companies don't disclose, health insurance companies can bank more of their members' premium dollars when claims are filed under out-of-network benefits or under the No Surprises Act.

Wellstar has seen firsthand the actions by large health insurers who refuse to negotiate with us, insist on going out of network and rely on the independent dispute resolution process. We see this as a prime example of how flawed the No Surprises Act implementation has been.

Summary

The challenges that have been created by the implementation of the No Surprises Act have created financial strain that has created an environment where fewer dollars are able to be

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reinvested in the communities we serve; instead, these dollars are going to some of the largest and most profitable conglomerates that exist in the United States — for-profit health insurers.

Chairman SMITH. Thank you, sir. We will now proceed to the question-and-answering—answer session, and I will begin.

Dr. Bleier, one of the areas of fallout that we have seen from the flawed implementation of the No Surprises Act is how the regulations incentivize health insurers to limit the number of physicians with whom they have contract agreements to cover their services. What does that do for patients' access to care, especially for those living in rural and underserved areas who already suffer from a lack of care options?

Dr. BLEIER. It makes it much more challenging for those patients, as well as the providers taking care of them. If physicians are excluded and become out of network, basically, that reduces their reimbursement. And their reimbursement is what covers the staffing hours, adding additional provider coverage to those needing emergency departments. And by reducing physician hours, physician—emergency medicine provider hours, that reduces the care that those patients need. So it has a downstream effect, unfortunately.

Without that additional reimbursement, we aren't able to potentially provide the same level of care that we ordinarily would want to to those rural emergency departments who are already suffering for a number of different reasons.

Chairman SMITH. Mr. Bobeck, as an Independent Dispute Resolution Entity, you have a front row seat to how this process is operating. We have heard concerns about how the law's implementation has complicated the dispute resolution process and has contributed to a backlog of claims. How has this process gotten off the rails, and what can be done to ensure that dispute resolution ultimately is fair for all parties?

Mr. BOBECK. Mr. Chairman, three big things that we would like to say at the beginning are when it comes to some of the matters regarding the implementation and then how it moves along the process, the words "misunderstanding," "miscommunication," and "misinformation": parties not understanding how the process was intended to work; miscommunication among the parties about the information they need to provide each other to even try to get to reasonable offers; and then ultimately, the misinformation that occasionally goes out about how they just actually put cases into the system.

The biggest thing that could happen—and it is starting to happen right now—is that parties are getting much better at formulating their responses, communicating with each other, and then ultimately getting more cases eligible for the process and decisions being made. Right now, this process still is in its—just over one year that it has been going on.

It was set up for a certain amount of cases, and certainly that has gone overboard. But at the same time it is set up to move forward on this, and parties, providers, and the IDREs are working much better together to get cases moving along.

Chairman SMITH. Mr. Budzinski, emergency department wait times have more than doubled since 2020, and more than 600 rural hospitals are currently at risk of a closure. As a hospital administrator, how have you seen the implementation of the No Surprises

Act affect the ability of hospitals to maintain appropriate staff and critical emergency services for patients?

Mr. BUDZINSKI. Thank you, Mr. Chairman. There is no question that the implementation of the Act has had impacts on organizations such as ourselves. The impact reduces resources, and administrators then have to allocate their scarcer resources to staffing and other activities. So there clearly is a direct correlation. Whenever resources are reduced, then the allocation of those reduced resources impact care in some way, shape, or form.

Chairman SMITH. Ms. Spicer, thank you for your work helping patients understand our complex health care system. Three or more years ago, patients across the country would still be receiving surprise medical bills. You have been firsthand—you have seen firsthand how the No Surprises Act has largely protected patients from this practice. While the implementation hasn't been perfect, can you speak to how the law has benefited patients?

Ms. SPICER. Thank you, Mr. Chairman. The law has benefited patients tremendously. It goes beyond many—many states don't have—didn't have surprise billing laws before the NSA, but goes—this—the NSA goes even beyond the protections that are in your average state surprise billing law, as in New York's surprise billing law.

Many, many, many of the cases that I had on my help line prior to the No Surprises Act were cases that were unaddressed by New York's law, specifically network directory misinformation. When you call your health plan and you ask them who is in-network, or you look at their online directory and it is—the information is outdated, hundreds and hundreds of cases of consumers who just get bad information from providers or plans about the network are now protected.

And so many more protections in terms of air ambulance, also the—just the resolution processes, though complicated for consumers to avail themselves of, are available for them to appeal surprise bills and even go through the internal appeals process and to external appeal with those bills.

Chairman SMITH. Ms. Thornton, the rulemaking surrounding implementation of the No Surprises Act has been subject to multiple legal challenges. This has naturally disrupted the dispute resolution process, delayed payments, and thrown a blanket of uncertainty over the whole law. How are health insurers doing their part to alleviate the current backlog of claims and ensure that payments are made in a timely manner?

Ms. THORNTON. Thank you for the question, Mr. Chairman. You are definitely correct. All of the repeated starts and stops from the litigation, as well as the changes in regulations have really created a lot of uncertainty with health plans with regard to how they have to plan their staffing and operations for when the arbitration process brings—comes back online.

There is also a concern that when the process does go online, there have been such a large backlog of cases that we will not be able to meet the required deadlines and payment timelines because there is such a backlog and so much within the system.

And finally, you know, we are really concerned around what the updated rules will look like, and whether that will mean that the

process becomes more unbiased towards the—more biased towards the providers versus the health plans. I think our goal is a very balanced process. We would love to see a 50/50 outcome, right? Some cases will be decided with providers, some to plans, and that means the process is working well.

Chairman SMITH. So how are health insurers ensuring that payments are made in a timely manner?

Ms. THORNTON. That is a really important question, and we understand how important for providers and their cash flow that they are getting paid in a timely manner.

One of the really important things about the Act is that you built in the requirement that we have to make an initial payment within 30 days. So providers are getting paid upon receipt of a claim within 30 days.

I think what is often at issue here is how quickly health plans are making payments as a result of an IDR decision. As I said in my statement, there have been at times delays in those payments, and that really has to do with some challenges with the implementation technology, as well as very difficult deadlines and having to go through, in some cases, thousands and thousands of lines of code, match it up to our systems, and then make those payments on time.

But we are certainly—really strive to meet the deadlines that are provided.

Chairman SMITH. Mr. Neal is recognized for questions.

Mr. NEAL. Thank you. Before I begin my opportunity to question our witnesses, I want to take a moment to remind members of the committee of the role that this committee played in ensuring that Congress would pass a strong and balanced law—emphasis on "balanced." And that is what we did.

The idea was, almost like binding arbitration, to make sure that people of goodwill and good intentions would try to avoid the process at the end, and it would bring them to a better decision-making process at the beginning; this was done in a bipartisan manner, and it unanimously passed this committee. It was a good product that passed out of here because of the work of this committee and the product that became law.

Dr. Bleier, I have heard from many providers across the country that implementation of the No Surprises Act has led to financial uncertainty. While HHS revises the regulations to comply with the law as enacted, other peripheral issues are causing financial difficulty. As with implementation of any new and sweeping law, there are certainly growing pains. I have been pressing HHS at the top all the way through the members of the staff on many issues.

So beyond the need to revise the standard and the dispute entities that are trying to comply with the law, can you summarize what other issues in the No Surprises Act are affecting payments to the Wake Emergency Physicians?

Dr. BLEIER. Sure. We had been in-network, as a reminder, with all of the major carriers in our area for years. We never went back to them and asked for an increased rate. Our contracts did not have any cost-of-living indexes, no inflationary adjustments year over year. They were tied to Medicare fee schedules from years before that.

In addition, we have also seen significant decrease in payments from some insurers over the years not only due to inflation, but also due to the fact that a lot of the health care expenditures are being pushed to patients in high-deductible plans. Despite that, we never went back and asked for more. We have always intended to be in-network with all of these providers. Then—with all of these insurers, excuse me.

Then the No Surprises Act comes out, and suddenly we are getting letters from insurers saying, "You are out of network unless you take a 40 percent reduction," sometimes more. Since the passage of the law, we have been kicked out of network unilaterally by two different insurers, and are seeing reductions in reimbursement from one of them by 70 percent from our previous contracted rates, which we believe were very fair at the time, because at no point up until the No Surprises Act came out did any of the insurers come back and ask for us to adjust our rates. They were evergreen year over year.

So, because of the No Surprises Act, we have subsequently been kicked out of network. We have seen a tremendous decrease relative to what we believe were fair market rates. And in addition, there is no recourse for action due to the IDR issues that have been ongoing.

So even when we win in an IDR case, we effectively lose due to the fees associated with it, and then we do not get paid afterwards.

Mr. NEAL. Thank you. So our intent here was not to be punitive, not to pick on anybody, and not to favor one side or the other. It was, as I indicated, a balanced piece of legislation, I think, to provide ample opportunity to all sides of the dispute.

So, Ms. Spicer, let me thank you for your testimony. I'm grateful for the good work you do every day. And you report that patients remain confused about whether their medical bills are covered or not and, if they are, how much cost-sharing they are responsible for. Why do you think patients are still receiving bills they should be protected from, and how would you suggest that patients help navigate this process to protect them from illegal surprise billing practices?

Ms. SPICER. Thank you for the question. Health plans—consumers are not always held harmless, as they should be under the No Surprises Act. Consumers still receive surprise medical bills. And what we do at Community Health Advocates is help a consumer who doesn't know they have a surprise bill, but calls to say, "I have a bill I can't afford," or, "Why didn't my health insurance pay," and then we go through a complicated process to help them figure out whether or not it is a surprise bill, and to make the plan hold them harmless, go through the appeals processes, or complain to the regulator.

Mr. NEAL. Okay. Thank you, Mr. Chairman.

Chairman SMITH. I recognize the chairman of the Health Subcommittee, Mr. Buchanan.

Mr. BUCHANAN. Thank you, Mr. Chairman. I want to thank all our witnesses for being here today.

As a business guy for 30 years before I got here, I am just looking at everybody talking about the backlog. It is outrageous, especially when you are talking about cuts. You send a bill in, you

might not get paid for multiple years or whatever that timeframe is. You know, obviously, it is just shocking.

So, I don't know, is it—are there firms out there? Is this frivolous lawsuits? Is it hedge funds? What is driving—Mr. Bobeck, you mentioned the idea of 110,000 claims. I can't imagine that. But the other gentleman over here mentioned it would be 10 years before he might get paid. How do—nobody can run a business like that, especially in the whole health care field, where a lot of people feel like they are not getting paid fairly to begin with. Compound this, you are out of business for a lot of small firms, as we talked about earlier. But what is your thought on this? What is driving this massive amount of backlog?

Mr. BOBECK. Congressman, just as a brief note, there are 13 different IDREs, of which we are 1. Although FHAS has received 81,359——

Mr. BUCHANAN. But on year 1 there is 130,000 claims you are managing?

Mr. BOBECK. We have received, since the inception of the program, 81,359.

Mr. BUCHANAN. And you are one of how many firms?

Mr. BOBECK. There are 13 firms, overall.

Mr. BUCHANAN. What are you talking about, a million—you know, millions of claims?

Mr. BOBECK. So, since the inception of the program—and the CMS has not released the latest statistics since March, but it is conceivable that by this point it is close to that—but for FHAS, we don't have any backlog. The timeline to get a decision out by law is 30 business days. We are doing it in only 23 calendar days. And the reason for that simply is we have a large staff who is working around the clock to get these cases out.

We have a sincere, humble understanding and responsibility to know that how our cases—the arbitrations we make affect the entirety of the provider and the payer system, as well as patients. We understand that we need to make these decisions—ultimately, in any decision we make there is somebody who is normally upset. Somebody wins and somebody loses.

But ultimately, what we suggest is that people continue to move forward with the process. We will continue to have no backlog. We will continue to make decisions. Program rules around it did ultimately—do create backlogs. As noted, the program has been on hold since August 3, so——

Mr. BUCHANAN. But the backlog that has been created, how long does it take to get paid under normal circumstances, ideally, of the ones that are in the dispute area?

Mr. BOBECK. When a decision is made, as noted by Ms. Thornton, the plan needs to make their payment within 30 calendar days. However, even before we get the case, most likely two to three months has already passed by before we even get the case. The parties going back and forth among payments, trying to negotiate it on their own. So conceivably, the process can take about possibly five to six months. And again, that is why we make our standard when we receive a case that is 23 calendar days to get out, to get those payments moving along.

Mr. BUCHANAN. Thank you.

Dr. Bleier, let me ask you, there was a point made on behalf of the organization you are with or work for or something that 52 percent of the payments are not made on time or not made at all. Is that what you said?

Dr. BLEIER. I don't recall that specific number. But if you are speaking to our experience with the IDR process, the overwhelming majority of the cases—we have only—the IDR process has effectively been unaccessible—inaccessible for us for a number of different reasons I think everyone is already aware of. Out of the 400–plus submissions, I think 20 have gone through arbitration thus far. The rest have been unadjudicated, haven't been——

Mr. Buchanan. And how long does it take to go through arbitration in a case, normally?

Dr. BLEIER. You know, I—from our experience, I think there is some statistics that say 90 percent of cases or 91 percent of cases still haven't been adjudicated after 6 months. I have seen some information along those lines. I don't have that information in front of me.

But I can tell you this. The majority of cases that we have won, the overwhelming majority of cases that we have won, we have received zero payment from.

Mr. BUCHANAN. Yes, but the other side of that, the time, the energy of your executives or employees through that whole administrative process, is a nightmare and very costly. And then you get paid, and it is not half of what you think it should be. So it is challenging.

Are there any other outside factors that are creating this environment in a negative way?

Dr. BLEIER. You know, I would imagine there are. You know, the main issue is it is just inaccessible. And we have been put into this position because, again, we have been kicked out of network from payers that we were in-network with for years.

We don't want to access the IDR process, especially given what is going on right now. We have no choice. And unfortunately, despite that being our only recourse, it is a bit of a false recourse for us right now because if we do enter that, you know, it takes forever to potentially be adjudicated. Number two, often times the—typically, the fees associated, especially when they are $350 for the non-refundable fee let alone the additional administrative fees that are part of this IDR process, far exceed typically our bills in the first place.

So, if we enter the process, pay the $350 non-administrative fee, and then win the case, and then not get paid on top of——

Mr. BUCHANAN. Thank you. My time is up. I yield back.

Chairman SMITH. Mr. Doggett is recognized.

Mr. DOGGETT. Well, thank you very much.

Eight years ago, I introduced the very first surprise billing legislation in the Congress, and I was inspired by stories like the one Ms. Spicer referred to. In my case, a Texas woman who did all the checking to be sure she was in network,—and then some instrument was used, unknown to her, in the course of the surgery and she got a huge bill for that instrument, which was out-of-network, or the constituent in Austin who got a $4,000 bill for a colonoscopy out of network.

It took another five years after the bill was first introduced, a blitz from private equity companies urging us to do nothing, and heavy lobbying before any legislation was passed out of this committee or became law. The battle largely became between health care providers and insurance companies, with some justified claims on each side and some abuses on each side that we produce this final piece of legislation.

And it should come, I suppose, as no surprise today that whether the bill is adequately protecting consumers is not being fully explored.

Ms. Thornton, you testified in the very first subcommittee hearing we had about surprise billing in Congress. And I note your testimony, confirmed by other consumer protection groups, that consumers are being protected from about a million surprise billings every month as a result of this legislation.

But today's hearing fails to explore the loopholes referred to by Ms. Spicer and others of you, such as urgent care centers, ground ambulances, some of the problems that developed concerning pathology and lab tests and other areas, and I think that is where the focus should be—is why aren't we providing more comprehensive protection to consumers?

Consumers, of course, in a discussion like this, are not the sole concern. This Congress has shown a consistent inability to address the problem of soaring health care costs. It gets talked about a lot. There is finger-pointing and trying to blame one party or the other for those soaring costs. But when it comes to really doing something about it, and that is at stake here, Congress fails to act.

On the other hand, the notion that a private practice of physicians can't be treated fairly is a legitimate concern. Ms. Thornton, if I understood your testimony, the way the system is now, with all the improvements that may be needed in the system, it is the health care provider, are you saying, that prevails 71 percent of the time?

Ms. THORNTON. Yes, that is according to data released by CMS.

Mr. DOGGETT. So really, the question is whether there are enough changes that are necessary in the way this law is being implemented to increase it so that it is higher than 71 percent.

Ms. THORNTON. Yes, we would certainly love to see a more balanced process.

The chairman mentioned the advanced explanation of benefits earlier. We certainly think that that transparent process could be a potential game-changer to make sure that consumers, when they are scheduling services, can make sure that their providers are in-network.

Mr. DOGGETT. One of my concerns is that so often the conflict is not between a private medical practice of a small group and a giant insurance company, but between private equity and a giant insurance company. I noticed that about a third of the complaints are coming from one Atlanta-based equity-backed private staffing company. Do you have any sense as to why that is happening?

Ms. THORNTON. Well, that is a really great question. I think we need to go have a little flashback to why our—why you all passed this law to begin with. At that point in time, there were cer-

tain private equity-backed staffing firms that were really using the threat of surprise medical billing to extract really high, relative to Medicare reimbursement, rates from health insurance providers, right? And that is the reason that Congress really took bold action to pass the No Surprises Act.

Unfortunately, what we are seeing, and the data released by CMS does bear this out—that we continue to see a really small subset of providers really taking advantage and using that arbitration process. You know, it is not the small mom-and-pop-type of providers that are taking advantage of this. This is large, very well-established private equity-backed firms.

Mr. DOGGETT. Well, I am concerned about the testimony of all our witnesses, particularly some of the comments Mr. Budzinski made about the cost this has. But it has to be a balance, not a phony balanced billing, as occurred and produced surprise billing in the past.

I think we can make some improvements, but the focus ought to be on the consumer, first and foremost. Thank you very much.

Chairman SMITH. I recognize Mr. Smith from Nebraska.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman.

Thank you, certainly, to our panel here today for sharing your expertise and insight. It is—I think we have got many great perspectives here to try to help us take what is obviously a bipartisan, I think, achievement previously, and look for ways to improve upon what the situation currently is.

It is disturbing to hear the various data points, and certainly delays. And time is money, we know that. And the disruption associated with lack of payment, I think, should concern all of us. So I hope that we can take away, you know, from this timely hearing some solutions.

Dr., or I am sorry, Ms. Spicer, thank you for your work with Community—as a community health advocate. Have you observed any patterns that would be disproportionate perhaps in terms of underserved areas or rural areas impacted by the shortcomings that currently exist?

Ms. SPICER. We have—in our program we have—some of our agencies in the Community Health Advocates Program, they are—serve communities in rural areas in upstate New York, and we have seen problems across insurers for 20 years or more around access to care in those rural communities. And so, yes, there are—you know, there are still issues that are there and can—will potentially be worse if networks shrink. They are already very, very small in rural areas in New York.

Mr. SMITH of Nebraska. And so the difficulty of navigating the whole process for those you know, from rural areas for example, is there anything that stands out to you that we should be especially mindful of?

Ms. SPICER. Just access to help. You know, in rural areas, access to everything is a little bit less than in urban areas, potentially. So access to help with them for them to—for those patients to find in-network providers, understand what costs they may be facing if they have to—if they are forced to go to out-of-network providers, and access other options like low-cost care and clinics.

Mr. SMITH of Nebraska. Okay, thank you.

Dr. Bleier, can you give us a little more detail about what you have observed as unique challenges perhaps that rural providers face when complying with the No Surprises regulations?

Dr. BLEIER. Sure. So our overall payer mix is probably about 15 percent in general self-pay, and probably about 30-ish percent Medicaid. So about 42 to 45 percent self-pay and Medicaid, both of which, you know—for self-pay, unfortunately, you know, they are not able to essentially, you know, pay anything. And Medicaid certainly reimburses at a much lower rate than the cost of the care we are providing. And we have roughly another 25 percent that are Medicare as well, which is also relatively low. And then the rest are commercial.

And for those rural communities that already have a lack of resources in the outpatient setting, often times these patients can't get in to see their primary care physicians. They may not have a specialist available. In addition, they have limited resources to begin with. So they wait and wait and wait. And a common thing that we see is these patients present to our emergency departments with a true emergency in extremis, things that could have been preventable to begin with.

And when the emergency medicine providers there are also suffering under this law, you know, the law itself fully supported in bipartisan fashion, but when the law is not being regulated in the manner of the legislation itself, that puts undue pressure on those groups because they can only spend what they bring in on resources. And all of that money for a group like ours that we receive in reimbursement goes directly back to pay our providers and our staff that helps our providers.

So in a rural community, when they are already under-resourced, we are the true safety net of those communities. And if we don't—and we are not able to provide the staffing in those rural EDs, when there is a crisis that rural community will suffer, unfortunately. And it is heartbreaking, as a physician, to have to see that. But, unfortunately, those are the unintended consequences.

Mr. SMITH of Nebraska. All right. Thank you, I yield back.

Chairman SMITH. Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you to all the witnesses for being here today.

As has been mentioned numerous times already this morning, we passed this bipartisan legislation to protect our constituents from surprise medical bills. It was needed. I heard in my district offices, my Capitol offices, and probably daily—that is not an exaggeration—from constituents who had received surprise billing and were having difficulties with this.

As Mr. Doggett pointed out correctly, this has been something we have been working on for five years before we passed the original bill, and I think it is important to acknowledge that our goal of protecting our constituents was met by the bill that we passed, for the most part, but there are still challenges. And I agree with all the witnesses and my colleagues that we need to figure out how to address those and make this an even better bipartisan solution.

I would like to ask about something I have heard from providers in my district, and that is that insurers are often simply ignoring the timelines for dispute resolution that were required by the law

that we passed. And I think it is important to be clear that when we pass a law requiring payers and providers to go through a dispute resolution process, we intend for the relevant parties to participate in that process, not ignore it.

Mr. Budzinski, you alluded to this in your testimony. Could you talk a little more broadly about the issue of payers unwilling to participate promptly in the process, and how we as Congress could address that?

Mr. BUDZINSKI. Thank you, Representative.

It is a fact that timelines are not being adhered to by many parties. Providers are required to hit certain timelines, to submit determination requests on a timely basis, and the penalty for missing a deadline for filing a determination is that that determination request is dead for a provider. End of story. It is just gone.

With respect to other parties involved in missing corresponding deadlines, that is no—that is not the case, and we would be glad to provide further detailed evidence to you and your staff about where insurance companies and IDR Entities have missed their timing and still there is no result except an increase in inventory of delayed results that we are seeing at our Health System.

Mr. THOMPSON. Yes, I would like to see that data, if you could provide that, please.

Mr. BUDZINSKI. We certainly will, sir.

Mr. THOMPSON. Thank you.

Ms. Spicer, you mentioned that insurance plans, at least in some instances, fail to automatically hold patients harmless for surprise bills. This is a fundamental problem. Holding patients harmless was the central point of the law that we passed and what all of us wanted to accomplish for our constituents. What are some things that Congress can do to make sure plans know their obligations and meet those obligations under the No Surprises Act?

Ms. SPICER. Thank you for your question.

Yes, I have seen on—at Community Health Advocates, on our help line, consumers call with classic surprise bills that should be covered under the NSA, however, plans are not holding consumers harmless for those surprise bills.

I would say that, you know, there is—health plans get coding and information on when a claim is submitted, and should know that claims fit certain criteria, and should be paying and negotiating with a provider in a way that holds a—holds the consumers harmless. This is done for—even before the NSA, before New York surprise billing law in certain commercial health insurance plans called HMOs. That is what our surprise billing law in New York was modeled after, the protections that HMO—some protections HMOs—consumers had already in place.

So I think it is—it should be kind of built into the claims system that the health plans can see what kind of claim, and whether the claim would be a surprise bill, and hold the consumer harmless for that claim.

Mr. THOMPSON. Thank you. I yield back.

Mr. BUCHANAN [presiding]. Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Chairman, and thank you all for coming.

So Mr. Buchanan and I are in the same business. We sell cars. The biggest customer we have in our service department, by the way, is the manufacturers. And we have—the health care plan for the owner of the vehicle is their warranty. That is also the biggest revenue stream we have coming into the store. I can't imagine how you are running a business with the accounts payable never being paid.

I have been in a personal situation where—and my wife will get mad at me for this, but I think it is important for people to understand this—we have a son who is a heroin addict, and he was in a halfway house in LA. He passed out on a sidewalk. Somebody called an ambulance. They took him to a hospital. I kept wondering why he wasn't answering his phone, and the reason why is he was in the hospital.

So eventually, within four days, he got out of the hospital, and we had a chance to talk to him. And the reason I bring this up is because, unless you have gone through it, you can't understand it.

About two months later we got a bill for $260,000. And my wife went absolutely—she says, "Oh my God, what are we going to do?"

I said, "I will tell you what I am going to do. I am not paying any attention to it at all," and it went away. I don't know what happened.

And I don't know how you all absorb the accounts receivable that you have on your books that you never receive. It is absolutely incredible.

This invasive species, being government, has got its hands into everything, and made it so difficult for normal businesses to absolutely survive. I don't get it. I have been in business all my life, and the two most important dates of every month for me are the 6th and the 21st. And people say, "Is that an anniversary time?"; I say, "No, that is payday."

But we don't always see the revenue stream, so I can't understand how can you possibly run the businesses you are in when your biggest customer doesn't pay the bill?

And I talk about—we talk about wonderful things that we are going to do legislatively, and that is all good. We can put it out there. But following the model is incredible. I would never take advice, by the way, from the company that was $33 trillion in debt. I would say there is probably not one of the plans I want to follow. But you have—so complicated.

So you can't fix something with nothing. Now, Dr. Bleier, you—in many ways—to a young man that grew up in Wisconsin and then went to Pittsburgh. His name is Rocky Bleier. Is that somebody that——

Dr. BLEIER. My grandfather would tell me that I was fourth cousins.

Mr. KELLY. Okay.

Dr. BLEIER. I don't know if I have a——

Mr. KELLY. Yes.

Dr. BLEIER. I can't verify that.

Mr. KELLY. Well, you know, the fact that you take time out of your life to come here today and try to help us understand what we don't understand and how the policies that were well-intended are actually not working and that your business model is a busi-

ness model that is totally unsustainable, I don't know how rural hospitals exist anymore. It is incredible—when you don't have the people on the shelf that could service the patients that come in. And I think what they mostly rely on now is just emergency care because they don't have people that can handle more complicated issues, and there is just no people out there to do that anymore.

If you could just give me a hint, just a little, what is it that we could actually do?

It is nice that you came in here. It is nice that we are talking back and forth, but I don't know. I still—if I was at the dealership, the first thing I would look at every, every day is our accounts receivable. And the ones—if they were over 90 days, write them off, they are not coming back. They are not coming back to get anything from me, and we are never going to see them again, but they walked away, you are on the hook for what it is that they have done. We had to pay the mechanic that did the work, and we have to pay the parts department for the parts we put on.

So what is it that you can do? Because I will tell you what, it is incredible today, the accounts receivable that we are all trying to balance out. You are graced with the fact that the government now is involved in it. So I—that is an eye-roller. But what could we do? Just simply tell us what we could do to help you.

Dr. BLEIER. I would say some different things.

Number one, you know, we are the safety net for the health care community, you know, for the health care system across the country. And we take care of patients under the most adverse circumstances, when they are most vulnerable, as I am sorry to hear about your experience, you know, from your family.

Mr. KELLY. Thanks.

Dr. BLEIER. But I think that, you know, some type of reimbursement for unfunded care would go a long way to providers who take care of those patients.

And I would say, with regards to the NSA, some enforcement, enforcement that insurers are calculating the QPA correctly and enforcement in teeth that they abide by the arbitrator's decision and submit payments to providers or hospitals——

Mr. KELLY. Yes.

Dr. BLEIER [continuing]. When the ruling goes in that way, because right now there is just no enforcement, even though it is a great bipartisan piece of legislation. And that is—that is my concern.

Mr. KELLY. Yes, my time is running out, but I got to tell you, I don't know how you do it. I don't know how you write off in your accounts receivable of things you never receive. It becomes a taxable event for those that don't pay it, I think. But we don't—and I don't think we enforce that. But I want to thank you for everything you do. It is incredibly important, what you do, and the fact that you face an unbelievable, complicated business model. I don't know how you do it. God bless you. Hey, thanks for coming in today.

Chairman SMITH [presiding]. Mr. Blumenauer is recognized.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

And I must say, Mr. Kelly, I appreciate making it personal—I know that is not easy, but it helps give the committee a sense that there are human consequences.

Mr. KELLY. So, Mr. Blumenauer, you and I understand each other, and Ranking Member Neal, the things that we go through personally, I think we sit up here and somehow we don't connect. And I say to people, yes, we do connect with you because we go through the same thing. I wish we were the only family that had that problem. It is incredible. And especially mothers. They can't walk away from it. They just can't. And it is really—all you do is just keep supporting them. And I think that is what we do.

So I appreciate your comments. And I—my wife is going to kill me for talking about this today, but I got to tell you, until you actually go through it—you know how when you are little, when you are growing up, and your parents would tell you, don't touch the stove, it is hot? Everybody has to touch the stove. You don't know it until you get burnt.

So it is good being with you, sir.

Mr. BLUMENAUER. Well, I appreciate the reminder that, in the final analysis, we are talking about people, and there are areas, regardless of our differences, that we can come together.

This legislation was actually an example of coming together. It has largely solved the problems. But we have heard today from witnesses that it hasn't gone far enough, and there are things that are head-scratching. And I appreciate the chair and ranking member bringing this back before us, because we ought to have a commitment to follow through on a good start. We ought to do better. And I would think that there is a chance to do that. And the witnesses have helped give me a better sense of the shortfall.

Mr. Bleier, I mean, you explained that the majority of the cases you won, there was zero payment, and that the bills are often more than they are worth. Can you talk for a moment about that dynamic, and what you think we could do to help you move that forward?

Dr. BLEIER. Yes, I appreciate that.

You know, I think enforcement of the legislation would go a long way. I think that a lot of groups are—like ours are forced to enter the IDR process.

Mr. BLUMENAUER. Yes.

Dr. BLEIER. We have no choice. We have been kicked out of network from contracts that have been standing for up to or more than a decade with unchanged reimbursement rates. And, because we are kicked out of network, we are forced to go through the IDR process.

Right now, we have no leverage with the health insurance companies. We can't—we want to go back into network. And initially we received, for example, a 40 percent reduction. We, a few months ago, went back to one insurer and said, hey, can we go back in network? We had a 60 percent reduction.

So until there is enforcement and, you know, I think that the insurers are forced to pay in—consistently with the arbitration ruling, we will be at a disadvantage, and this process will continue.

Mr. BLUMENAUER. And I would appreciate, if you have some thoughts about ways that we can implement that, what you said

makes sense. I don't want to do it now, because my time is almost up and I have another question, but your thoughts and observations about what would make a difference for practices like yours would be very useful.

Mr. Budzinski, you talked about large insurers who refuse to negotiate. Could you elaborate on what you think we can do to try and remedy that, to make sure that people are playing by the rules, operating in good faith, and doing the roles that have been assigned to them?

Mr. BUDZINKSI. Thank you, Representative. I think the number-one framework of this phenomenon is that—the unintended consequences of how the Act has been implemented is large insurers no longer need to have emergency departments in network in the counties where they sell insurance. They are selling insurance in counties where they don't have any emergency departments in network. How is that possible?

The reason is they don't have a need to have an in-network emergency department. They don't have to negotiate with a hospital or a health system or a physician group because they can use the No Surprises Act process as it is currently being implemented to pay in-network rates for out-of-network care. And that has never been the case in the last 30—I have been in the health care finance business for over 40 years. That has never been the case.

Out-of-network care, because of its uniqueness, is always reimbursed, historically, at greater than in-network rates because, with in-network rates and discounts, there is always an expectation of more volume, and therefore more discount. With out-of-network care, all elective care is steered away from you, and now you are left with only emergency care.

So I think that the solution to this is require that—under the Act, that the initial payment being made by insurance companies meets a minimum level that is consistent with historical out-of-network payment for emergency services.

Mr. BLUMENAUER. Thank you, sir.

Chairman SMITH. Mr. Schweikert is recognized.

Mr. SCHWEIKERT. Thank you, Mr. Chairman. And Ranking Member Neal and the chairman and many of us have been around from the beginning of the debate and discussion on this, so I want to walk through and make sure I am listening—sometimes something I don't do well.

The discussion is almost—has two ends on this. Some of it is the actual administering of the law, of the rules as it is, how long it is taking the bureaucrats, the time, and some are—maybe some of the game-playing has happened from the Administration's rule-drafting and those things of what we thought we were getting compared to how it has been drafted.

Setting that aside—and Mr. Bobeck, forgive the nature of the question, but I am going to beg of you, be as brutally honest with me as you can. If the rule set is saying, okay, here are the rules, that this is an out-of-network—this is, you know, what—the arbitration, why can't you and I just automate that? Why can't we just write computer code that says here is the market area, here is what it is, and here is—and it is spit out?

Tell me where my—and it is not AI. That would actually technically be even more an algorithm with constant updating of the data. Why can't I completely automate this?

Mr. BOBECK. Congressman, thank you for the question. AI relies upon one thing to do those algorithms, which is set data. The data is not set in this particular case.

Our firm, since its inception, its founders, told us there is a very important piece of technology that we have to rely upon that has been helpful for us through this process, and it is called the telephone. We have to continually talk with the parties to make sure that they understand what are they dealing with.

When parties want to submit a claim, many times the provider doesn't even know which health plan that they are trying to dispute. They are not even quite sure who they have to tell that they would like to dispute. They are not quite sure of the evidence they have to provide. And the same thing on the payer perspective as well.

Mr. SCHWEIKERT. But Mr. Bobeck, in many ways, you are—and I want to make sure we are not crossing each other, but that is actually where automating it—check, check, put this in, check this—I mean, the hyper-standardization. You could take away my friend from Georgia's time problem and filing problem. It is—and collapse the—actually, some of the cost, but also the speed. Why can't we ultimately—because picking up the phone—it is friendly, and you and I know how inaccurate a conversation can be.

Mr. BOBECK. Thank you. Ultimately, since the program has been involved for one year, parties are still getting to understand the process.

But I will say this. Where parties provide the right information, you are exactly right, the process goes much faster. Processing decisions can be made in less than two weeks, and that is frequently happening right now.

CMS, I cannot speak for them, but I do know that, through the portal that they have created, they have continually made improvements, and they have more improvements to make, which will automate many parts of the process. They did not put that out in the first model. The first model is simply to get it off the ground.

But you are exactly right, that those are future improvements that can be made, they will be made, and they will make the process much more seamless and, I will say, very cost effective for everybody.

Mr. SCHWEIKERT. Thank you, Mr. Bobeck.

Mr. Chairman, maybe as we start to have our discussions, our bipartisan discussions on the side, the—finding out where we do not believe the rule sets fit our vision, okay, fine, that may require us to push some letters or do some statutory. But what we should also maybe have an interesting discussion is what would make this as seamless as possible. That if there is going to be a dispute, it moves fast, quick, efficiently, inexpensively. And that may be making it very clear that technology can be the arbitrator.

And with that, I yield back.

Chairman SMITH. Mr. Pascrell is recognized.

Mr. PASCRELL. I thank the witnesses.

Surprise medical bills were once on the top of the list of expenses Americans really do worry about. Whether it is an emergency, an inpatient case, or inpatient care, Americans must be protected. We came to that conclusion.

Despite the tired promises, insured patients keep facing lawsuits, wage garnishments, garnishments for medical debt. That is pretty gross. In fact, it may be outrageous. But it is unacceptable.

So, in 2020, when committee Democrats enacted the bipartisan No Surprises Act to protect patients, it was a law I believe was carefully crafted to take patients out of payment disputes. I remember back in that debate.

The Administration must implement the law as Congress intended, no ifs, ands, or buts. Our law was designed not to jeopardize patients and tilt the scales for industry. Regulations that avoid these goals are not going to help the patients. I don't think we are of like mind about that issue. Patients need transparency provisions fully implemented, and the law must be followed.

So, Dr. Bleier, yes or no, do health plans that fail to follow binding dispute resolution decisions that collect interest on money owed to physicians threaten physicians' financial stability? Yes or no.

Dr. BLEIER. Yes.

Mr. PASCRELL. Dr. Bleier, yes or no, should there be a financial penalty on an entity that fails to pay within the 30-day required time period?

Dr. BLEIER. Yes.

Mr. PASCRELL. So, quickly explain how health insurers issuing timely payments can help ensure patients retain access to physicians. Give me a quick explanation, if you will.

Dr. BLEIER. If physician groups and emergency medicine groups are reimbursed promptly, it allows them to have the resources needed to take care of patients in any environment, including rural environments, with less advantageous payer mixes where perhaps they have a disproportionate number of Medicaid and self-pay patients. And by increasing those resources, I think the patients will get much better care.

Mr. PASCRELL. Dr. Bleier, in August of this year, the courts stepped in to resolve guidance disputes for the Independent Dispute Resolution that could have increased administrative fees by 600 percent. Remember that. What is the negative impact of higher administration fees, Dr. Bleier?

Dr. BLEIER. The higher administrative fees, both the non-refundable and potentially refundable if you win, often times greatly or significantly outsize the professional side or provider side bill. So——

Mr. PASCRELL. And therefore?

Dr. BLEIER. And therefore, it precludes us from entering the process.

And even if we win a dispute, we often times lose because of the non-refundable portion of those fees.

Mr. PASCRELL. Does that make sense, Dr. Bleier?

Dr. BLEIER. I think—I hope so. Yes. Not always, but yes.

Mr. PASCRELL. And what is the impact of the higher patient fee access? What is the impact?

Dr. BLEIER. From a patient perspective?

Mr. PASCRELL. Yes.

Dr. BLEIER. So again, you know, an independent group like ours, we have no private equity backing. We have zero debt. If reimbursement levels fall, and that is—can be through higher expenses associated with fees, then we have fewer resources to allocate towards what we really want to allocate our resources towards: our providers taking care of patients at the bedside. If we have less reimbursement coming in, we have less to staff and provide those resources.

Mr. PASCRELL. How deeply is private equity involved in this?

Dr. BLEIER. It is hard for me to say. In our experience we have never had any equity backing, so I really can't speak to that. We have been an independent group since 1992, so it is hard for me to say, sorry.

Mr. PASCRELL. Mr. Chairman, thank you for your time.

Chairman SMITH. Thank you. Dr. Wenstrup is recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman. I appreciate all the input today from all the people on the panel and our members. And I want to thank Chairman Smith and Ranking Member Neal for having this hearing today.

You know, when we put together the No Surprises Act, we worked with all of the doctors in Congress, Republican and Democrat, who I might say, if I can, the real protectors of patients in this world. And we considered patients first. We wanted to alleviate their anxiety by taking them out of the equation. I can tell you firsthand there are some times when patients worry more about their bill than they do their illness. And we wanted to take that anxiety away. It is very important in the healing process.

We thought about providers who just want to help patients but get reasonably paid for the work that they do, and go on to see the next patient, and help the next one, and not spend a lot of time in arbitration and other areas.

We thought about insurers. We wanted them to be able to pay a reasonable fee so that they can stay in their ability to insure those that they claim to protect, and that they will have providers, especially quality providers.

We created a system that we believed would lead doctors to want to be in-network and lead insurers to strive to have doctors in-network, and provide their patients with a quality panel, and a reimbursement to providers that was respectful of the care that they rendered to the patients, and to fulfill the promises made to the patients that they insure.

You know, I can remember once I had a patient in tears in my office because she said, "I chose this plan because they listed you as a member."

I said, "We haven't been in it in three years."

That was some of the motivation right there for getting some of the changes made into this bill, that insurance companies could no longer give false advertising, basically, saying, "This is our product," when it wasn't. That is what was happening.

And we go through the process where a patient wants to know what their elected procedure is going to cost. We ask the insurance company, and they say, "You have to perform the procedure and

then bill it first." Oh, that is a real doozy for the patient that you claim to protect.

You know, Dr. Budzinski, you talked about out-of-network. Out-of-network always paid more. Patients always had to pay more out-of-network. They knew that, and they made that choice willingly. Those were the rules. You have summed that up very well.

And when—you know, here, when it looked like one committee was going to go ahead and have a benchmark, well, what happened? We have the documents. Insurance companies immediately started sending notices out to doctors saying, "We are going to reduce your fees," because this was going to work for them. Providers got the letters. We have got them.

Dr. Bleier, you talked about what is happening now because of this. "We are going to cut your fees, we are going to cut your fees."

I mean, in situations like we have now doctors quit taking calls. I was in a large orthopedic group. You just say, "We can't afford it anymore," because—especially if they are out-of-network. We know what is going on. And without doctors, what is your product?

So why are we going towards this? And at a time when HHS and other agencies, they get a cost of living increase, doctors are getting paid less under Medicare. And all this just makes it worse and worse and worse. And these are the ones that actually provide the care.

I asked the rhetorical question, "Who would have the motives to change the clear intent of the law that we have discussed today, and why? And what were the arguments that were made? Who had the influence for these changes?" It certainly wasn't Congress, because we made it very clear.

I will submit for the record the three letters that we sent to HHS before the rulemaking process, giving it—spelling out the clear intent. We had a Zoom call with HHS, Labor, and Treasury, spelling out the intent before the rulemaking process. Bipartisan, we did this.

Congress of the United States
House of Representatives
Washington, DC 20515

November 5, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 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 Secretary Becerra, Secretary Yellen, and Secretary Walsh:

We write regarding the interim final rule (IFR) released on September 30 entitled "Requirements Related to Surprise Billing; Part II". The bipartisan No Surprises Act, passed by Congress in December 2020, was one of the most important patient protection bills in American history, but its success will depend on your departments following the letter of law in its implementation. We urge you to amend the IFR in order to align the law's implementation with the legislation Congress passed.

Congress passed the No Surprises Act after extensive bipartisan and bicameral deliberations to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between insurance plans and health care providers. During these deliberations, multiple proposals were considered including a benchmark rate, an independent dispute resolution (IDR) process, and a hybrid. Following a comprehensive process that included hearings, markups, and extensive negotiations, Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process.

The No Surprises Act specified an IDR process that takes patients out of the middle of payment disputes. It allows providers and payors to bring any relevant information to support their payment offers for consideration, except for billed charges and public payor information. Per this process, the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- In the case that a provider is a facility: teaching status, case mix, and scope of services
- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years

The process laid out in the law expressly directs the certified IDR entity to consider each of these listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered.

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. 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.

We appreciate the complex nature of the patient protections that must be established and look forward to a final rule that accurately reflects Congress's multi-year bipartisan and bicameral work to pass this landmark legislation. Therefore, we urge you to revise the IFR to align with the law as written by specifying that the certified IDR entity should not default to the median in-network rate and should instead consider all of the factors outlined in the statute without disproportionately weighting one factor.

Thank you for your continued efforts on this important matter. We look forward to working with you to ensure the best outcomes for our patients and the health of our communities.

Sincerely,

Thomas R. Suozzi
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Additional Signatories

Alma S. Adams, Ph.D.
Colin Allred
Jodey C. Arrington
Cindy Axne
Ami Bera, M.D.
Jack Bergman
Andy Biggs
Dan Bishop
Sanford D. Bishop, Jr.
Mike Bost
Julia Brownley
Vern Buchanan
Tim Burchett
Michael C. Burgess, M.D.
Salud Carbajal
André Carson
Earl L. "Buddy" Carter, R.Ph.
Liz Cheney
Judy Chu
Steve Cohen
Tom Cole
J. Luis Correa
Jim Costa
Charlie Crist
Jason Crow
Sharice L. Davids
Danny K. Davis
Madeleine Dean
Suzan DelBene
Mark DeSaulnier
Neal P. Dunn, M.D.
Jake Ellzey
Tom Emmer
Adriano Espaillat
Ron Estes
Dwight Evans
Randy Feenstra
A. Drew Ferguson, IV
Brian Fitzpatrick
Chuck Fleischmann

John Garamendi
Andrew R. Garbarino
Louie Gohmert
Jimmy Gomez
Josh Gottheimer
Mark E. Green, M.D.
Glenn Grothman
Michael Guest
Josh Harder
Andy Harris, M.D.
Brian Higgins
J. French Hill
Ashley Hinson
Chrissy Houlahan
Richard Hudson
Ronny L. Jackson, M.D
Sheila Jackson Lee
Chris Jacobs
Dusty Johnson
Eddie Bernice Johnson
Henry C. "Hank" Johnson Jr.
John Joyce, M.D.
John Katko
Mike Kelly
Daniel T. Kildee
Derek Kilmer
Young Kim
Ron Kind
Raja Krishnamoorthi
Darin LaHood
Doug LaMalfa
Conor Lamb
Doug Lamborn
James R. Langevin
Jake LaTurner
Barbara Lee
Debbie Lesko
Julia Letlow
Mike Levin
Ted W. Lieu
Barry Loudermilk
Alan Lowenthal
Frank D. Lucas
Stephen F. Lynch
Nicole Malliotakis
Carolyn B. Maloney
Sean Patrick Maloney
Tracey Mann
Lucy McBath
James P. McGovern
David B. McKinley P.E
Peter Meijer
Grace Meng
Dan Meuser
Carol D. Miller
Mariannette J. Miller-Meeks, M.D.
Alex X. Mooney
Joseph D. Morelle
Frank J. Mrvan
Gregory F. Murphy, M.D.
Stephanie Murphy
Jerrold Nadler
Grace F. Napolitano
Dan Newhouse
Eleanor Holmes Norton
Devin Nunes
Jimmy Panetta
Bill Pascrell, Jr.
Ed Perlmutter
Dean Phillips
Bill Posey
Tom Reed
Guy Reschenthaler
Tom Rice
David Rouzer
Lucille Roybal-Allard
Bobby L. Rush
Tim Ryan
Linda T. Sánchez
Bradley S. Schneider
David Schweikert
Austin Scott
David Scott
Pete Sessions
Terri A. Sewell
Brad Sherman
Mike Simpson
Albio Sires
Christopher H. Smith
Jason Smith
Lloyd Smucker
Elise Stefanik
Eric Swalwell
Van Taylor
Mike Thompson
Rashida Tlaib
Ritchie Torres
Michael R. Turner
Jefferson Van Drew, D.M.D.
Beth Van Duyne
Nydia M. Velázquez
Jackie Walorski
Daniel Webster
Bruce Westerman
Robert J. Wittman
Steve Womack
John Yarmuth
Don Young

Congress of the United States
Washington, DC 20515

September 10, 2021

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

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Martin Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Dear Secretaries Becerra, Yellen, and Walsh:

Last year, Congress passed legislation to ensure patients are protected from surprise medical bills, holding them only to their in-network cost sharing amounts for unscheduled out-of-network care. The issue of surprise medical bills has been a significant and often times unavoidable problem for Americans in need of medical care. Even when patients take every precaution to ensure their health care provider is in network, circumstances beyond their control may lead to an out-of-network provider's involvement in their treatment, followed by an unexpected bill.

In our landmark legislation, Congress stipulated that the patient's cost sharing amount be based on a "qualifying payment amount," which in most cases is a calculation based on the median in-network payment for the out-of-network service. The QPA will also be one of several factors that an arbiter will consider should payers and providers disagree on a fair reimbursement amount.

The Tri-Agencies released their Interim Final Rule related to the QPA earlier last month. In the rule, the agencies made several decisions clearly intended to reduce out-of-pocket costs for patients when having services performed by an out-of-network clinician. While we share the agencies' focus on reducing patient out-of-pocket costs, we note that the approach to calculate the median-in-network rate outlined in the IFR also reduces the calculation's utility as a proxy for real-world payments of contracted services. In the preamble of the rule, the agencies clearly state that this was an intentional choice; the agencies decided to err on the side of lower patient cost-sharing, with the understanding that the prescribed formula would calculate a QPA that ignored the volume of claims actually paid.[1] **We support the decision to prioritize the patient experience, but urge the agencies to remain consistent in their thought process as it relates to the purpose of the QPA in future rulemakings related to the Independent Dispute Resolution Process.** The QPA calculation's exclusion of any consideration of claims volume makes it an

[1] Requirements Related to Surprise Billing; Part I; Fed. Reg. 36930 (July 13, 2021).

effective tool for reducing patient cost-sharing, but ineffective as a means of approximating the actual prevailing contracted rates for a service. **This reality makes it even more important for the agencies to follow Congressional intent, as clearly outlined by the committees of jurisdiction[2], and give each of the arbitration factors equal weight.**

In developing the No Surprises Act, we spent considerable time thinking of patients in underserved areas and the impact that further limitation of provider networks could have on their access to hospitals and hospital-based providers in their communities. Ensuring final payment determinations through the IDR process represent a fair, market-based, and geographically accurate reimbursement amount is critical to ensuring clinicians and doctors are not dis-incented from serving in these communities.

The GAO conducts regular studies on the financial health and viability of rural hospitals. In January of this year, the Office published a report concluding that over 100 rural hospitals had closed between January 2013 and February 2020. What's more, the GAO found that these hospital closures led to reduced access to health care services for patients. Following a hospital closure, the median increase in distance patients had to travel for common services like inpatient care was about 20 miles, and about 40 miles for less common services like alcohol or drug abuse treatment.[3]

The unsurprising pattern and precursor to hospital closures, as determined by the GAO, was financial distress. These hospitals faced several years of negative total facility margins that grew more negative over time until operations could no longer be sustained. Most troubling of all, rural hospital margins are declining generally – putting more facilities at risk of closure. The GAO found that the total percentage of rural hospitals at high or mid-high risk of financial distress increased from 24% to 26.2% over the past 5 years.[4]

Studies have also found troubling trends in access for urban low-income communities of color, suggesting that "a high level of residential segregation, in combination with a high percentage of poor residents, conferred a higher likelihood of hospital closure."[5] Although urban hospital closures have been less frequent than rural closures, a troubling trend of financial pressure in communities already facing disparate outcomes and access to care is emerging.[6]

While patients enrolled in Medicare and/or Medicaid, often representing the most vulnerable populations, are already protected from surprise medical bills, adding pressure to the system of healthcare providers in an unfair manner could greatly impact access to healthcare in areas with high concentrations of such enrollees. The guidance and rules the agencies prescribe under the IDR process of the No Surprises Act will undoubtedly have a significant impact once implementation occurs in 2022. With the vulnerability of these communities in mind, we request that you consider the following:

- The effects of regulatory policy on access to care related to the *No Surprises Act* on at-risk communities.

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[2] *Protecting Patients from Surprise Medical Bills*. Ways and Means Republicans. (2020, December 21). https://gop-waysandmeans.house.gov/protecting-patients-from-surprise-medical-bills/

[3] Government Accountability Office, 2020, Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services; GAO-21-93

[4] ibid

[5] Ko M, Needleman J, Derose KP, Laugesen MJ, Ponce NA. Residential segregation and the survival of U.S. urban public hospitals. Med Care Res Rev. 2014 Jun

[6] Jordan Rau, E. (2020, September 18). Urban Hospitals of Last Resort Cling to Life in Time of COVID. Retrieved May 13, 2021, from https://khn.org/news/urban-hospitals-of-last-resort-cling-to-life-in-time-of-covid/

- Safeguards to ensure final payment determinations through the IDR process reflect actual market payments within a given geography, rather than tying them to a QPA designed to reduce patient out-of-pocket costs.

Further, it is critical that the rule implementing the Independent Dispute Resolution process of the No Surprises Act include clear guidance to arbiters that the process captures the unique circumstance of each billing dispute and does not cause any single piece of information to be the primary one considered. This is consistent with Congressional intent, and critical to ensuring continued access to local clinical care for patients. Thank you for your consideration. We look forward to working with you to implement this legislation and ensure the highest level of protection for patients.

Sincerely,

Terri A. Sewell
Member of Congress

Brad R. Wenstrup
Member of Congress

Danny K. Davis
Member of Congress

Jodey C. Arrington
Member of Congress

Congress of the United States
House of Representatives
Washington, DC 20515

June 17, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 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 Secretary Becerra, Secretary Yellen, and Secretary Walsh:

As you know, Congress passed the No Surprises Act as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260) after a multi-year bipartisan and bicameral effort to protect patients from surprise medical bills and resolve payment disputes between insurance plans and health care providers. **As you begin to implement the No Surprises Act, we urge you to reflect congressional intent in your rulemaking by ensuring a balanced process to settle payment disputes between health plans and providers.**

In drafting this law, we laid out a process that keeps patients out of the middle of payment disputes between providers and health plans. It also incentivizes parties to act in good faith and resolve disputes amongst themselves. However, if the parties are unable to resolve their differences, the law provides a backstop in the form of a certified independent dispute resolution (IDR) entity who must consider a number of factors in deciding whether to select the provider or payor's offer.

The dispute resolution process established in the No Surprises Act prevents artificially low payment rates that would incentivize insurance companies to keep providers out of their networks. Providers and payors are able to bring relevant information with the exception of billed charges and public payor information for consideration, and the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- Teaching status, case mix, and scope of services of the facility
- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years

The No Surprises Act instructs the certified IDR entity to consider each of these listed factors, as well as any allowable information brought by either party or requested by the certified IDR entity. **To match Congressional intent, your implementation of the law should ensure an IDR process that captures the unique circumstances of each billing dispute and does not cause any single piece of information to be the default one considered.**

Additionally, in passing the No Surprises Act, Congress gave patients important tools to navigate their health care. It is critical that our intent is recognized as you implement the transparency and consumer protection provisions of the law. One such tool, the advanced explanation of benefits, will give patients access to information about the expected cost of their treatment and the network status of the provider before they go in for a procedure. The requirements for insurance companies to offer patients up-to-date provider networks, price comparison tools, and clearly print in- and out-of-network deductibles and out-of-pocket maximums on insurance cards will make patients more informed in their health care decision-making.

As you begin to craft rules to implement the No Surprises Act, we stand ready to work with you to ensure that your rulemaking reflects congressional intent. We also encourage you to work with the stakeholders that this law will impact. In order to ensure a smooth rollout of these landmark patient protections, it is important that each step of the process provides sufficient time for public comments and evaluation through proposed notice and comment rulemaking. Working together, we are confident that successful implementation of this patient-centered law will resolve billing disputes, take patients out of the middle, and empower patients to make more informed health care decisions.

Thank you for your work on this important matter. We look forward to continuing to work with you to protect access to affordable, high-quality health care.

Sincerely,

Thomas R. Suozzi
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

/s/
Brian Fitzpatrick
Member of Congress

/s/
Joseph D. Morelle
Member of Congress

/s/
Jerrold Nadler
Member of Congress

/s/
Sanford D. Bishop, Jr.
Member of Congress

/s/
Bill Posey
Member of Congress

/s/
Liz Cheney
Member of Congress

/s/
Steve Cohen
Member of Congress

/s/
Grace Meng
Member of Congress

/s/
Vern Buchanan
Member of Congress

/s/
Gregory F. Murphy, M.D.
Member of Congress

/s/
John B. Larson
Member of Congress

/s/
Jeff Van Drew, DMD
Member of Congress

/s/
Mike Kelly
Member of Congress

/s/
Mariannette Miller-Meeks, M.D.
Member of Congress

/s/
Jim Cooper
Member of Congress

/s/
Susan Wild
Member of Congress

/s/
James R. Langevin
Member of Congress

/s/
Eddie Bernice Johnson
Member of Congress

/s/
Alex X. Mooney
Member of Congress

/s/
A. Drew Ferguson, IV
Member of Congress

/s/
Haley Stevens
Member of Congress

/s/
Scott DesJarlais, M.D.
Member of Congress

/s/
Tim Burchett
Member of Congress

/s/
Lucy McBath
Member of Congress

/s/
John Garamendi
Member of Congress

/s/
Rodney Davis
Member of Congress

/s/
Andy Harris, M.D.
Member of Congress

/s/
Pete Sessions
Member of Congress

/s/
Ronny L. Jackson, M.D.
Member of Congress

/s/
Jason Smith
Member of Congress

/s/
Eleanor Holmes Norton
Member of Congress

/s/
Neal P. Dunn, M.D.
Member of Congress

/s/
Tom Cole
Member of Congress

/s/
David G. Valadao
Member of Congress

/s/
Jodey C. Arrington
Member of Congress

/s/
John Joyce, M.D.
Member of Congress

/s/
William R. Timmons, IV
Member of Congress

/s/
David N. Cicilline
Member of Congress

/s/
Juan Vargas
Member of Congress

/s/
Cindy Axne
Member of Congress

/s/
Adriano Espaillat
Member of Congress

/s/
Steve Chabot
Member of Congress

/s/
Derek Kilmer
Member of Congress

/s/
Tim Ryan
Member of Congress

/s/
Michael C. Burgess, M.D.
Member of Congress

/s/
Ami Bera, M.D.
Member of Congress

/s/
Raja Krishnamoorthi
Member of Congress

/s/
Jimmy Panetta
Member of Congress

/s/
Ron Estes
Member of Congress

/s/
Randy Feenstra
Member of Congress

/s/
Bill Pascrell, Jr.
Member of Congress

/s/
John Katko
Member of Congress

/s/
Darrell Issa
Member of Congress

/s/
Brian Higgins
Member of Congress

/s/
Linda T. Sánchez
Member of Congress

/s/
William R. Keating
Member of Congress

/s/
Frank D. Lucas
Member of Congress

/s/
Adrian Smith
Member of Congress

/s/
Glenn Grothman
Member of Congress

/s/
Josh Harder
Member of Congress

/s/
Colin Allred
Member of Congress

/s/
Stephanie Bice
Member of Congress

/s/
Christopher H. Smith
Member of Congress

/s/
André Carson
Member of Congress

/s/
Daniel T. Kildee
Member of Congress

/s/
Lloyd Smucker
Member of Congress

/s/
Terri A. Sewell
Member of Congress

/s/
Rick W. Allen
Member of Congress

/s/
John Yarmuth
Member of Congress

/s/
Chris Jacobs
Member of Congress

/s/
Peter Meijer
Member of Congress

/s/
Barbara Lee
Member of Congress

/s/
Young Kim
Member of Congress

/s/
Anthony Gonzalez
Member of Congress

/s/
French Hill
Member of Congress

/s/
Donald M. Payne, Jr.
Member of Congress

/s/
Julia Letlow
Member of Congress

/s/
Sean Patrick Maloney
Member of Congress

/s/
Tom Emmer
Member of Congress

/s/
Ron Kind
Member of Congress

/s/
Jahana Hayes
Member of Congress

/s/
Vicky Hartzler
Member of Congress

/s/
Andrew R. Garbarino
Member of Congress

/s/
Tom Reed
Member of Congress

/s/
David P. Joyce
Member of Congress

/s/
J. Luis Correa
Member of Congress

/s/
Tom Rice
Member of Congress

/s/
Dean Phillips
Member of Congress

/s/
Marilyn Strickland
Member of Congress

/s/
Nydia M. Velázquez
Member of Congress

/s/
Glenn "GT" Thompson
Member of Congress

/s/
Chrissy Houlahan
Member of Congress

/s/
Guy Reschenthaler
Member of Congress

/s/
Stacey E. Plaskett
Member of Congress

/s/
Diana Harshbarger, Pharm.D.
Member of Congress

And I might add that until Dr. Ruiz, who was on the call, an emergency physician, until he spoke up, they wouldn't even show their faces on the Zoom call. And he said, "Would you mind showing us who you are?"

And we asked who made the decision. Nobody could answer that. Who was—who really made the decision? Who made the argument?

I mean, Ms. Thornton, I would imagine, I would guess that, in the comment and rulemaking process, that your organization and others affiliated with you probably made comments to HHS and others, right?

Well, my only question to you is would you mind sharing all the communications that you had with HHS, Labor, and Treasury concerning this topic? Would you mind sharing those with Congress?

Ms. THORNTON. Yes, we are happy to have conversations with your office about that.

Mr. WENSTRUP. Well, I would like to see your actual communications that you sent. I appreciate that. Thank you.

Chairman SMITH. Thank you. Mr. Davis is recognized.

Mr. DAVIS. Thank you, Mr. Chairman, and thanks to all the witnesses for a very serious discussion.

You know, when we passed the No Surprises Act into law, it was designed to protect patients from predators, surprise medical billing, establish a third-party mediation process called Independent Dispute Resolution to determine the amount of money doctors will receive for their health care services to patients from insurance companies.

The problem is often profits versus greed.

The law uses an IDR process as a framework where payers and providers negotiate and submit offers of what they believe is a responsible, reasonable payment for medical services. And the arbiter considers the qualifying payment amount, or OPA [sic], to be paid to doctors. The arbiter, by law, is to consider a range of factors, including a measure of median in-network contracted rates for the health plan, the history of in-network contracting with plan and provider, the complexity of the case, and the education and skill of the physician. All these factors are supposed to produce a fair compensation for the doctor.

Instead, the insurance companies are the ones that produce the sole data used in this process without the consideration of other pertinent factors that tend to deflate the rates to in-network providers and narrow the number of doctors in-network.

We understand that the impact of these policies is causing ripple effects through the health insurance market and impacting physicians' ability to negotiate fair contracts with insurers to be in-network because all contracts are now being negotiated under the OPA [sic] ceiling, as plans know that this amount is the most they will pay, whether the physician is in or out of their network.

Dr. Bleier, how important is it that IDR Entities are permitted the independence to look at all the allowable information submitted by a party to support their offer, and then make a determination of payment?

Dr. BLEIER. I think it is extremely important, and that is why I think all—my understanding is all related physician specialty groups and physicians supported the Texas Medical Association's

lawsuit against HHS to make sure that all of those factors were considered, and undue emphasis wasn't solely placed on the QPA when making those determinations.

Mr. DAVIS. And then let me ask you, what is the impact of these policies on the stability of physician practices and, in turn, patient access to physician services?

Dr. BLEIER. Unfortunately, the way the system is currently operating, I think it is going to become debilitating if it goes on too long. I think certainly I can speak for my group, as an independent group that wants to go out into rural communities and potentially provide our services in those emergency departments—we already have four in those rural communities, we are actually looking to potentially expand—I think it is debilitating.

I think we simply will—our reimbursement and revenue will be cut to such an extent we will have no recourse, if this continues much longer, but to cut expenses. And our expenses are provider staffing hours, our providers. So unfortunately, I think it will have a harmful effect on our patients.

Mr. DAVIS. And finally, I understand that patient wait time in emergency rooms is getting longer. Does this impact the service?

Dr. BLEIER. Unfortunately, yes, there is an ongoing boarding crisis across the country right now due to a number of, I believe, workforce issues—is my understanding. But it absolutely creates a difficult work environment for my fellow colleagues in the emergency department and, more importantly, a very difficult situation, I think, for our patients.

But as always, as emergency physicians, we do the best we can, and we are resourceful with the limited resources that we do have. So we still try to provide excellent care to every patient, no matter what the conditions are.

Mr. DAVIS. Thank you very much, and I yield back, Mr. Chairman.

Mrs. MILLER [presiding]. Thank you. I now recognize the gentleman from Illinois, Mr. LaHood.

Mr. LAHOOD. Thank you, Chairman. I want to thank our witnesses for your valuable testimony here today, and I am pleased that this committee put this timely and important hearing together today.

Understanding the cost of health care services in advance empowers patients to make informed decisions for their families, better manage their health care finances, and advocate for fair and reasonable health care costs.

Like many of my colleagues, the cost of health care is one of the top issues that I hear about from my constituents back home in central and northwestern Illinois. Enacted in 2020 with strong bipartisan support in Congress, the No Surprises Act, which we have heard about today, has largely been a success in providing certainty for patients when receiving care. Because of this committee's bipartisan work and leadership, today patients in every state across the country are better protected from most surprise medical bills.

While this committee made great strides towards protecting patients from costly and unnecessary out-of-network costs, we have unfortunately seen agency officials bypass congressional intent on

surprise medical billing protections, which ultimately harms patients' access to care. In rural counties in my district, access and choice for health care services can be a significant challenge. Flawed implementation of the No Surprises Act has reduced patient access to care, which in—particularly, has—which, in particular, has affected rural and underserved areas.

As I visit with my rural health care providers, they continually stress the fact that IDR process has been virtually inaccessible for small practices, given their limited capital availability, compared to many large and urban practices. Hospitals and health care facilities should be focused on delivering needed care and services, not worrying if IDR billing process costs outweigh any benefits for patients and providers.

The No Surprises Act was carefully drafted so as to not tip the scales in favor of one party over the other, and my hope is this committee and the executive branch can work to remedy this imbalance.

My question for Mr. Bobeck and Ms. Thornton, in your testimonies you both mentioned the need to look at the IDR process and how reforms in this space would better allow dispute filing and compliance with the No Surprises Act. Can you both expand on what could be done by CMS to improve the functionality of IDR process to streamline and to reduce burdens on the parties?

Mr. Bobeck.

Mr. BOBECK. Congressman, thank you very much for the question.

The first thing that can ultimately be done is regarding the batching process. As many of the congressmembers know, batching is a process by which different disputes can be put together. Right now the process does not follow normally how providers and payers bill each other. They usually bill in an episode of care. Somebody comes in, there are various codes associated with giving that care, and then they will be paid upon that. That is not how the batching process works right now.

CMS is currently undergoing the batching process and changing those rules. Making those rules more in tune with how people bill would be a very good step in the right direction.

Additionally, one of the biggest things that could be done is ultimately the portal itself. With more implementation of the portal, making more fields more clearly defined, parties can provide better information. And the more information and the better information they will provide, you will get a more streamlined process that will have decisions happening at a much more rapid rate.

From our perspective, we have run various algorithms on our own end, and we can see very clearly that the better the data that is put into the system, the better the outcomes that will come out. Thank you.

Mr. LAHOOD. Thank you.

Ms. Thornton, do you have anything to add on that?

Ms. THORNTON. I 100 percent agree with whatever—everything that he just said. I think technology can really help streamline this process.

Mr. LAHOOD. Thank you. Those are all my questions.

Thank you, Madam Chair.

Mrs. MILLER. Thank you. I now recognize the lady from California, Ms. Sanchez.

Ms. SANCHEZ. Gentlelady, please.

Mrs. MILLER. Sorry, gentlelady.

Ms. SANCHEZ. Thank you, Ms. Chairman. I appreciate the opportunity to have this much-needed discussion on the historic bipartisan progress that we made under the leadership of Mr. Neal and Mr. Brady in passing the No Surprises Act back in 2020. And I am incredibly proud of the work that we did to help patients struggling with unexpected out-of-pocket costs.

Since then, Democrats have worked tirelessly to narrow the coverage gap for Americans. We passed the Inflation Reduction Act and increased ACA subsidies to decrease out-of-pocket costs for lower and middle-income working families. And, as a result, we now see our nation has the lowest uninsured rate that we have had to date.

And while the No Surprises Act is largely accomplishing its goal in protecting patients and consumers from surprise medical bills, many Americans are still saddled with high costs and, sadly, very confusing provider networks. For those who are struggling with high costs, this also means, unfortunately, that they must take on medical debt. One in ten residents in Los Angeles County, including many of my constituents, are burdened with medical debt, and medical debt is one of the largest sources of debt in collections, more than credit card debt, more than utilities and car loans combined.

And it is not surprising that Latino, Black, and Native American residents are disproportionately burdened by medical debt, and many of these folks are insured. It is not that they are not insured, they are insured. So, these networks still need to deliver on the promises of the No Surprises Act. We still have more work to do.

Now, Ms. Spicer, you mentioned that health insurance plans and providers do not automatically hold patients harmless when there are billing disputes. How long, on average, does it take for you or one of your employees to help consumers resolve a billing dispute?

Ms. SPICER. Thank you for your question. It depends on the case. It depends on the capabilities of the consumer.

Sometimes, if you are going through cancer treatment, you can't call me back for a month. So I don't know what your notice says and what—how it relates to your bill and your EOB. And I can't really help you until you are well enough to communicate with me.

So, you know, and then other cases we can tell from a quick call and an intake script, whether or not a bill is a surprise bill and what to do about it. So it really just depends on the case. But I would say, on average, anywhere from six weeks to six months.

Ms. SANCHEZ. Six weeks to six months. And that is what the help of someone who is very familiar with the insurance system. Would it be fair to say that consumer assistance programs are still under-utilized by many Americans?

Ms. SPICER. Yes, I think that is fair to say. We get, at New York's Health Insurance Consumer Assistance Program—we get 8 to 10,000 calls a year. We are on the Explanation of Benefits and the Adverse Determinations of Commercially Insured Consumers, and recently last year added to the Adverse Determinations of

Medicaid-Managed Care Consumers. So we have kind of a broader audience that is—those are state regulations that require that notification to consumers. Otherwise, they wouldn't know that we existed.

Ms. SÁNCHEZ. And so, what happens to the families and patients who don't know to seek out the help that a consumer assistance program provides?

Ms. SPICER. They would pay a bill, or they would not be able to pay a bill and go into debt.

I got a client on our help line last week who received a bill for an out-of-network lab, but not a corresponding EOB. And if you don't have an EOB to explain that your bill was denied as out-of-network but could be a surprise bill and follow that process, and you are not held harmless by the plan, and you are not savvy enough to know, you would pay.

Ms. SANCHEZ. Thank you. So, often times the people who are least in a position to pay end up paying.

We have also seen provider networks grow narrower over the past few years. Mr. Budzinski, have you seen the provider network in your community change over the last few years?

Mr. BUDZINSKI. Yes, Representative. We do see, particularly with the advent of the Health Insurance Exchanges, major insurance companies in the country have decided that narrow networks are an appropriate structure for Health Insurance Exchanges. And many of the major insurance companies in this country operate narrow networks in the service areas we serve.

Ms. SANCHEZ. Thank you.

And Ms. Thornton, how do narrow provider networks impact the likelihood of a patient receiving a surprise bill?

Ms. THORNTON. Thank you for the question. I do think it is really important to talk about affordability.

We all benefit when people can afford their health insurance coverage. And to do that, our plans need to provide, you know, high-quality networks of providers where they can go and get care in a time of need.

To directly answer your question, all of our plans provide provider directories that allow consumers to search. And thankfully, the No Surprises Act included new provisions, new consumer protections that, in the case that someone receives inaccurate information, they are held harmless from that. So that was a really important part of the No Surprises Act.

Ms. SANCHEZ. Thank you.

I want to thank all our witnesses for their testimony today, and I yield back.

Mrs. MILLER. The gentlelady's time has expired. I now recognize the gentleman from Georgia, Dr. Ferguson.

Sorry, Mr. Estes from Kansas.

Mr. ESTES. Well, thank you, Madam Chair, and I want to thank you, all the witnesses, for joining us today on this very important topic.

Mrs. MILLER. That goes off.

Mr. ESTES. It wasn't too long ago that the committee passed meaningful, bipartisan legislation to address a very real problem in the country around surprise medical billing. I am sure all of us

here have constituents who have been impacted by surprise medical bills.

Erin in my district has told me about a nightmare she faced after her husband was in the emergency room in Wichita. They have insurance, thought they were doing the right thing by going to an in-network hospital, only to find out that one of the doctors who saw her husband in the emergency situation was out-of-network, causing a massive surprise medical bill.

This is happening all too often in hospital rooms and medical facilities across the country, and Republicans and Democrats came together to stop it. The No Surprises Act was designed to remove patients from the middle of the surprise billing, empowering patients with up-front information for scheduled procedures, protect patients when emergency services were provided, and create a fair mediation process for providers and the insurers.

This bill was the type of common-sense legislation that folks like Erin and her husband needed. An emergency room visit or scheduled procedure is stressful enough, but it can be even more challenging if it is followed by an unexpected medical bill from an out-of-network provider.

But today's hearing is a reminder of why Americans are so frustrated with Washington. The unelected bureaucrats at CMS have failed the American people by not complying with the language in the bill we passed, and instead creating a dispute resolution process that doesn't follow the spirit or congressional intent of the law.

Even though elected lawmakers passed the bipartisan No Surprises Act in 2020, the Kansans I represent continue to suffer because unelected D.C. pencil-pushers are more concerned with keeping the status quo than helping patients. The failure in the D.C. swamp has led to fewer medical choices, longer wait times, and higher costs for patients, while at the same time has failed to deliver the transparency this body sought to provide for those seeking medical care. Today we are calling on CMS, that is entrenched in putting Washington first, to stop slow-walking the implementation process and put patients first.

Mr. Budzinski, I have heard from many providers in my state about the incredible wait times for not only the Independent Dispute Resolution, IDR, process, but also for receiving payment once the IDR process has been concluded. Can you please tell me how many of these IDRs you have gone through, and how many that have been paid for successfully?

Mr. BUDZINSKI. Yes, thank you, Representative. Of our 8,000 requests for determination at Wellstar, 588 have been resolved: 288, I believe, are in our favor and, unbelievably, only one-third of those determinations in our favor have been paid by insurance companies. And the deficiency is with some of the largest insurance companies in this country.

Mr. ESTES. If that process or that approach continues without some change, what does that mean for your business and, more importantly, for the patients that you serve?

Mr. BUDZINSKI. As mentioned earlier, accounts receivable that have never—that are never paid will impact our operations in the long run. We are hopeful that there will be enforcement of the

timelines to remit payments to providers who have been successful in getting favorable determinations from the IDREs.

Mr. ESTES. Well, thank you.

And Mr. Bobeck, I didn't really have a question for you, but I did want to say thank you for raising the comment about the IDR website being closed, that you can't add any more IDRs. I mean, that is one of the things that we have identified by law, this process that should be helping people, and we need to make sure that it is highlighted that it is not being done. So thank you for bringing that up as part of this hearing.

I just want to say, you know, the No Surprises Act explicitly required that we have an Independent Dispute Resolution process that should be concluded in a timely manner, and payments should be paid no later than 30 days after the final decision. These considerable wait times must be addressed to ensure that our providers, especially those in rural areas, can keep caring for the patients that need them most. That is really what we want to focus on, is how do we make sure we provide the right care for the right patients, which I think is what all of you are focused on, as well.

So thank you, and I yield back.

Mrs. MILLER. Thank you, Mr. Estes. I now recognize the gentleman from New York, Mr. Higgins.

Mr. HIGGINS. Thank you, Madam Chair.

Surprise billing is a weapon in our decades-long war between players in the health care industry over who gets to keep the fortunes generated each year from patients. What is at stake here? According to the American Medical Association, health care spending in the United States in 2021 was $4.3 trillion, or more than 18 percent of the U.S. economy.

You know, 30, 40 years ago, most health care providers were not-for-profits. Businesses paid premiums. Patients typically were confronted with pretty modest co-pays and deductions. Those days are over. Health care has become big, big business. So hospitals, doctors, and insurers are now in competition for the health care dollar.

And then we have found even more egregious players in all of this called private equity firms. The Kaiser Family Foundation, an article called "Sick Profit," or, "Investigating Private Equity's Takeover of Health Care Across Cities and Specialties"—that are highly profitable, private equity spent nearly $1 trillion into nearly 8,000 health care transactions in the past decade alone.

Private equities are not health care professionals. They are moneymakers. In fact, according to Forbes, to doctors private equity firms offer an alternative value proposition promising to ease physician dissatisfaction with insurance hassles. In exchange, physicians agree to relinquish significant control of their practice to non-health care professionals.

Ms. Spicer, you have some thoughts about patient protections in this area, but it seems to me that what is occurring here is Big Money's takeover of health care, compromising the best interests economically and in terms of health care of the patient.

Ms. SPICER. Thank you for your question. Yes, many times consumers are left with the balance bill, and they are left holding the bag. All of these transactions make it more expensive in the end for consumers.

Mr. HIGGINS. Yes, and the surprise medical billing legislation, it really is ineffective in addressing this issue. Would you agree?

Ms. SPICER. I wouldn't say that the—all of the surprise billing legislation is ineffective in addressing the issue.

I would say that if all the different provisions of the No Surprises Act were implemented, if price—you know, the transparency provisions move forward, patients would be able to make more informed decisions regarding the care that they are getting and to—and thereby, you know, avoid debt.

I think that, you know, the arbitration, the piece about arbitration and the fees, depending upon the rate that is set, it passes additional fees on to consumers. But I believe that if the original intent of the law is followed, those—that debt would not be passed on to consumers.

Mr. HIGGINS. Yes, it is undeniable that for a for-profit or private equity that has taken over a medical practice: what is their objective, and what is the leadership's objective? It is to reduce expenses and to amplify profits. The only way that you do that is to jack-up co-pays, jack-up deductibles, and then, when someone goes to use the insurance they have already paid too much for, there is very little underlying insurance.

And I am just concerned that Federal legislation can't stop the trend that has begun in health care, and that is it is a $4.3 trillion industry annually in America, 13,000 per capita in America. And the profit motive is so strong that I am concerned that legislation, while appearing to be helpful in the margins, is not addressing the fundamental problem.

With that I will yield back.

Mrs. MILLER. Thank you, Mr. Higgins. I now recognize myself for five minutes.

I would like to thank Ms. Chu for sitting in here for the ranking member, and I would like to thank all of you for being here today, taking your time to discuss with us such an important issue.

Being from southern West Virginia, which is a very rural district, my top priority is making sure that my constituents have the best access they can to quality health care. In 2020 I was absolutely thrilled that the House passed the No Surprises Act to help patients all across the nation to deal with their medical bills, especially in rural areas, because many patients don't have much of a choice about where they receive their care. And this policy was a huge win for patient-centered health care.

So you can imagine my surprise when I learned just how wrong the implementation of this bill has become. One concern I have about the No Surprises Act's implementation is that Congress was very clear that ground ambulance services were not included in the NSA. However, I understand that some insurers are telling customers that ground ambulance services are subject to NSA.

I would like to note that the failure of CMS to issue a clarification is creating real problems. Rural ground ambulance services are particularly harmed because they are often small companies or businesses with very limited resources, and many are struggling just to keep their doors open. Reports that some insurers are trying to force these rural providers to use the time-consuming and expensive process when they aren't even subject to it, nor do they have

established qualified payment amount, this is concerning to me, and I am dismayed that CMS hasn't issued the written clarification that would solve this confusion. And I hope that this is an issue that we will continue to keep an eye upon.

Dr. Bleier, I would like to thank you for your hard work in providing emergency medical care to rural patients. In rural areas where access to care is so often limited, it is important that patients who are seeking medical treatment—that they can do it without the fear of a surprise medical bill.

One issue that we hear about time and time again is the lack of staffing available in our health care workforce. In rural areas it is becoming harder and harder to find physicians that are willing to practice where their reimbursement rates are so much lower. This is due to the coverage mix of their patients.

Can you speak further about how compliance with the NSA, as implemented by this Administration thus far, has contributed to physician burnout in your workforce, and how this might influence physicians looking to start their careers in rural areas?

Dr. BLEIER. Yes, I appreciate the question. I think physician burnout is very high among emergency physicians for a wide range of reasons, you know, going back toward the COVID pandemic. And emergency—I believe it is the highest burnout right now out of any of the specialties, based upon some of the recent polls that I have seen, unfortunately.

You know, it is a little bit of a moral hazard right now. Our physicians will always want to do right by their patients, and we try to do the best we can, and we are used to working under very adverse circumstances. But due to a wide variety of issues, including workforce-related issues, boarding, workplace violence, these are all issues that emergency medicine providers and other emergency medicine workers, nurses, et cetera have to deal with in the emergency department.

From the emergency medicine physician and nurse practitioner and PA perspective, when our resources for a group like ours are fully debilitated—again, we were shocked when we find out—found out—when this law was passed, this bipartisan piece of legislation, we thought it was a great advancement. We did not think we would be affected by it, because we had been in-network with all the major payers in our region.

But then we were kicked out of network, and it is like putting salt in a wound, quite frankly, for us. Because not only are our providers working as hard as they can to do the best they can under very adverse circumstances, but when on top of that their reimbursement, their fair market reimbursement is cut, it makes it very damaging to them. I think their psyche—I think it puts us in a very difficult position.

And we want to do right by the patients, we want our resources not going—having to go to an IDR process. We want them to go towards our providers working in the emergency department to provide the very best care they can in these rural emergency departments or any emergency department we work at.

Mrs. MILLER. Thank you. I yield back my time. I now recognize Gentlewoman DelBene from the State of Washington.

Ms. DELBENE. Thank you, Madam Chair. Thank you to all our witnesses for being with us today. I appreciate it.

Like many of my colleagues on this committee, I was proud to pass the No Surprises Act into law to protect Americans from unfair surprise medical bills. Prior to this bipartisan legislation and similar state laws, including in Washington, regular people and families were frequently at risk of being hit with devastating surprise medical bills for emergency room visits and other procedures that were completely out of the patient's control.

And while we have made great progress, there is definitely more to do. In particular, there is a critical gap in our consumer protection framework, which is surprise bills for ground ambulances. According to Washington State's Office of the Insurance Commissioner, the vast majority of surprise billing complaints are for ground ambulance services, which were exempt from the No Surprises Act.

So, if someone with private insurance in my state has an emergency and calls 911 and gets driven by an ambulance to the hospital, they are not only on the hook for the co-pays and cost sharing if they haven't met their deductible, but may also have to pay a surprise bill of $500 on average. For non-emergency ground ambulance services, that surprise bill could go as high as $1,000.

And it is not just a problem in my state. The Urban Institute's Health Policy Center has identified the lack of protection against ground ambulance surprise bills as a major issue for consumers across the country. And so, Ms. Spicer and Ms. Thornton, how has surprise billing for ground ambulances impacted people's willingness to seek care in emergencies and other situations?

Ms. Spicer, you want to start?

Ms. SPICER. Thank you for your question. In my state, in New York, ground ambulances are covered under our surprise billing law, and were actually covered under the definition—in the definition of emergencies. So many, many insured were protected from out-of-network ground ambulance surprise bills even before our surprise billing law.

But we still get a number of calls from consumers who are federally insured, who have ground ambulance out-of-network bills, and they can't afford them. It is hard for them to afford, it is hard for them to understand why their plan isn't paying, and it deters them from going to the emergency room and getting care when they need to.

Ms. DELBENE. Ms. Thornton. Thank you.

Ms. THORNTON. Sure. And first it is important to acknowledge that our member health plans want to have a robust network of ground ambulance providers in their network, because we all know when you least expect it that something that you may need to take, you may need to need in an emergency or other situation.

You know, it is important to recognize that Congress did not include ground ambulances in the No Surprises Act, but we do understand that the regulators are really taking active input on that question, and really debating how—what recommendations to make along that area. So we are actively participating in those discussions, and look forward to next steps on that.

Ms. DELBENE. Do you—do you think that surprise billing for ground ambulance should be prevented, and we should do something here in Congress on this?

Ms. THORNTON. You know, we do want to make sure that patients are protected and held harmless.

One of the things that I would caution us in thinking about is if the arbitration process is broken, like has been discussed during this hearing, I would caution us as throwing more, you know, cases at that process. So I think it would require first fixing that process before we add more to it.

Ms. DELBENE. Thank you. We will continue to work with all of you as we try to move forward on this.

Also, Dr. Bleier, as you know well, the widespread use of prior authorization delays and discourages medical care for millions of Americans that are entitled to care. That is why I have led the effort in the House, alongside my colleague, Congressman Kelly, and others to modernize and streamline this very outdated practice. And we have legislation, Improving Seniors Timely Access to Care Act, to increase accountability and help Medicare Advantage enrollees get faster care by doing crazy things like establishing electronic prior authorization process, making sure people are responding to provider requests faster and in real time, and requiring plans to report on the extent of their prior authorization use and how often they are denying requests.

When we talk about the challenges that providers are facing, could you discuss the challenges you and your patients have faced due to abuses of prior authorization, as well, and why legislation is so important?

Dr. BLEIER. Yes, we—I haven't dealt necessarily with that issue directly from my perspective in the emergency department, but I think we have certainly all dealt with it indirectly, where patients maybe go to a community provider, they are evaluated by that community provider, that community physician feels that that patient study is warranted and medically necessary, but they are unable to do so. And then the patient is referred to the emergency department because they are then able to get the very necessary study in the physician's perspective.

Ms. DELBENE. And we talk about doing a good job of helping providers and patients, here is another area we need to address.

Thank you, Madam Chair. I yield back.

Mrs. MILLER. Thank you, Ms. DelBene. I now recognize the gentleman from Tennessee, Mr. Kustoff.

Mr. KUSTOFF. Thank you, Madam Chair, and thank you for the witnesses for appearing today.

I know that a lot of you have talked about the—maybe the common experiences that you have had, and the frustrations you have had with the whole process.

I could, Dr. Bleier, with you—and if I can, I tried to talk to as many providers as I could about all these issues, and one thing that kept coming back was—and you have talked about it, Mr. Budzinski, you have talked about it—is you go through the process and you prevail, whatever that means, and then you have got however long it takes for you to get paid. And cash flow is an issue

whether you are operating a medical practice, or a hospital, or a retail store, or any business.

So, Dr. Bleier, I am going to turn it around, if I could, to you. You know the framework. You know what has been implemented. If you could wave a magic wand, what would you do to fix it? How would it be fixed?

Dr. BLEIER. Well, I believe I will be speaking out of my turn to some extent, but I would, I guess, hire a lot more IDREs, a lot more arbitrators to quickly and efficiently handle the backload—backlog of cases. There is a lot of cases in the pipeline.

And then I would also put a lot of resources into enforcement. I would want—I would like to see enforcement. I think it would be beneficial to see enforcement that the QPA is being calculated appropriately—without ghost rates, for example, et cetera. Even with the judicial ruling, they sort of set the framework stating that that shouldn't occur. But there is no enforcement or transparency, currently, as far as I understand.

And then certainly, some enforcement in making sure that the arbitrator's rulings are carried out and payments are sent to providers and hospitals appropriately. So I would say enforcement, transparency are the big things.

And then to do something to efficiently work through the backlog right now in the system.

Mr. KUSTOFF. I will come back to the backlog in a moment. How would you enforce payment?

Dr. BLEIER. I would imagine there would have to be some teeth in it. You know, a small—you know, a $350 non-refundable arbitration fee for a group like mine is a lot. That is probably not a lot for, you know, very large insurance companies, given their size and their net profitability quarterly, which is—dwarfs a small group like ours.

So I don't know what that price point would need to be in order to enforce payment and then carrying out what the law states they are supposed to do——

Mr. KUSTOFF. Right.

Dr. BLEIER [continuing]. But it would need to be significant, I would imagine.

Mr. KUSTOFF. I think in your testimony or in your written testimony you talked about—that the majority of your submissions are $1,000—under $1,000, I think, is how you characterized it.

Dr. BLEIER. Yes, that is correct. That is my understanding.

Mr. KUSTOFF. And do you know how many submissions, how many claims you have submitted, your practice has submitted?

Dr. BLEIER. I believe we have submitted about 400 claims because it just seemed like, you know, number-one, early on, you know, despite what the bipartisan piece of legislation stated, the regulations, I believe, stated that the QPA should be the primary determinant. We knew we were going to lose those cases, so we had those sorts of issues.

We also had the associated very high fees which excluded us, the backlog, the fact that even when we did submit we didn't receive payment. So all of those issues prevented us, essentially, from accessing the system. We are hoping to moving forward, but that has been our experience.

Mr. KUSTOFF. Thank you, Dr. Bleier.

Mr. Budzinski, in your written testimony—and I was going to ask you about how you would solve it, but you talked about how this law disincentivizes health networks. I think the way you characterized it was from having robust networks. So if you could wave a magic wand, what would you do to resolve issues and fix it?

Mr. BUDZINSKI. Yes, thank you for your question, Representative.

First and foremost, the framework is as follows, as we understand it. The courts have found that the administrative process has been tilted in payers' favor.

Number two, we have just discussed today the fact that 70 percent of the providers are found—the IDREs are finding in favor, in favor of providers. So the deck is stacked toward the payer in the process, and the providers are still winning 70 percent of the time.

Why is that? What is causing this? What is the root cause? The root cause, I believe, is that the payers' initial payment to providers is being found to be substantially below what is necessary.

So the magic wand is to require administrative processes that the initial payment from payers be consistent with the historical practice of payment for out-of-network providers. If that were the case, I believe these backlogs would disappear. That is what I believe.

Mr. KUSTOFF. Thank you very much. I yield back my time.

Chairman SMITH [presiding]. Thank you. Mr. Steube is recognized.

Mr. STEUBE. Thank you, Mr. Chairman.

Earlier this year HHS Secretary Becerra acknowledged before this committee that there have been more claims than initially estimated, and the arbitration process has been overwhelmed. The Centers for Medicare and Medicaid Services have contracted with 13 entities to arbitrate cases. All 13 have different processes for arbitration, and CMS has not had a uniform or concise action in implementing the law. The Department of Health and Human Services has been very slow to roll out this law, and it is the constitutional obligation of the executive branch to carry out what Congress passes.

Ms. Thornton, I would like to start with you. I would like to ask you a few questions about the bureaucratic failures at CMS, and maybe help me understand the almost inexcusable directives and inability to follow congressional intent with how the No Surprises Act has been rolled out. How much of this can be cleared up by congressional action, as opposed to CMS issuing clearer guidance?

Ms. THORNTON. Right. Thank you for the question.

I do think, you know, it is important to recognize that the—you all passed the No Surprises Act to make sure that coverage was more affordable, and to really make sure that patients were held harmless from one perspective, but also we didn't do anything to drive up premiums. So I do think it is really important, as CMS is putting out guidance and regulations, that we are looking at the affordability impact.

You know, we have weighed in on all of these different guidance and regulations. We do stress the importance of ensuring a balanced process between providers and health insurance plans to

make sure that we are not using this process a lot. Unfortunately, in how it is rolled out, there certainly has been an over-reliance on the use of IDR, 14 times more than was initially anticipated, and that has certainly been really challenging, from our perspective.

Mr. STEUBE. Are there reforms that CMS can make today to clean up the dispute resolution process?

Ms. THORNTON. Absolutely. I think it is really important to focus on solutions.

You know, there has been a lot of talk with my co-panelists here around payment and challenges with getting paid on time. I think by rolling out more robust infrastructure and technology to give us a clearer dashboard of all of these various claims and where they are in the process would really go a long way to mitigate any payment delays that any of the panelists are experiencing.

Mr. STEUBE. Is there a variation across the 13 arbitration firms handling the cases and how they process the claims?

Ms. THORNTON. Absolutely. We have seen a lot of really challenging scenarios, you know, making decisions for claims that were really Medicare claims and not subject to the No Surprises Act, really wide variations in the decisions that are coming out—the same provider, the same area, the same service, but a drastically different decision coming out. And definitely, we would recommend the regulator to do more to ensure consistent processes among the different entities.

Mr. STEUBE. Wouldn't it bring more efficiencies if CMS standard [sic] the processes across the board?

Ms. THORNTON. Absolutely.

Mr. STEUBE. Are there certain suggestions, other than what you just mentioned, that you would suggest?

Ms. THORNTON. I think greater oversight and review of the practices of those entities would be well received from us.

Mr. STEUBE. Mr. Bobeck, I have got a couple of questions for you. What steps, if any, can Congress take to resolve the dispute resolution process between the hospitals, doctors, and insurers, while at the same time protecting consumers from the balance—from balance bills?

Mr. BOBECK. Congressman, thank you for the question.

Number one, I believe that Congress continue to see the No Surprises Act through. As noted, millions of consumers are not getting surprise bills. That is a success story that has happened, and that is a universal agreement across the entirety of the spectrum.

When it comes to the payers and the providers, continue to put the pressure and the onus on the parties, as well as the government to put forth rules that will clearly allow them to speak with each other, understand what exactly they are disputing. And I assure you those claims will go faster and smarter.

Again, in our group we don't have a backlog. We have never had a backlog. Cases go out within the 30 days. And the more information the parties can share with each other, the cleaner their claims will be and more disputes will go out the door.

Mr. STEUBE. How accessible is it for you to get questions answered by HHS?

Mr. BOBECK. It is a continuing conversation that we have to have with the government upon various aspects of how they would like the process to be implemented.

To be fair, and it has been noted, yes, IDREs do have to make decisions based upon the best evidence that they are provided. In certain cases there is not a uniform standard that is published. But in guidance we are all instructed to move in the same way. With that being said, yes, there can be some small delineations among the IDREs of how to go about that process.

Mr. STEUBE. And I will just—I have only got a couple of seconds left here. Dr. Bleier, does it make sense for HHS to charge a $350 administrative fee even to hear disputes that are less than that amount of money, especially with x-ray and other radiological services?

Dr. BLEIER. No, it doesn't.

Mr. STEUBE. Thank you. Thank you all for being here today. I yield back.

Chairman SMITH. Ms. Chu is recognized.

Ms. CHU. I would like to thank all the witnesses for your testimony today on this important issue.

Prior to the No Surprises Act becoming law, millions of patients struggled with financially devastating surprise medical bills. As this law continues to be implemented, it is important that we build on the progress and continue to protect patients from unexpected out-of-pocket costs, while also promoting fairness and payment disputes between insurers and providers, as the law intended.

Ms. Spicer, as you highlighted in your testimony, consumer assistance programs like CSS New York have played an incredible role in helping millions of Americans navigate all kinds of health care concerns, from understanding how to use their health insurance, resolving medical bills that are often confusing and conflicting, appealing health plan decisions, and disputing surprise medical bills.

Now, New York is fortunate in having your organization. However, Congress has not appropriated funds for these programs since 2010, leaving many states without this resource. Most consumers who are eligible for CAP assistance are enrolled in employer-sponsored plans. And the majority of these plans are federally regulated. But CAPs that operate with no Federal funding cannot manage this large scope of work.

So as patient confusion around health care continues to grow, can you talk about the importance of increasing Federal funding for Consumer Assistance Programs, and how CSS New York and other programs could use this funding to help more patients navigate surprise billing?

Ms. SPICER. Yes, thank you for your question.

Health insurance generally is incredibly complicated. We have all, as insured, gotten a notice that we don't understand, an EOB that doesn't make sense in terms of the care that we received, a bill that we feel we shouldn't pay for a giant package in the mail, or an online login that explains our network directory or our summary of benefits, our plan contracts that we have no idea what it says and don't even read it.

And currently our state funds our program after we lost Federal funding in 2010.

It is hugely important for people like you and me to get help with their health insurance because, unfortunately, in America you need a lawyer in order to properly access care sometimes and get insurers to pay claims and get providers to stop billing you.

Ms. CHU. So that Federal funding was important. Yes. And also——

Ms. SPICER. Absolutely.

Ms. CHU [continuing]. You are in a unique position, being in New York. I would like to ask about the differences you have witnessed in terms of patient experiences in the time following the enactment of New York's out-of-network surprise billing law in 2014 and then after the enactment of the Federal No Surprises Act. What changes have you observed in patient dispute volumes, types of billing disputes, and other factors between 2014 and now, before the No Surprises Act became law and in the years following the law's enactment?

Ms. SPICER. Thank you for your question.

After the—before the passage of New York's surprise billing law, we saw all sorts of out-of-network—classic out-of-network billing cases that the NSA now covers, in-network hospital, out-of-network radiologists, or out-of-network lab, or out-of-network slew of services that were uncovered. After our state law those classic cases were covered by the NSA.

And there were some things missing, including network directory misinformation, which was the largest volume of calls that we got after we passed our own law in New York State. The second largest volume, of course, was federally insured consumers who just had no protections.

And now, since the passage of the NSA, the volume is less, but we still have many calls just about understanding what the process is and whether there—the consumer—the bill that the consumer is getting is a surprise bill, and how to cure, if it is.

And then we still get many calls about ground ambulance for federally-insured folks and other kind of follow-up to the ER. You are not—if an ER doctor puts a stent in, you are not going to get another doctor to take that stent out, so you have to incur an out-of-network cost outside of the ER for that. So there are some loopholes there.

Ms. CHU. So there is improvement that is needed. But there was some improvement with the No Surprise Act bill.

Ms. SPICER. Absolutely, huge improvement. And also in regards to air ambulance.

Ms. CHU. Okay, thank you.

Chairman SMITH. Dr. Murphy is recognized.

Mr. MURPHY. Thank you, Mr. Chairman, and I want to thank the witnesses for showing up today.

It is really, I think, a very sad state that we passed a very, very good law that had a lot of debate internally, bipartisan support over here, bicameral support, signed into law by a president, and then, when there was a new administration that came in, decided—what was a balanced law between providers and insurers—

to pretty much put everything in the insurers' pocket. It is an absolute disgrace.

And we have met with Secretary Becerra once, two, three times, and the answer was it is always in court.

I absolutely applaud the Texas Medical Society for suing against this, because what has happened is, yes, I think we all have a consensus agreement that the No Surprise—or that surprise billing was an absolute problem. Take it out of the hands of the patients, absolute. But when you turn a process in which is supposed to be equal and balanced, which was absolutely done, and you turn it all over to insurance companies, I am not sure what the Administration is trying to prove, but this has become an absolute boondoggle for insurance companies.

Mr. Speaker, I would like to ask unanimous consent to enter into the record a letter from Blue Cross Blue Shield of North Carolina to a physician practice stating that the interim final rules—and this was probably two days after the interim rules came out—provide enough clarity to warrant a significant reduction in your contracted rate with Blue Cross Blue Shield.

In some instances, insurers, the next day after the rule was proposed, cut fees 40 percent. Guys, we all know that medicine is a business, sad enough, but there is no stability in that when the insurance company is absolutely raping (reaping?) profits off of the backs of those who provide the care.

So with all—unanimous consent I ask that this be done.

Chairman SMITH. Without objection, so ordered.

[The information follows:]

November 5, 2021

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

Dear Provider:

[redacted] 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 with n 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). TheQPA paid by health plan to the out-of-network provider constitutes payment in full unless certainlimited 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 [redacted] as one of our outliers 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 CrossNC. 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 1\o 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

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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 providea 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 [redacted]

Sincerely,

[redacted]
Vice President, Provider Networks

Mr. MURPHY. There was no teeth in the legislation, sadly enough. Thirty-day rules once things were adjudicated. We are going to get to some teeth in this, and the people who are holding out the money may not like it, and I invite them to come in my office and help us craft legislation.

Dr. Bleier, thank you for being in here. The statutory language was very, very clear. The Administration chose not to use it, and only to use the QPA as the primary consideration in the IDR process, which insurance companies have deflated on the dollar.

And by the way, they are not hurting. United, 20 billion—with a B—in profits, while we have practices that are not being paid for months, for months after they have been adjudicated.

So, Dr. Bleier, what has your experience been with the QPAs offered by the insurance companies?

Dr. BLEIER. Sometimes we don't know if we are being offered a QPA. It is often times not listed on the initial payment. But the QPAs can vary tremendously, and sometimes they don't really make a whole lot of sense with the marketplace.

So, you know, our understanding in speaking to colleagues, as well, is these QPAs are cited, and a lot of smaller groups—and our own, for example—have even less bandwidth to deal with that decrease in reimbursement, given their staffing models, and often times are forced to come out of network. They are kicked out of network due to a cited QPA that may or may not be correctly calculated with no transparency to verify, and they are forced back in-network at a substantially lower contracted rate. And I think that has been a real issue for a lot of groups, from what I hear.

Mr. MURPHY. It is a destruction of medicine, and I lay that flat on the hands of our insurance companies.

You know, we have seen this with PBMs, the absolute extortion that is going on with them. And it is all vertical integration charged by our insurance companies.

According to a survey, 50,000 doctors, those who take care of patients, said that 100 percent of providers have been threatened with contract termination. What a way to treat your clients. What a way to treat your clients. "We are cutting your prices, those of you who take care of the patients. We are cutting your prices so our CEOs can earn millions and millions of dollars."

On average, 81 percent of providers had an average of nine in-network—in-network—contracts terminated by payers, things that were going fine until, all of a sudden, insurance companies decided, well, we can take advantage of this. Payment cuts up to 52 percent. Nearly 60 percent of payments won in arbitration were not paid within the 30–day termination.

And I want to ask Ms. Sailer there, you said that it didn't fit—holding back money did not fit your business model. Can you explain what you mean by that?

Ms. THORNTON. Ms. Thornton? You meant me? Sorry.

Mr. MURPHY. Yes, I am sorry. Yes, yes, yes, yes.

Ms. THORNTON. Sure. You know, we really depend on having a robust network of high-quality insurers. An employer is not going to want to buy coverage that doesn't have a robust network. So we need to have a collegial relationship with providers.

So I think, with the goal of bringing more providers in-network, it is not in our best interest to withhold payments. Because eventually——

Mr. MURPHY. Yes, well, you just heard Dr. Bleier, where basically people get bullied, kicked out of network to come in-network at a much lower cost.

And you know, last I checked, patients' premiums have not gone down, have not gone down. They have skyrocketed. And insurance companies' profits have absolutely skyrocketed. The folks in the middle are what is destroying American medicine. The doctor-patient no longer—taking care of the patient, it is the folks in the middle who are absolutely, absolutely extorting money off of the American patient.

I will just say this, and I will close. I am going to work on proposing legislation. Thirty days is fine, but when we put no teeth in that bill, that is going to add one percent compounded daily for insurance—to insurance companies who do not pay their claims on time. And I am happy to work with you all, but this is ridiculous. When you all don't pay claims eight months, nine months out, are you just waiting for the practices to go bankrupt? Because that is what is happening. I am happy to work with you all, but I am moving forward with this. Enough is enough is enough.

Thank you, Mr. Chairman. I will yield back.

Chairman SMITH. Ms. Tenney is recognized.

Ms. TENNEY. Thank you, Mr. Chairman and Ranking Member, and thank you to the witnesses for your work and for the insight that we have received here today.

It is hard to believe that just under three years ago we came together in a bipartisan way, bicameral way to come up with a No Surprises Act, groundbreaking legislation. And this legislation, as we all know, is intended to finally hold patients harmless for surprise medical bills and encourage payers and providers to come up to create larger networks.

Since then, as we—you have heard pointed out by many, we have had unelected bureaucrats really fail to comply with the language intent of the law, and this has diminished the achievement of the No Surprises Act.

And I just wanted to come up with a couple of—I have a couple of different things I wanted to bring, just some examples. And I wanted to cite one first, and then I want to get into questions to each one of the witnesses.

So my first example is in May of this year an air ambulance provider transported two twin infants from the same transferring hospital to the same receiving hospital. Each infant required its own ambulance, and each was delivered safely to the receiving hospital. I am told the same insurer provided the health insurance for each of these critically ill twin infants. The situation was identical: two transports of sibling infants with the same origin and the same destination and the same ambulance service. Yet the insurer applied two drastically different qualifying payment amounts, QPAs. One QPA was nearly $13,000 more than the other for the base rate, and greater than $100 more per mile traveled.

I am not sure who to direct this to, but I am thinking maybe, Mr. Bobeck, you could explain to us. How is this possible, that we

have this completely identical circumstance and the QPAs would be completely—would be—how can this be appropriate and compliant with our regulations under law?

And maybe just give us a quick explanation, because I want to ask Dr. Bleier about that, as well.

Mr. BOBECK. Thank you for the question. Respectfully, under the rules we are not allowed to even determine the QPA. We are only allowed to use the QPAs as given to us.

The IDRE's job is then to look at other evidence that would support whether or not—that the payment made in this case was correct or not. So respectfully, I would yield to the other parties on this, as we can only make decisions based upon the evidence that is presented to us in a particular case. Thank you.

Ms. TENNEY. Thank you.

Dr. Bleier, how does this happen with this? How can we—how do we fix this?

Dr. BLEIER. I——

Ms. TENNEY. It is a real injustice to our—to the people that we are trying to serve.

Dr. BLEIER. Yes, it is a horrible set of circumstances. I am sorry to hear. I have no explanation, because I also have no transparency, you know, no view into how that QPA is calculated. It is not——

Ms. TENNEY. How would we—maybe we could just pass this on.

How would we solve this problem, Ms. Spicer? I am going to ask you the next question. Similar issues with dispute resolution, but this is something that is really maybe a failure on the part of our—of CMS and our enforcement. And as Dr. Murphy alluded to and others, there is no teeth in this legislation to make sure this doesn't happen.

I don't know if you would have a——

Ms. SPICER. It is—I would also defer to others on the panel. I really—I am not privy to what information is submitted with that—with those claims to come up with two separate——

Ms. TENNEY. Let me—in reference—I have found it interesting that you mentioned in your recent discussion with one of my colleagues that you need a lawyer, basically, to deal with some of these issues. And I recently had an organization come to me with complaints that, despite the No Surprises Act, some insurance companies are continuing to apply entire balances to the patient's responsibility.

In one example, a family was billed for the full amount after the insurance company denied their providers—again, an infant situation, a neonatal critical care claim for their underweight newborn. I mean, how often do we see these illegal billing practices like this?

And if so, are you seeing any enforcement of it—referring again to there is no teeth in this, we need lawyers. I mean, I don't know if you——

Ms. SPICER. Yes. So in my experience—thank you for your question. In my experience, the bill comes directly from the provider to the family. The family doesn't understand why. And so then what I do in my practice is to get the—put the plan on the hook, make them aware that this bill is something that the consumer should be held harmless for, and that it falls under the No Surprises Act.

But if the consumer doesn't understand that there is even a protection in existence that they can take advantage of, they might pay that bill or go into debt for that bill. And then it is about really fighting with the insurer to make sure that the consumer is held harmless, filing grievances and complaints with the regulator.

Ms. TENNEY. Thank you.

I don't know if I have time for another question, but Dr. Bleier, in your testimony you outlined how some health insurances are using the No Surprises Act to finally—financially squeeze providers and, in some cases, drop them entirely and instead depend on the No Surprises Act IDR process. This leaves some patients with an insurance plan that does not have a network provider in their area, the opposite of the law's intended result.

And I believe I am out of time. You could either answer or maybe answer us online in another forum, it is up to the chairman. Just—I just want to—how does the lack of this local network, you know——

Chairman SMITH. Respond briefly.

Ms. TENNEY. Yes.

Dr. BLEIER. Ironically, when there is not enough resources in the community because of a narrow network, those patients end up coming to the emergency department. We take care of them. We take care of them no matter what. It is our duty, our Hippocratic Oath. It is part of EMTALA. So it increases—it drives the patients to the ED.

Ms. TENNEY. Thank you. My time is expired. I yield back. Thanks so much to the witnesses.

Chairman SMITH. Ms. Moore is recognized.

Ms. MOORE of Wisconsin. Thank you so much, Mr. Chairman, and I want to thank the witnesses for their patience.

I had a couple of questions that I wanted to ask. One of the things that really wasn't clear to me—and maybe Ms. Spicer, Mr. Budzinski, Mr. Bobeck, any of you might be able to answer—is there a particular pattern which will characterize those sort of claims that are disputed that fall through the dispute resolution process?

You know, all of you talk about the thousands and ten of thousands of transactions that come through. Is there a particular medical practice? Is it OB–GYN? Is it baby care, elder care? Is there a certain type of expenditure which might inform some sort of repair of the dispute resolution process, where you could start to say, "This is where it seems to be failing the most in terms of denials?"

Uh-oh. Wrong question, huh?

Ms. SPICER. Thank you for your question. I can say I haven't seen a pattern in my practice, but we are—our state doesn't use the same process for—before the NSA we had this baseball arbitration process, and it was all kinds of claims.

And to echo what members of the panel had said, what I would do in these sorts of scenarios was try to figure out first if it was even worth it for the patient to do IDR. Because if the patient was engaging in IDR, they would have to pay the fee unless they won. And so was—you know, there is kind of these baseline inquiries. Are you eligible? Does your bill count towards the surprise billing law? And then does it even make sense for you to file?

But I didn't necessarily—I would—people would get to me when they had really big bills, like surgery, for example. That is when you engage with a lawyer.

Mr. BOBECK. Congresswoman, thank you for the question. One pattern that we have noticed clear throughout the process is the more information that the parties have and that they share, the better the process becomes.

In the beginning of this process, when people submitted claims, only about 50 percent actually became eligible. That number for us right now is closer to 87 percent of these cases are eligible. And the ones that are not, that are determined ineligible, that is mainly because of information they did not have. If they are trying to put various claims together and then they miss a certain key piece of information with it, that claim will get kicked out. If they miss certain timelines that they were not aware of, that case will get kicked out.

And as I also mentioned before, if they try to submit a claim that is Medicare, something related to the VA or Medicaid, those cases also would get kicked out.

These are cases of misunderstanding of the process. People are getting better, and it is the one salient point we have seen through this process. The more people share and understand that information, the more seamless the process goes, and the better it works for everybody.

Ms. MOORE of Wisconsin. So maybe this is to Mr. Bobeck or someone else. You have talked about—and I think you, Ms. Spicer, talked about in New York that you would have as many as a million of these claims come through in a a month's or a week's time. Is there a plan, once the portal is open again, to do the huge backlog that will be there?

What do you anticipate in terms of the workload and the workforce after the portal is reopened?

Mr. BOBECK. Congressman, from our perspective—and the providers can certainly speak for themselves, and the payers, on how they initiate claims—from our perspective, we have been on hold now since August 3, 2023. We have a large staff that is standing ready. They are training, they are going to do everything possible to be ready, because we do know that there is going to be a large tsunami of cases that will be coming through that door.

For our staff, we have also made increased investments in our technology on our own case management systems to more seamlessly get through these cases whereby we will not have that backlog, cases will move forward. But we also have to move lockstep with the payers and providers because they are allowed 10 business days, or 2 weeks, to provide us their payments, to use the system, and at the same time provide us their offers. They are also going to need to be our partners in this in making sure we get that information seamlessly.

But from our perspective, we have people ready, waiting, and looking forward to starting this process sooner, because that backlog of new cases will only get worse the more this holds out. Thank you.

Ms. MOORE of Wisconsin. Anybody else with any? I got nine whole seconds left.

Mr. Chairman, I yield back.

Chairman SMITH. Mrs. Fischbach is recognized.

Mrs. FISCHBACH. Thank you, Mr. Chair.

And I think Mr. Kustoff asked maybe the doctor a little bit about, you know, if there is something Congress should do to help enforce payments once they are settled. But I wanted to ask Mr. Budzinski—I am sorry, I pronounce German names, but not—and Mr. Bobeck about if they have some input on that.

Mr. BUDZINSKI. Yes, thank you. It is Budzinski, and I appreciate your challenge.

With respect to what is the one root cause that is causing all these disputes, I think there is no question about it. The initial payment from the insurer to the provider is being set by the insurer, and it is being proven that the insurer is underpaying providers under the Act. And until that issue is resolved in some way, shape, or form, the process is going to continue to unfold, I believe, in a similar fashion.

Insurers no longer have a need to contract with emergency departments of hospitals or emergency physician groups because they can underpay, and it gets into this process, and then the disputes blossom. And now we have backlogs like this.

So the initial payment should be established with a minimum floor. That minimum floor should be consistent with out-of-network historical practices for payment or, frankly, insurance companies often have a secondary contract. They have a secondary contract with a third party that providers often do, as well. These are out-of-network service arrangements with discounts to providers. Insurance companies are ignoring those contracts, and they are simply paying the initial payment amount under the Act without regard to their access to another contract.

Mrs. FISCHBACH. Thank you very much.

Mr. Bobeck, do you have some input on that?

Mr. BOBECK. One thing we continue to repeat throughout this is that, ultimately, the more the parties have experience and expertise in submitting these claims, the better the process becomes.

We don't believe the answer is having more IDREs, because, ultimately, that would be bringing in more groups that don't understand the system and how the rules are put forth. You need groups who have the understanding and expertise to move forward and get these claims paid and adjudicated in a timely manner. That is where all of our people over the last year have spent their time.

We are referees. We do not come up with the rules, but we are the ones to enforce the rules, and that is ultimately the process that we move forward on best. And we have noticed when people understand the rules, it makes it a lot easier for us to make the decision. Thank you.

Mrs. FISCHBACH. Do you think there is room for more enforcement? Should Congress be acting on something?

Mr. BOBECK. One of the pleasures of being the referees is we are not allowed to comment upon the rules. [Laughter.]

Mr. BOBECK. But we may not be able to define the strike zone, but I assure you we will call the balls and strikes as you give it to us. Thank you.

Mrs. FISCHBACH. Thank you very much, and you are very diplomatic.

Voice. I can explain the sports references.

Mrs. FISCHBACH. Oh, he—my good friend is going to explain the sports references to me.

But—and maybe what I should do is ask if there is anyone else on the panel who would like to comment on that.

And I don't see any. Oh, here we go. Ms. Thornton.

Ms. THORNTON. I just wanted to respond to the question that—or the comment that we are making artificially low payments as our QPA. You know, the regulations have, and the—your legislation had pages and pages of very detailed information that we have to abide by when we calculate those QPAs, which are based on actual contracts between providers and plans. So I just wanted to emphasize that we are following those regulations when we are calculating that, and we are following it by the line.

Mrs. FISCHBACH. Okay, thank you.

Since I don't see any other volunteers, I will yield back, Mr. Chair.

Chairman SMITH. Mr. Fitzpatrick is recognized.

Mr. FITZPATRICK. Thank you, Chairman. Thank you for holding this hearing.

The No Surprises Act was signed into law, as we all know, back on December 27, 2020 to protect patients against surprise medical billing. However, the law has not been fully and correctly implemented in the way that this Congress has intended it to be. And as a result, patients are hurting in my district and districts across America.

Emergency departments' wait times have more than doubled since this law's passage in 2020. I personally have many hospitals in my district that have reached out to our office about the influx of people and increased wait times in their emergency departments, resulting in overworked hospital staff and patients, literally, being left in hallways.

Studies have suggested that 20 percent of emergency department visits and 10 percent of elective inpatient care stays involved at least one out-of-network provider.

I want to thank our witnesses for being here today to provide us with your firsthand knowledge and your experiences on how this law was implemented and is being carried out.

First to you, Ms. Spicer, the No Surprises Act, obviously, was intended to give patients peace of mind that they would not receive surprise medical bills weeks or months after what they thought was a covered in-network service. Due to your interfacing with patients every day, can you speak to what has changed for patients since the enactment of the law, and what outstanding concerns you continue to hear from patients today?

Ms. SPICER. Yes, thank you for your question.

What has changed for patients? They—obviously, in our state, in New York, we had a surprise billing law before the NSA. So what—I see the change is that now federally-regulated consumers are protected from surprise and emergency service bills.

What is outstanding for consumers is—which are complaints that I normally get, are grounds ambulance, post-ER visits to out-of-network doctors who provided the ER service.

And one of the things that we do most is just to counsel people on what the law means for them, and how it can help them, and how to engage in the process. When a mistake is made and they are not held harmless, or when they receive a bill, usually those two things go hand in hand.

Mr. FITZPATRICK. Mr. Budzinski, what is your perspective, from the hospital standpoint, your concerns about implementation, and what are some of the solutions you think would address that?

Mr. BUDZINSKI. Thank you, Representative. I need to ask you if you want the whole list, or just the top 10.

Mr. FITZPATRICK. You can start with the top several. How is that?

Mr. BUDZINSKI. Very good.

Number one, as I said several times today, the reason there are disputes is because the insurance company is in charge of making the initial payment amount to providers. There is no regulation that currently specifies what that amount needs to be. There is confusion about that in some of the administrative rules that have come out and that have been addressed through other processes where the QPA might be the correct initial payment amount, but there is no—it was not the intent of Congress to establish that.

But unfortunately, we believe that the insurance companies are now driving a big truck through that loophole and are establishing initial payment rates that are very low, creating disputes and that what we have heard today is that, when the dispute is listened to by the independent person, the independent entity, 70 percent of the time the providers are right that they were under-paid. And this is when the deck has been stacked against providers in the administrative rules.

So that is number one: initial payment amounts are being set by an organization whose benefit is to set them as low as possible. There needs to be a minimum established amount consistent with what out-of-network payment rates used to be prior to the legislation or, at a bare minimum, insurance companies should be required to access all their contractual agreements for specified discounts, and not ignore those contracts.

In addition to that batching was mentioned earlier. Batching needs to be revised, there is no question about that, and the bundling of services. Hospitals in particular are typically provide—paid on bundled arrangements. In an inpatient setting, that is what is called a diagnosis-related group case rate. Most of the time, in outpatient ER settings, those are called ER case rates. In addition to that, observation care that sometimes follows up on emergency care is often reimbursed on a case rate. We believe that the bundling of those types of things, consistent with how hospitals are typically paid, is the right answer, as opposed to every line on a bill having to be adjudicated through the process.

By the way, what that does, from a provider perspective, if we can—if we send in one dispute for an ER service, an ER visit, that is one administrative fee. If we have to go through four or five or

six CPT codes on an ER bill, each one of them become, in effect, an administrative dispute with payment.

So batching administrative fee refinement, we believe that the loser should pay all administrative fees, quite frankly.

Those are just the top few.

Mr. FITZPATRICK. Thank you, Mr. Budzinski.

Ms. Thornton, I was going to ask you about the insurance perspective, but my time is over-expired.

So Mr. Chairman, I yield back. We will take that for the record, that question. Thank you.

Chairman SMITH. Thank you. Mr. Beyer is recognized.

Mr. BEYER. Thank you, Mr. Chairman. Mr. Chairman, Ranking Member Neal, thank you for holding this hearing. Incredibly essential.

Mr. Budzinski, you just repeated something that was in Ms. Thornton's testimony about 71 percent of the disputes that reached determination favored the health care providers in the area and suppliers. But you have also said that the law was never intended to pick winners and losers, and that the health insurance companies are winning overwhelmingly. Can you explain the arbitrariness of the process, and how we can make it less arbitrary?

Mr. BUDZINSKI. Yes, thank you, Congressman.

I am going to come back to the law was never intended to pick winners and losers. But inside the framework the initial payments paid by insurance companies are unregulated, unspecified. And that process has created a situation where ER physician groups, emergency rooms of hospitals are being underpaid initially. And through that process, it only leads to dispute. And so this——

Mr. BEYER. So let me follow up on that because Ms. Thornton, again, said thatthey estimated 17,000 claims and said they had 334,000. Are you suggesting that the insurance companies, by intentionally under-paying, are creating an IDR process? You know, creating the surprise billing complaint appeal in the first place?

Mr. BUDZINSKI. That is the belief of our organization. Yes, sir.

Mr. BEYER. Okay. Dr. Bleier, again, leveraging off Ms. Thornton's testimony, she pointed out that there is only a handful of companies, a handful of states that are filing all these claims. You know, 60 percent of the claims from 5 states. All the numbers are in her testimony. How do you respond to that, that this is not just a handful of emergency room practices that have figured out how to game the system?

Dr. BLEIER. It is hard for me to say what the intent of anyone else's business is. I can tell you from our perspective, and I suspect by extension a lot of other independent ER groups as well, emergency medicine groups out there, I think the number of arbitration cases—I believe you cited roughly over 300,000——

Mr. BEYER. Yes.

Dr. BLEIER [continuing]. Would be far, far higher if we felt that the arbitration process was working more efficiently.

We have only submitted 400 claims, and it is largely because the process hasn't worked up until now the way we would like. And yet we have, you know, institutional damage, so to speak, because the loss of revenue that we have experienced because of those underpayments up front, we can't get that back. There is no process. Un-

fortunately, with the Texas Medical Association lawsuit rulings, they didn't allow for us to submit claims, for example, at lower IDR fees going back to the beginning of this year. That was not part of the ruling.

So—but I can't speak to why other groups are submitting claims to the—you know, through the arbitration process.

Mr. BEYER. Okay.

Dr. BLEIER. But I can tell you our—that has been our experience.

Mr. BEYER. Yes. Mr. Budzinski, Mr. Bobeck mentioned that all they do is apply the QPA. They have nothing to do with it. You complain in your testimony about the cloak of secrecy that QPA has. Where does the QPA come from, and how transparent should it be?

Mr. BUDZINSKI. Yes, so there is a couple of things.

First of all, we actually have had a number of our requests for determinations with Mr. Bobeck's company. And let me just say for the record their organization is one of the most transparent and engaged IDR Entities that we have come in contact with. So, from our perspective, we understand their role as a referee, as an arbiter of the facts.

With respect to the QPA, the QPA is there, I believe, in the legislation to protect the consumer. The QPA was not established as the correct payment rate for a provider.

Now, I will tell you we don't really understand how QPAs are calculated, nor do we ever receive calculations of what QPAs are. But relative to payment to providers, it has not been established that a QPA is the correct payment for providers. And in fact, we believe in most situations that is not the correct payment to providers, and our determination requests reflect that.

Mr. BEYER. Okay, thank you.

Mr. Chair, I yield back.

Chairman SMITH. Mr. Moore is recognized.

Mr. MOORE of Utah. Thank you, Chairman, and I would like to thank the chairman and the ranking member for holding this hearing today.

We—let's take a quick moment of pause to just recognize what we are doing. We passed something. It has created some good for many patients, and we are now reflecting on it. We are identifying the challenges of the implementation of it, and we are trying to make improvements on it. Any time you give me a chance to do that, I will be ready to do whatever work is necessary. So thanks for moving the ball forward on this, and for having us be able to discuss it today.

I am going to talk a little bit most mostly about the Independent Dispute Resolution, so the IDR process, because this implementation of this has not been without its challenges, and there has been periodic pauses from this IDR process, and it required that several regulations be rewritten as agency officials strayed from congressional intent in implementing the law.

So today I would like to focus on how this ever-changing regulatory landscape creates a lack of clarity for parties resolving claims in the IDR process. And so I would love to hear from the

witnesses on this particular issue, how has it affected your operations.

Mr. Bobeck, as you note in your testimony, over the last two years, as HHS, Treasury, and Labor have implemented regulations for the No Surprises Act, the IDR process has periodically been suspended. This prevents new cases from being initiated through the Federal IDR portal, and prevents IDR entities from adjudicating disputes between providers and health plans. Can you speak to the operational challenges that the—or stop-and-go implementation of this law has had, particularly on IDR entities?

Mr. BOBECK. Congressman, thank you very much for the question.

From the IDRE perspective, the biggest thing that happens with the start-and-stop nature of the process is essentially that you need to be able to staff up for a process that you are never quite sure when it is going to begin again and then also have a staff that is ready to handle a tsunami surge of cases when it starts back up again.

So the biggest thing we have to look for in all of our staff is, are you prepared for flexibility? And this process is only going on for one year. So, if you were to look for experts in the IDRE reprocess over one year, you will not find them.

Mr. MOORE of Utah. Right.

Mr. BOBECK. So the people that we have on staff, we need to maintain them, even if they don't have anything to do. We are maintaining them for their expertise and their knowledge. That does create costs, obviously, for the IDREs as we move forward.

But as noted, again, this process is still in its infancy. It is moving forward. We have seen the benefits of cases moving through the system, payment determinations being made, and we know that it is a great responsibility for our job to make sure that all the parties, payers, and providers can have their job done to help consumers. So we are ready to stand by, and whatever challenges we face we feel are much smaller compared to what the providers and the payers have to work through, and then their patients.

Mr. MOORE of Utah. Backlogs. Can you speak to—a little bit to the backlogs in particular?

You know, you have generally addressed it, you have talked about a year timeline only. But specifically backlogs, how has complying with this sort of changing regulatory landscape affected that?

Mr. BOBECK. When it comes to the backlogs right now, when the parties ultimately are going to start submitting all their cases again, the timeline is still—for us, is still going to be clear. The moment that we receive a case, we only have 30 business days to make an ultimate decision on it. When you have an increased number of cases, it does put more impetus on having a staff that is cost effective and streamlined, that they will be able to handle that.

And again, we can only speak for ourselves. Yes, there are other—12 other IDREs within this process, and ultimately some of them are working through some of their older cases that they have. But with that being said, for us the only thing you can do is continually have a staff that is ready to move through those cases because, for us, timelines are non-negotiable; you have to do them.

Mr. MOORE of Utah. Dr. Bleier—and I would welcome comments from Mr. Budzinski, as well—I have heard that small and independent practices in Utah—I represent Utah—have negatively impacted—they have been negatively impacted by the IDR process, including from the dispute resolution backlog, as I mentioned, and the 600 percent increase in IDR fees.

Well, these fees—this fee increase was reversed. Could you speak to the operational challenges of this stop-and-go implementation on provider practices as well as what financial impact the IDR backlog has on providers?

Dr. BLEIER. For a relatively small group like ours, it really cripples our operations to a significant extent. You know, we don't have the bandwidth or capacity to—you know, when we are receiving 70 percent less than our prior longstanding in-network contracted rates, to submit a payment for $350, $350, let alone $50, right?

And in addition to that, we have been effectively excluded from the IDR process due to all of the things that we have discussed today, right?

The—initially, the way that the QPA was given unfair weighting, the backlog, the fact that even when we do submit and win a case we are not reimbursed, so that really affects our ability to provide the resources that we want and towards effective provider and patient care at the bedside—I should say patient care at the bedside by our providers.

Mr. MOORE of Utah. Any final comments? Maybe even has it affected rural patients?

Dr. BLEIER. There is no question that when resources are reduced, it is going to affect the capability of providers to provide care in the communities they serve.

Mr. MOORE of Utah. Thank you. Thank you all. I appreciate it.

Chairman SMITH. Ms. Van Duyne is recognized.

Ms. VAN DUYNE. Thank you very much, Mr. Chairman, and thank you to our witnesses for coming to today's hearing.

In August, I was able to gather with health care leaders from across Texas. And during this meeting I heard over and over how unelected bureaucrats are failing to comply with the No Surprises Act. And while this is not surprising, and frustrating for everyone involved, it is the patients stuck in the middle that are hurt the most.

And I am glad to see that we are holding this hearing, with my state leading the most amount of disputes, and in Q4 of 2020, with a total of 25,277 disputes according to CMS reports, further adding to the nearly 250,000 unresolved payment disputes that are currently clogging the IDR backlog.

And, while I am also glad to see that my state's medical association currently challenging in court—and I do want to associate myself with my colleague, doctor and congressman Greg Murphy, in his comments lauding TMS—it is—based on these decisions, it is apparent that the CMS bureaucrats have elected to go around the intent of Congress and make unilateral decisions on what they think would be best, causing patients to lose care and trust in their providers.

Every day that passes with the NSA and IDR portal that remains closed, it pushes medical practices across America closer and

closer to insolvency. If the tri-departments keep the portal closed for an extended period, potentially up to six months, the consequences could be catastrophic. And such a prolonged exposure could disrupt emergency medical services disproportionately in the State of Texas, my state, putting patients at risk and further straining the health care system.

And it is not just this committee that is dealing with this. We are looking at CMS in—changing its intent, hurting a number of private practices, small group practices, increasing costs, decreasing quality of care. This is a problem, and we need to figure out—there is a lot of solutions to it. Getting this Administration to actually put forward those solutions and getting CMS to actually do its job is another challenge.

But Mr. Bobeck, I really appreciate your comments dealing with the IDR and some of the problems that they are facing there. But, in your testimony, you talked about batching and how that led to roughly 40,000 cases deemed ineligible due to current batching rules. In your opinion, should CMS consider revising the batching criteria to be more closely aligned with what Congress intended?

Mr. BOBECK. Congresswoman, thank you for the question. On particular with regards to batching, it doesn't totally represent all the 40 cases—40,000 cases ineligible, but does represent a substantial portion.

The feedback that we provided CMS ultimately when it comes to episode of care and finding different ways to batch is primarily what we hear from both the payers and providers which more closely align to their billing practices. And we believe the more in line you make practices, dispute resolution process with billing, you will get better results, and the parties will much more understand the process and they will come to much more resolutions, as well.

Ms. VAN DUYNE. I appreciate that. When Congress drafted the No Surprises Act, this committee was very specific about what criteria should be used in IDR to settle the payment dispute. And this is something back in my home state of Texas that the Texas Medical Association has consistently advocated for.

My question, Mr. Bobeck, is before the IDR process was halted, what criteria were used—were you using to determine a case?

Mr. BOBECK. Congressman, do you mean before the Act's implementation, or the new court cases as they were going forward?

Ms. VAN DUYNE. The new court cases in which IDR actually closed the portal.

Mr. BOBECK. From the beginning of the process, the Act itself outlined very clearly the factors that had to be represented, one of which was the QPA, and the number two was what they called additional information. Additional information included various aspects, one of which was previous contracted rates over the last four years, the market share of both the payer or the provider, patient acuity of how they presented in a particular facility, the teaching status of that provider facility, the level of training, and, obviously, as we already mentioned, the QPA.

Initially, when it came out, the rules written by CMS required that you look at the QPA first, as the first aspect of it, and then you would look at the other factors to see if there was some type of rebuttable presumption, if you will, upon the QPA.

The court cases that came out in February made it very clear to the arbitrators that you were to look at all of these factors together equally. The weight that you give them is ultimately up to the arbitrator in that particular aspect. And so with those changes that come through the court cases, and then obviously the CMS rules, we have adjusted how we have to review those cases because that is the rules which we were given.

Ms. VAN DUYNE. Dr. Bleier, real fast, would you say that this weight on the median in-network rate represents the unique circumstances of a case?

Dr. BLEIER. If you are asking me if I think the QPA should be overweight, the answer is no.

Ms. VAN DUYNE. All right. Thank you very much.

Dr. BLEIER. Thank you.

Ms. VAN DUYNE. And I yield back.

Chairman SMITH. Mr. Kildee is recognized.

Mr. KILDEE. Thank you, Mr. Chairman, for recognizing me and for holding this hearing. It is a very important subject.

I share the views expressed by some of my colleagues, and my questions might be a little redundant. But as you can see, we sort of come and go, and I may have missed some of the answers.

But as the ranking member, Mr. Neal, said, we knew with pretty good clarity what we were trying to produce when we put together this legislation. And it is something that was a bipartisan product, something that doesn't happen often enough around here. And it is something that we, you know, take a great deal of pride in. So it is a cause of a lot of frustration for us to not see the legislation being implemented consistent with what we know was, in fact, our legislative intent and what we actually think the legislation does a pretty good job of articulating. We want to see that adhered to.

But if I could pose a couple of questions, one to Dr. Bleier and then another to Ms. Spicer, and you may have answered this before, but if you could just elucidate me on this subject a bit further.

One of the obviously challenging areas that we are seeing with No Surprises Act is the rising reports of terminated in-network contracts. And Dr. Bleier, you made mention of that. It obviously is a problem in terms of contributing to the challenges that we face in terms of trying to adjudicate these disputes.

But it also would seem to me that it would have an effect on overall health care costs generally. And I wonder if you might comment on the extent to which you are seeing this, and how it is playing out in the field.

And then, Ms. Spicer, more generally, I wonder if you have suggestions as to what the Administration might do, or what Congress may have to do to ensure that as we implement, we are not seeing a narrowing of providers that really does create a threat to patient care.

So, starting with Dr. Bleier, if you could comment, and then Ms. Spicer.

Dr. BLEIER. Sure. You know, as I stated earlier, I appreciate the question.

There wasn't—we didn't have an out-of-network issue before the NSA. We were in network with all of the major carriers, and that was always our strategy. We don't want to have patients in the

middle. We want to leave patients out of the middle during their most vulnerable times in their lives and their family's lives often times. And most of our contracts go back up to a decade or more.

And we certainly didn't ask for any rate changes, despite there being no inflationary clauses, despite the transfer of a lot of responsibility to the patients as far as high deductible plans go. And the insurers didn't ask for rate changes, either. There was—most of those contracts were on evergreen, yearly renewals, and they signed them without question, until the NSA.

Then the NSA comes out and, surprisingly enough, we really didn't think we would be affected by this very reasonable, well-crafted, bipartisan piece of legislation because we weren't out of network with anyone. We weren't part of this, you know, reported issue. But nonetheless, because of the NSA, ironically, we have then been kicked out of network by a couple of payers, and by a third payer as well, threatened, but thankfully, you know, did not actually ended up kicking us out of network.

Mr. KILDEE. So just out of curiosity, ostensibly, what is the justification that is being offered for that, for taking that step?

I mean, I understand what the reasoning might be behind the wall, but what is offered as the justification?

Dr. BLEIER. There is no justification that I am aware of. It is a, you know, 40 percent-plus reduction in reimbursement if you want to stay in network.

Mr. KILDEE. Right.

Dr. BLEIER. And sometimes it is much less. And then, once we are out of network, it is a 70 percent reduction in the upfront payment. And then there is an IDR process which we can't really access and take advantage of.

So it is an inherent—becomes a permanent loss of resources for our group to use towards patient care.

Mr. KILDEE. Right. Ms. Spicer. Thank you, Doctor.

Ms. Spicer.

Ms. SPICER. Thank you for your question.

In New York State, we have state laws that require robust provider networks. So I would suggest Federal laws are less robust in that area. So I would suggest network adequacy protections in the form—in that form.

And also, one thing that advocates in New York State bring to our regulators often is surveillance of those networks. Sometimes consumers complain of ghost networks. And, of course, we still see misinformation regarding networks. And I would advise surveillance of networks to ensure that the networks are as robust as possible.

Mr. KILDEE. Thank you for that, and I want to thank the panel for your contributions to this conversation.

I want to thank the chair for holding this hearing. It is so rare that we come together. We should do more of this, we should come together around a really difficult issue and find a bipartisan solution. And it is my hope that folks down the other end of the street are listening to this, and will work with us to make sure that the law is being implemented in the way it was intended.

With that, thank you, Mr. Chairman. I yield back.

Chairman SMITH. Thank you. Mr. Smucker is recognized.

Mr. SMUCKER. Thank you, Mr. Chairman, for yielding and for holding this important hearing today. And I think, as Mr. Kildee just said, you are hearing almost unanimously the view of members of this committee and from both sides of the aisle.

This is an issue that—there was considerable work done back in 2020. You know, we all want to ensure that our constituents have access to quality health care, they have access to the care that they need and at a price that they can afford. We want them to understand the costs. And then we don't want them to be surprised with large bills that they weren't expecting. And so it is—we are all frustrated that this hasn't been carried out in the way that was anticipated when this bill was passed.

And I am—again, I don't know that I have a lot more to add to this discussion other than what has already been discussed, but I represent an area in southeastern Pennsylvania, the 11th district in Pennsylvania, that has, you know, some large rural areas. And I am concerned about care being accessible there, and I am concerned about the impacts of this not being carried out properly, and how that impacts us.

And I think, Dr. Bleier, you—I may ask you to expand on this, although you have you have sort of just addressed the question. But, you know, you have said, I think, 52 percent of claims are not even paid. And you testified that there is not even a clear mechanism right now to ensure that there is a way to force that payment to come. So it has got to have an impact on hospitals and providers' ability to carry out care.

And so, again, as I said, I am concerned that—the impact this will have on patients who need to rely on your systems for their care. So I don't know if you want to expand on that at all. Have you had to alter or eliminate services? Do you know of other providers who have had to do that because you are being compensated at a slimmer margins than you should be, otherwise?

Dr. BLEIER. I would hazard a guess that there are many groups out there that have had to do that, but I can't say for certain.

As far as our group goes, you know, we are really trying to have a more medium sort of term view of this situation in the sense that we have—although our revenue has been slashed because of what has occurred, I think the owners of our group who all work in our emergency departments every month have taken the brunt of it. And we have tried to shield our nurse practitioners and physicians' assistants and other providers and administrative staff from that. But it can only go on for so long.

And we are very hopeful, very hopeful, fingers crossed, that these Texas Medical Association lawsuits will actually bear fruit, that the regulation of this bipartisan piece of legislation will be implemented consistent with the intent of the law. And, if that happens, I am hopeful that, you know, we will be able to continue to provide the level of resources that we want to—all of our patients, including those, you know, generally under-resourced communities within our state.

Having said that, though, if this continues, I don't see any way we can continue the level of care that we currently are providing. It absolutely will, for our group, lead to, unfortunately, reduction in hours, staffing hours, potentially reduction of positions entirely.

It may even lead to us having to withdraw, unfortunately, from certain contracts where, you know, it is not sustainable. That undue pressure with that razor-thin margin is just too much.

Mr. SMUCKER. So I think you have just articulated why this issue is important and why it is important we get this resolved as quickly as we can, why it should be implemented in the way that was intended. This will affect—and potentially is already affecting—individuals who need care who may not be able to access care because this issue is being carried out in a far different way than what was intended.

So with that, I yield back. Thank you, Mr. Chairman.

Chairman SMITH. Mr. Hern is recognized.

Mr. HERN. I thank the chairman and the ranking member for hosting this bipartisan oversight hearing on surprise billing legislation.

Almost three years ago, Congress passed the No Surprise Act to protect patients from surprise medical bills. Before this law you would hear stories of a patient being rushed to the hospital for an emergency, and then surprised with an out-of-network charge. With the passage of this law we are seeing the private market work to negotiate claims and leave the patient harmless.

I am proud I voted to support the No Surprises Act to end balanced billing and root out fraud in the system. Today I want to highlight another key provision in the No Surprise Act, the Advanced Explanation of Benefit tool, or the AEOB. The AEOBs are patient price estimator tools that empower consumers to shop for their health services by letting patients know the cost before—before—they get care.

This Congress is focusing on building out transparency data. Still, until this information is personalized and considers the patient's health insurance coverage, this data is meaningless for everyday Americans. That is why it is so—why I am so disappointed this Administration is dragging its feet to implement the patient price estimator tools price required by the No Surprises Act.

This committee has sent two bipartisan letters inquiring into the continued delays in providing patients with these tools. Mr. Chairman, I would like to insert for the record these two letters from the Ways and Means Committee to HHS inquiring about the delayed implementation of the AEOB.

Chairman Smith. Without objection.

[The information follows:]

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, D.C 20515-0348
http://waysandmeans.house.gov

October 4, 2021

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

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

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

Re: Implementation of the No Surprises Act

Dear Secretaries Becerra, Yellen, and Walsh:

We write regarding our concerns with respect to the implementation of the historic and bipartisan No Surprises Act by your Departments. We are concerned that the regulation published on September 30, 2021, as well as the decision to delay full implementation of the Advanced Explanation of Benefits (AEOB) and other patient protections, do not reflect the law that Congress passed. While this law represents one of the greatest consumer protection reforms in American history, its success depends on your Departments fulfilling Congressional intent and swiftly implementing all necessary provisions.

For far too long, patients received devastating surprise out-of-network medical bills and suffered from a lack of price transparency. Payers and providers put patients in the middle of their payment disputes. They kept patients in the dark about the cost of their care, then saddled them with insurmountable and unexpected charges. Congress stepped in to protect patients by ending the practice of surprise medical billing. In so doing, Congress sought to promote fairness in payment disputes between insurers and providers—carefully specifying all the various factors that should be considered during the independent dispute resolution (IDR) process. Your

Departments are also charged with ensuring that payers and providers work together to provide patients with transparent information that includes the patients' costs and the network status of their providers in the form of an AEOB.

The IDR process was subject to extensive Congressional consideration for nearly two years prior to the enactment of the No Surprises Act. The law incentivizes insurers and providers to act in good faith and resolve disputes amongst themselves while also recognizing that the parties may be unable to resolve their differences in certain instances. As a result, the 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. Such factors include median in-network rates, prior contracted rates during the previous four plan years, the relative market share of both parties involved, the provider's training and experience, the patient's acuity, the complexity of furnishing the item or service, and in the case of a provider that is a facility, its teaching status, case mix and scope of services, demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement, and other items. Congress deliberately crafted the law to avoid any one factor tipping the scales during the IDR process.

As you know, the Committees of jurisdiction worked through multiple proposals to end surprise billing throughout the 116th Congress. 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—that is the express result of substantial negotiation and deliberation among those Committees of jurisdiction, and reflects Congress's intent to design an IDR process that does not become a de facto benchmark.

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.

In addition, we are concerned by the Administration's decision to delay the implementation of certain key transparency provisions slated to take effect on January 1, 2022. In guidance from August 2021, the Centers for Medicare and Medicaid Services delayed the compliance date for when consumers should receive a good faith estimate of the cost of services

through an AEOB despite the date specified by Congress. We are concerned that without a strict implementation deadline, payers and providers will not work toward expanding the current data transfer technology framework to ensure full compliance with the law. This provision was enacted to bring unprecedented transparency to patients about the cost of their health care, and delaying its implementation will leave patients vulnerable.

We understand that implementing the No Surprises Act to end the practice of surprise medical billing in a year is no small task, and that complexities exist as your individual Departments work together, but we must remain steadfast in ending this predatory practice. We request a written follow-up explaining how the regulation issued last week establishing the IDR process and designing a new test for how factors should be considered comports with the law Congress enacted. We are also requesting a timeline for full implementation that declares interim plans to build on current technology available to allow for implementation of these patient protections, specifically the AEOB and true and honest cost estimate, as soon as practicable. Finally, we ask that you revisit this interim final rule and consider adjustments that better align with the law Congress enacted.

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means

Kevin Brady
Ranking Member
Committee on Ways and Means

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

November 18, 2022

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

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

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

Re: Implementation of the No Surprises Act

Dear Secretaries Becerra, Yellen, and Walsh:

We write to express serious concerns regarding your Departments' latest efforts to implement the bipartisan *No Surprises Act*. The final regulation, published on August 26, 2022, follows neither the letter nor the intent of the law. The statutory text of the law was unambiguous – as was guidance in a federal judge's ruling that struck down aspects of the previous interim final rule. Thus, we implore you to take swift action to remedy the latest rule.

In developing this historic and bipartisan consumer protection reform, Congress spent years seeking to protect patients and carefully construct parameters related to the independent dispute resolution (IDR) process so that it did not tip the scales toward either the health plans or providers involved in these disputes. That is why Congress intentionally required arbiters to *equally consider* a series of factors for their decision-making process. Although the qualifying payment amount (QPA) is an important factor, the statute lists the QPA as one of many factors an IDR entity must consider without giving preference or outsized weight to any one factor.

We wrote to you in October 2021 and again in March of this year expressing our concerns with how the 2021 interim final rules prioritized the QPA as the main factor for IDR entities to consider. A bipartisan group of 152 Members of Congress also wrote to the Departments in November 2021 expressing similar concerns. We are disappointed to have to write you again in response to the Departments' continued decision to flout the text of the statute in their August 2022 final rule.

Despite a federal district court correctly ruling that aspects of the interim final regulation were flawed in its implementation of the IDR requirements, we are severely disappointed to find that the August 2022 final rule violates the No Surprises Act in the same ways as before. Although the final rule makes some limited progress by no longer designating an unlawful "rebuttable presumption" towards the QPA as the interim final rule did (which a federal district court properly invalidated), we find that the new instruction to IDR entities largely would have the same effect.

In the new final rule, the Departments created a new "double counting" test that has no basis in the statutory text, directing IDR entities to "consider whether the additional information is already accounted for in the QPA." Further, the rule states that the IDR entities "should not give weight to information related to a factor if the certified IDR entity determines the information was already accounted for in the calculation of the QPA." As written, this perpetuates the flaws of the interim final rules and continues to unfaithfully implement the statutory text and intent of the law by skewing the determination of the IDR process toward the QPA. Even though the *No Surprises Act* explicitly requires an IDR entity to separately consider *all* of the statutory factors, the final rule precludes IDR entities from giving weight to factors like patient acuity and the complexity of furnishing the item or service at issue unless providers meet the heightened burden of disproving double-counting within the QPA.

Additionally, the market share of the entities in question, for example, may be a significant factor that should inform the IDR entity's decision, but it may also be a variable in the calculation of the QPA and, thus, could fail the "double counting" test. Disregarding this factor because of the "double counting" test goes against the law's intent for IDR entities to correct monopolistic pricing by either party. Moreover, this "double counting" instruction fails to acknowledge that the calculation methodologies for QPAs are a complete mystery to all but the plans and issuers. Neither the providers nor the IDR entity can intelligently evaluate the QPA to determine whether other factors are already accounted for, and, as a result, providers cannot prudently submit information that rebuts assertions of double-counting in the QPA.

Furthermore, although the final rule acknowledges the flaw in the interim final rule that forced the IDR entity to provide a rationale in its written decision only when it selects a final rate that was materially different from the QPA, we are concerned that the final rule perpetuates this same error. Immediately after directing the IDR entity to provide a written decision with a comprehensive rationale, the final rule still instructs IDR entities to provide additional information as to why the arbiter concluded that the QPA did not already capture other factors that informed the final decision. By contrast, there is no such burden if the IDR entity concludes that the other statutory factors are accounted for in the QPA.

Finally, we wish to express our concerns regarding the slow implementation of the Advanced Explanation of Benefits (AEOB) provision included in the *No Surprises Act*. The law instructed the Departments to finalize rulemaking to implement the AEOB by plan years beginning on or after January 1, 2022. Despite this mandate, the Departments only recently issued a Request for Information regarding the AEOB's implementation on September 16, 2022 – a full eight months after the provision should have been in effect. We are concerned that now, implementation will be delayed further into 2024 at the earliest. Patients deserve access to the

unprecedented and revolutionary transparency the *No Surprises Act* provided. We urge you to accelerate your implementation of this provision in accordance with the law.

We understand and applaud the substantial work the Departments have put into implementing the *No Surprises Act* and its transformative consumer protections. Millions of Americans have already immensely benefited from the new protections and many more are relieved by the elimination of the predatory practice of surprise medical billing. However, we are deeply concerned that the latest regulations continue to deviate from the statute and Congressional intent. We ask that you swiftly revisit portions of the August 2022 final rule to ensure it aligns with the law as written and take immediate steps to make the law's transparency provisions a reality for patients.

Thank you for your consideration.

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means

Kevin Brady
Ranking Member
Committee on Ways and Means

Mr. HERN. Thank you. Yet we have to get a clear answer about when we will see full implementation of this provision.

Fortunately, innovators in my home state of Oklahoma are working to ensure Americans can navigate the opaque health care system. For example, Medefy Health in Oklahoma partners with over 1,500 employers to provide approximately 300,000 members' access to personalized cost estimates within the provider selection process. Consistently, this tool delivers significant health care cost savings to patients and the small business owners administering their health insurance. It is an absolute failure of this Administration to delay implementation of this technology elsewhere.

Considering Americans' families' current economic struggles, anything to help with financial planning should be a priority. Knowing how much health services will cost removes some anxiety patients face when seeking medical care. Patients are nervous about their test results. There is no reason for the added anxiety of not knowing how much a service will cost them.

Ms. Spicer, in your testimony you mentioned the importance of consumer protections and the shared story of a parent—a patient who was not given an advance estimate of the cost of this procedure. The patient received his explanation of benefits from his insurance company after the procedure, and therefore had no idea how much surgery—this surgery would cost in advance.

Ms. Spicer, every day Americans shop for goods and services and know the costs in advance. Can you speak to the positive impact an Advanced Explanation of Benefits would have on patients?

Ms. SPICER. Yes, thank you for your question.

The Advanced Explanation of Benefits is a—would be a hugely positive tool for consumers to understand health care costs associated with the services they want in advance of getting those services. It would give them the ability to make informed decisions, considering their bank accounts and their, you know, other kinds of choices that they have in their health care before they incur these crushing—potentially crushing medical bills.

In one of the examples in my testimony, I talk about the notice of consent waiver that is required for each—for—when you go to a practice, each patient gets a notice of consent waiver, and that will tell you if there is out-of-network providers potentially involved in your care. But it doesn't end that you may have out-of-network costs because of that, but it doesn't give you any specifics about those costs.

It is also bundled with a bunch of papers that you sign automatically, that you have to sign to walk through the door, like the HIPAA release and the consent form, other consent forms. So it really—what is in place now doesn't necessarily give all that transparency and that information in order for consumers to make an informed decision.

I would say that even the Advanced Explanation of Benefits form, consumers are going to need help understanding what it is because it is going to be complicated.

Mr. HERN. I thank the chairman and the ranking member for working with us in a bipartisan way to make this happen.

There is nothing in America that consumers purchase that they don't know what it is before the price of it, before they pay for it,

except for their health care. It is time for us to get this resolved and fix this issue once and for all for the American people.

Thank you, and I yield back.

Chairman SMITH. Mr. Evans is recognized.

Mr. EVANS. Thank you, Mr. Chairman. I want to thank the Ranking Member Neal for all his work on surprise billing over the years to help our constituents.

Providing access to price information is important to Pennsylvania hospitals. In Pennsylvania, every hospital has a patient advocate for financial counsel. The individual is available to discuss pricing with everyone to clarify costs. Ms. Spicer, in your experience, how helpful would it be for the patients to have this kind of information to clarify costs when they leave the hospital?

Is there other information that you think would be important for hospitals to provide?

Ms. SPICER. Thank you for your question. Yes, it would be very helpful for patients to have advocates to explain to them costs. I think it would be even more helpful, as we discussed today, to have them in advance of the hospitalization.

But certainly, in New York, we have a hospital financial assistance law, and there are offices within that—the hospital that are charged with extending that hospital financial assistance and giving other information like patient advocates offices. And we often at Community Health Advocates act as a kind of intermediary and get information and share it out so that consumers understand their rights, and also their potential costs, and the costs that they have incurred, right?

We always get consumers who come to us to say, "I don't understand why the bill that I am receiving is so high. How could the cost of XYZ be what is on this bill?" Or the bill is for, you know, thousands and thousands of dollars, but the invoice doesn't tell me what is—what I received that they are charging me for.

So, definitely, transparency in billing and pricing prior to being billed is needed.

Mr. EVANS. Any thoughts you have in terms of implementing incentives to make it happen?

Ms. SPICER. For the Advanced EOB, I can't speak to why it hasn't been implemented. I think it would be great for consumers, for—you know, for those pieces to roll out.

Mr. EVANS. I yield back. Thank you, Mr. Chairman.

Chairman SMITH. Mrs. Steel is recognized.

Mrs. STEEL. Thank you, Mr. Chairman.

Before Congress stepped in, a patient receiving emergency care from an out-of-network provider or facility would receive surprise medical bills. Seven in ten patients were unable to afford their out-of-network medical bills, according to a previous Kaiser Family Foundation survey.

Unfortunately, this scenario happened to John Hagee, who survived a serious bicycle incident and had to visit an emergency room care in Los Alamitos. He received a $5,000 medical bill for his visit and later discovered that the hospital and physician group were both out of network. John, like many others, had to face medical debt and significant financial burdens due to receiving vital care.

The bipartisan No Surprise Act has been successful, but we can all agree that its implementation has not, leading to physician burnout and reduced patients' access to care.

I have heard from physicians across California, particularly in emergency medicine, that issues with implementation of the No Surprises Act have caused such financial instability that many physicians are retiring early and leaving medicine.

According to a local survey, 45 percent of California physicians said they are considering retiring early. Three out of four California physicians report patient challenges with timely access to care. And 60 percent of California physicians report difficulty staffing emergency on-call panels. Now patients are being onboarded in emergency rooms, waiting for specialists to become available.

To Dr. Bleier and Mr. Budzinski, since the recent court rulings in Texas against the Administration's implementation of the No Surprises Act, the Independent Dispute Resolution process for resolving payment disputes were put on hold. Now in this month the Administration has announced that it expects to direct certified IDR Entities to resume issuing payments determinations for some disputes very soon. This means that providers are still treating patients without a mechanism to get fairly paid.

For a provider, what does this freeze in the system do to you and to your practice?

Dr. BLEIER. I appreciate the question. It puts us in a very difficult situation.

You know, unfortunately, I think the insurers—and we all know that we emergency medicine providers and staff working in those emergency departments will take care to the highest level any patient that presents to the emergency department, no matter what, regardless of their ability to pay. We always do the right thing for those patients.

However, we can only staff those emergency departments with the resources that are available to us. So when our reimbursement is slashed below market rates, longstanding market rates in our area, and our revenue and resources are dropped, we are not—and then we have no recourse—you know, the No Surprises Act, this wonderful, bipartisan piece of legislation set up this process by which we would have recourse in that situation when suddenly a payer, where we had been in network with them for a decade or more, suddenly slashes our reimbursement by 40 to 70 percent, we would have this ability to still advocate for ourselves and potentially still receive fair payment.

But if we don't have—if our payments are reduced up front, and then we have no recourse, inevitably what is going to happen is we are not going to be able to staff those emergency departments and put the resources in that those patients and those communities need, which is most horrible for our patients but, as you alluded to with some of your constituents, horrible for the providers and nurses and other staff working in those emergency departments who want to do what is right for those patients.

Mrs. STEEL. Thank you, Dr. Bleier.

Mr. Budzinski.

Mr. BUDZINSKI. Yes. Thank you, Representative.

We are a large organization. But as I mentioned earlier today, the amount of reimbursement that we have tied up with the IDR process that is broken is over $40 million in under-payments to our organization. And even an organization our size, these are substantial amounts of funds that ultimately require us to balance our budgets in some way, shape, or form. And this ultimately missing revenue does impact our resource allocation. There is no question about that.

Mrs. STEEL. Thank you very much.

Mr. Chairman, I have another question but my time is up, so I am going to yield back. But I am going to ask for the recording of my question.

Chairman SMITH. You can definitely submit the question in writing——

Mrs. STEEL. Thank you.

Chairman SMITH [continuing]. And they will answer that.

Chairman SMITH. So——

Mrs. STEEL. Thank you.

Chairman SMITH. Thank you, Mrs. Steel. Mr. Feenstra is recognized.

Mr. FEENSTRA. Thank you, Chairman and Ranking Member. Thank you for the panel for being here today.

You know, we have challenges. We all see it. We understand it. We know there are flaws. My question—I want to really center around the batching. When you start looking at the various departments, to batch claims to avoid the buildup and—but the problem really becomes the implementation of the batching.

So, Mr. Bobeck, in your testimony you mentioned about 75 percent of disputes were determined ineligible due to non-compliance with the Administration's batching rules. Can you describe the eligibility criteria for determining validity of these claims?

I mean, what can be done here?

Mr. BOBECK. Congressman, thank you for the question.

Currently, right now, the eligibility is actually at 87 percent. So most of the cases are actually eligible. But of the percentage of cases that are determined eligible, batching is accurate as one of the reasons many cases are ineligible. And it does not result from the parties not trying to give their best efforts; it revolves around the parties trying to comply with how batching has to be done.

So, for instance, most of the codes, service codes that come through to an IDRE can be centered around 5 codes, 999281 through 999285. Those codes, you can batch those together when they are the exact same service code, and they involve the exact same health plan, the exact same provider, and also they come within the same 30-day timeframe.

That just simply is not how providers and payers track their claims. They don't track them over all of these different patients. They track a patient's claim and all the ancillary care that goes along with that. So it is a different mindset that has been enacted under the rules, and therefore that is what they have to comply with. And that is what they have to spend a lot of their time just to get information to an IDRE.

And when we get that information, we can only say whether or not that claim was done accurately or not, based upon what was

provided to us. So it provides not just challenges for the IDREs, but, again, for the patient providers. And that is what leads to ineligibility. It is not good faith efforts, it is just simply an inability to track cases as they are accustomed to, to be quite frank, over the last several decades.

Mr. FEENSTRA. So, Dr. Bleier, in what Bobeck just said, what can we do to ensure that providers probably can use a batching process in a meaningful way?

To me, there is merit here, but how can we get it done?

Dr. BLEIER. That might be a little bit above my pay grade. [Laughter.]

Dr. BLEIER. I think simplifying processes, in general, is beneficial. You know, I think sometimes in these regulatory processes they can be uber-complicated and difficult for providers to follow. Certainly, a lot of providers, you know, will use revenue cycle management companies to submit a lot of those payments. So, you know, the—batch those claims.

So it is a little bit outside my wheelhouse. But in general, I think simplifying the process, making the process more transparent on the submission side, I think, is always generally——

Mr. FEENSTRA. Yes, I would agree. I mean, I think transparency—and I just see all the red tape, all the issues. I mean, I think we can make this simpler, and make it more efficient.

Budzinski, similar. Can you describe what batching procedures would help hospitals in their IDR processes?

I mean, what are some—I am trying to aim at solutions here. That is what I am trying to do.

Mr. BUDZINSKI. We greatly appreciate that, Representative, and thank you for the question.

So, as we said earlier, hospitals for emergency-type care are typically paid on a case rate basis. Okay? Observation care, post-emergency as a continuation is a case rate basis. Inpatient care is a case rate. So that is how we are typically reimbursed, not CPT code by CPT code by CPT code by CPT code.

So the current process, the current process is required. In order to batch, you have to have the same exact CPT codes for every single patient with the same payer, the same exact identical care for every——

Mr. FEENSTRA. That doesn't happen very——

Mr. BUDZINSKI [continuing]. Every—it doesn't happen at all. Every patient is different.

Mr. FEENSTRA. Yes.

Mr. BUDZINSKI. Every patient has unique needs. So what we would be an advocate for is go back to a structure of batching and bundling that is consistent with how hospitals are reimbursed.

For example, emergency department visit, level one, level two, level three, level four, level five. It is a case rate, and that is how we are typically reimbursed. The CPT codes and all the ingredients are not really relevant. It is about the patient and the care, the level of care that patient is receiving. That is an example. Observation case rates would be another example.

Batching based upon how we are typically reimbursed would be ideal, and that would simplify the process and, I think, help—we think help reduce future backlogs by reducing the number of——

Mr. FEENSTRA. That is right.

Mr. BUDZINSKI [continuing]. Of determination requests.

Mr. FEENSTRA. See, boom, we got a solution. We can do this. I mean, it is not rocket science.

But thank you, and I yield back.

Chairman SMITH. Mr. Panetta is recognized.

Mr. PANETTA. Thank you, Mr. Chairman, I appreciate you holding this hearing. And of course, thank you, Member Ranking [sic] Neal, for all your work on this important issue.

And, ladies and gentleman, thank you for your patience and your testimony and your information about the issues and potential solutions for implementation of this very, very impactful bill—at least we want it to be impactful.

I come from the central coast of California, in the 19th congressional district. And when I am talking to my patients there, the number-one thing that I hear about is access to care. But I also talk to providers in my district. And the number-one thing I hear about from them is payment issues.

Now, I think that we know the intent of the No Surprises Act was to address a practice of balance billing that, unfortunately, decimated families' finances and limited access to care. But with the reports of a long and often arduous arbitration process, it is clear that there is more work to be done, as we are hearing today and, obviously, as you know. And that is why we want to try to ensure that we are truly improving access and, of course, lowering cost.

One of the lessons that I have learned in my limited time in Congress is that we can do a real good job of passing legislation, but we need the Federal Government to do an excellent job when it comes to implementing that legislation. And, unfortunately, today, as to what we have heard and what we know, this is a good example of that not happening.

Now, a key component of an effective Independent Dispute Resolution process is timely payment by the losing side. Under the No Surprises Act, that payment is supposed to happen within 30 days. However, a recent survey by the Emergency Department Practice Management Association found that 87 percent of payers did not meet this requirement. And obviously, as you know, that threatens the financial stability of already stretched providers like the ones that I represent.

Dr. Bleier, in your testimony you mentioned the impact of slow reimbursement by providers. How do these delayed payments impact providers?

And if you could, I know my colleague mentioned benefits, but how do you feel about the Administration penalizing parties that don't pay within the required period?

Dr. BLEIER. Well, you know, it is a structural loss for us the way that this has been rolled out, unfortunately. You know, we—there is no way to claw back any of that revenue that we have already lost, unfortunately.

As far as your comment on—or your question concerning whether there should be some type of penalty, it—whatever will ensure that, you know, the arbitrator rulings are followed in a timely fash-

ion, consistent with the legislation, certainly seems reasonable to me.

We are expected to make our payments up front as far as arbitration fees. We do that in timely. We are the ones where the onus, despite receiving an upfront payment—again, 40 to 70 percent less than what we have historically gotten for years and years and years—we are the ones where all the onus is on us to make that submission, to complete the paperwork, to complete the appropriate documentation. It seems only fair, I would—from my point of view, certainly—to expect that the other parties involved, as well, are held to a similar standard.

Mr. PANETTA. Great. Thank you, Dr. Bleier, I appreciate that.

Mr. Chairman, thank you again. I yield back.

Chairman SMITH. Ms. Malliotakis is recognized.

Ms. MALLIOTAKIS. Thank you very much. Thank you, Mr. Chairman. Thank you to the witnesses.

The No Surprises Act was a major bipartisan achievement, as was discussed from my colleagues on both sides of the aisle. But, you know, the goal was to protect patients from receiving these exorbitant bills from out-of-network care, often without their knowledge and consent. And the establishment of the Independent Dispute Resolution spearheaded by this committee was designed to provide a fair mechanism for settling the payment disputes between the providers and insurers.

However, as has been mentioned, in its implementation unelected bureaucrats have gone against the congressional intent and created a lopsided dispute resolution process which favors health insurers over the medical providers. Medical providers are now being forced to accept artificially low payments, leading to reduced staffing and exacerbating rural and underserved workforce shortages.

I am also continuing to hear from providers in my home state of New York that—over the backlog of dispute resolution claims waiting to be resolved. Recent surveys find that 91 percent of filed IDR claims remain open and unadjudicated.

CMS has recognized that the primary cause of delays in processing disputes has been the complexity of determining whether disputes are eligible for Federal IDR process. They found that the health plan type was unknown upon dispute initiation in more than half the disputes, causing certified IDR entities to conduct additional outreach and further delaying the eligibility review process.

I will start with Mr. Bobeck.

Do you believe that there is additional information that could be provided that would help expedite this process and help providers determine claim eligibility?

Mr. BOBECK. Thank you very much for the question. Yes is the answer to your question.

During the open negotiation process, this follows the process by which a provider has received a payment that they disagree with. They have a 30-business-day open negotiation process. What is supposed to be happening during that process is the parties should be sharing that type of information.

As an example, you mentioned parties don't know which health plan. If you are a TPA, let's say you are a TPA who represents several health plans, self—many self-insured funds. The provider themselves does not actually know who the health plan is. They just see the TPA, they see a name, and then they see other cases and they think that is all the same health plan. It is not. There are different ones.

Parties are supposed to be sharing that type of information throughout the process. And the more that they share that, the more that they understand who they are dealing with, and then those claims—we have seen it time and time again, it makes for a much better IDRE process. You don't see delays in those cases. You see timely and very quick adjudications.

Ms. MALLIOTAKIS. And what portion is the backlog attributed to states like New York that have their own surprise billing laws already in place?

And what is the current process for determining state or Federal IDR eligibility?

Mr. BOBECK. When it comes to ultimately—right now, most of the cases are coming from other states, as Texas. Texas, like New York, also has its own surprise billing law, as well. But that does not prevent cases still coming into the system that are not captured by that state process.

When it comes to the backlog, again, we currently don't have one, but there is one that has been newly created simply by the portal not being open. And with the portal not being open, providers and payers cannot resolve their disputes and move forward.

Ultimately, when it comes down to the state process and which state process applies, there are regulations, there are rules to—which apply. But ultimately, those rules are not always even clear to the parties. We always, again, have to say that we are like a judge. We can only go on the evidence as provided to us. The parties have to provide that evidence to us, as well as what we can find about whether a state process applies or not.

Ms. MALLIOTAKIS. Thank you.

Dr. Bleier, on that note, would including remark codes like CARC or RARC help to ease the current backlog?

Dr. BLEIER. I think it would. I think anything, again, that promotes transparency on the provider submission side would be incredibly helpful.

Ms. MALLIOTAKIS. Okay. And Ms. Spicer, I understand you are a constituent of mine from New York. It is great to have you here. How has the experience been for patients in New York navigating both the state and the Federal patient protections?

Ms. SPICER. So in New York we had our own system prior to the NSA. I think we—it took a couple of years to get it off the ground, and there are still issues with it. But I—consumers in New York now that are—we have many, many consumers in New York, especially in New York City, in the five boroughs, that have self-insured plans. And they are—the NSA applies to them specifically. They use those Federal processes and they appeal if they are not held harmless for surprise bills, and they are dealing with how to navigate those two at once.

Ms. MALLIOTAKIS. So it is my understanding, based on the whole conversation today, more transparency, more information, being more forthcoming with whether these are state or Federal would be helpful in the matter. And also contributing to the high volume of claims moving through the IDR process is that there hasn't been a meaningful, open negotiation period, which is supposed to help address these out-of-network claims.

I thank you all for your time, and I look forward to working with our committee to address these issues.

Chairman SMITH. Mr. Carey.

Mr. CAREY. Thank you, Mr. Chairman and Ranking Member Neal, for bringing together—and all of you—for being here today and going through this many hours of questioning. It has been enlightening.

You know, the flawed implementation of the No Surprise Act has created burdensome and often confusing guidance for health care providers, including those that are in my home state of Ohio. This is leading to patients facing longer wait times, increased health care facility closures, and exacerbating workforce shortages, ultimately reducing access for those in the rural and underserved areas, particularly in my district. Today we have heard from many of those providers who are impacted, and see the harm caused by the poor implementation of the No Surprise Act.

Dr. Bleier, my question for you, Congress created an open negotiation, a 30-day period, for payers and providers to settle the disputes before a third party would step in. How has this open negotiation designed in the law worked for your practice, or maybe not worked?

Dr. BLEIER. So my understanding and discussion with our revenue cycle management company is that there has been effectively no response on any of the submissions from the insurers.

Mr. CAREY. Interesting. Okay.

Ms. Spicer, I want to compliment you on bringing up the name of one of the people in your written testimony who was a concert pianist and who had also—we had some time, I Googled her, and I would ask all my colleagues to do the same. She is very talented. But it really shows you the face of what happens to people that, really, you would think something like that would not happen to.

I just have a couple of questions. I have one question for you. But the No Surprise Act was signed into law in late 2020 to give patients the peace of mind that they won't receive a surprise medical bill weeks or months after they thought they were covered in a network service. Since the enactment—and I—some of my colleagues have asked this in a roundabout way, but since its enactment almost three years ago, how have patients benefited from this law?

Ms. SPICER. Thank you for your question.

Patients like Claudia have benefited hugely in being protected from out-of-network bills that—our New York State law would not have protected Claudia, did not protect Claudia because it was based on network directory misinformation. She received her $35,000 bill, and the NSA does protect consumers against network directory misinformation.

Also, you know, thousands and thousands of consumers are held harmless for out-of-network emergency service bills as a result of the NSA.

Mr. CAREY. So do you have any—

Ms. SPICER. And air ambulance bills are also——

Mr. CAREY. Yes.

Ms. SPICER [continuing]. An inclusion that New York's law did not have.

Mr. CAREY. So do you have any concerns that patient access to care, which is already in jeopardy due to the health care workforce challenges that we face, will be diminished due to the implementation of this law at all?

Ms. SPICER. At Community Health Advocates we see access to care issues every day. We have—I have, in my career of 24 years, I have always had clients who call me and say, "I can't—I want—I don't—I can't find a provider in my network" that does a certain thing. So I—it seems that if this process, the arbitration process, isn't fixed, that that could be a result.

Mr. CAREY. Okay. And thank you again. Thank you to the witnesses.

And Mr. Chairman, I yield back.

Chairman SMITH. I would like to thank our witnesses for appearing here today. I appreciate your testimony and your several hours of endurement.

Please be advised that members have two weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

With that, the committee stands adjourned.

[Whereupon, at 1:56 p.m., the committee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

October 18, 2023

Additional Questions for the Record

U.S. House Committee on Ways & Means
Hearing on Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections
September 19, 2023

Responses from Jeanette Thornton, AHIP

The Honorable Brian K. Fitzpatrick

1. **How has competition with regard to insurance networks changed since the passage of the No Surprises Act?**

Health insurance providers compete to offer health benefits to employers, families, and individual consumers that are affordable, comprehensive, and deliver the highest quality health care through participating health care providers. Participation by high quality health care professionals, including hospital-based and air-ambulance providers, is essential to our success and allows health plans to facilitate the best possible care at an affordable price.

Research is underway on changes in network participation since the passage of the No Surprises Act. While our members continually evaluate the breadth and quality of their provider networks on an ongoing basis, we understand there are provider groups that have entered into network participation agreements because of changes ushered in by the No Surprises Act. By participating in more health plan networks, providers know they will be paid a competitive market rate for their services and have certainty there won't be any need for independent dispute resolution (IDR) with a group health plan or health insurance issuer when they are providing services to a patient covered by that health plan.

We believe market competition is good for consumers and promotes better care, responsive customer service, and more affordable premiums. Increased consolidation among provider groups helped increase the prevalence of surprise medical billing that was ended by the No Surprises Act and we continue to view the No Surprises Act as a law that benefits consumers not only through protection from surprise bills but through the increased incentive for health care providers to participate in health plan networks.

2. **Are more providers seeking to contract with insurers who didn't have relationships before?**

While we do not have data from health insurance providers to demonstrate a national trend, we know from AHIP members that many provider groups and facilities have joined health plan networks since the enactment of the No Surprises Act, including providers, facilities and air ambulance providers who previously did not widely participate in health plan networks. We

continue to believe that the No Surprises Act and a federal IDR process rooted in predictability and an emphasis on local market rates will create incentives for more health care providers and health insurance providers to come to mutually agreeable terms on network participation agreements, which benefits consumers through more quality health care choices at more affordable rates.

The Honorable Brad R. Wenstrup, D.P.M

In response to your request for AHIP communications with the Tri-Departments we are sharing the attached public comments and data that we have provided. Attached we've included:

- AHIP Comment Letter, IFC 1, September 3, 2021
- AHIP Comment Letter, IFC 2, December 6, 2021
- AHIP Comment Letter, Proposed Rules: "Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement," October 18, 2021
- AHIP Comment Letter, ICRs on Requirements Related to Surprise Billing, September 26, 2022
- AHIP Tri-Agency Letter on NSA Contracted Rates, December 21, 2022
- AHIP Surprise Billing Data Findings Report, July 24, 2023

We appreciate your questions and would welcome the opportunity for further discussion with you or your staff. In the meantime, please reach out to Aron Griffin (agriffin@ahip.org) if you have any questions about these documents.

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

October 18, 2021

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Marty Walsh
Secretary of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Director Kiran Ahuja
Office of Personnel Management
1900 E Street, NW
Washington, D.C. 20415

Submitted via the Federal Rulemaking Web Portal: http://www.regulations.gov

RE: Proposed Rules: "Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement" (CMS-9907-P)—AHIP Comments

Dear Secretary Yellen, Secretary Becerra, Secretary Walsh, and Director Ahuja:

On behalf of AHIP, I am pleased to offer comments in response to the Notice of Proposed Rulemaking, "Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement" published September 16, 2021 in the Federal Register (86 FR 51730). AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

AHIP strongly supported legislative efforts to ban the practice of surprise medical billing. This egregious business model went on for far too long and eroded Americans' confidence in our health care system while harming the financial security of millions of families each year. Strong enforcement of the No Surprises Act, including new accountability for air ambulance providers will be crucial to protecting consumers as the era of surprise medical billing ends. We offer comments in response to these proposed rules with that perspective.

Overall, we are largely supportive of the approach taken by the Departments with respect to new air ambulance reporting but offer technical feedback on how to streamline the reporting process. With respect to individual market disclosures of agent and broker compensation, we strongly support the approach that provides flexibility and reduce administrative burden by allowing plans to incorporate agent and broker compensation disclosure with enrollment materials, permitting electronic disclosures, and not specifying a format for commission schedules or other documentation. Finally, we urge caution with the proposed expansion of the Department of

Health and Human Services' (HHS') investigatory authority as to not duplicate existing authority of states.

Thank you for your consideration of our comments and recommendations and, as with other sections of the No Surprises Act, we look forward to continuing to engage with the Administration to ensure timely and successful implementation of this important law to ensure consumers will be protected from receiving surprise medical bills and have greater transparency into their health care.

Sincerely,

Jeanette Thornton
Senior Vice President
Product, Employer & Commercial Policy

AHIP Comments: Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement Proposed Rule

AHIP's comments on the proposed rule are organized into the following sections:

I. Reporting Requirements for Plans and Issuers Regarding Air Ambulance Services
II. Reporting Requirements Regarding Air Ambulance Services for Providers of Air Ambulance Services
III. Disclosure of Agent and Broker Compensation to Individuals in Individual Health Insurance Coverage or Short-term, Limited Duration Insurance
IV. CMS Enforcement of Group and Individual Insurance Market and Provider and Facility Requirements

I. Reporting Requirements for Plans and Issuers Regarding Air Ambulance Services (45 CFR 149.230)

We support efforts by the Departments to collect valuable new information regarding air ambulance services. Providers of air ambulance services have been among the professional groups most likely to entirely avoid contracting with health insurance plans and issuers and have sent some of the highest dollar amount surprise bills consumers have seen. Including these providers in requirements under the No Surprises Act was a huge victory for patients and reporting requirements will go a long way to better understanding their business practices and allow more health plans to bring them in network. We are hopeful the fruits of this reporting will provide valuable information to eventually bring down the cost of this critical, life-saving emergency transport method.

We offer the following comments on the specific reporting requirements:

A. Calendar Year Reporting

The proposed rules establish a calendar year reporting system with 90-days following the close of the preceding year for group health plans and health insurance issuers to submit data relevant to air ambulance services furnished within the calendar year, as well as data relevant to services for which payments were made within the calendar year.

Recommendations:

- We support calendar year reporting but recommend a June 30th (6 month) furnishing deadline, rather than 90-days as proposed. A March deadline does not provide adequate time to ensure all claims are processed and could result in missing data from the reports. Providing a reporting timeframe that runs through June 30th of the following year would be more appropriate and align to other reporting requirements such as annual reporting requirements of the National Association of Insurance Commissioners (NAIC).

- Additionally, as plans and issuers may not always have complete claims information submitted by air ambulance service providers, for the benefit of all parties involved, we recommend the inclusion of a *de minimis* safe harbor for minor oversights or exclusions of unavailable data.

B. Mergers and Acquisitions

An issuer that acquires from another issuer a line or block of business that provided coverage of air ambulance services during calendar years 2022 or 2023 would be required to report the air ambulance services data on behalf of the acquired business for the entire applicable calendar year. The Departments propose that these reporting requirements would apply to the selling and acquiring issuers if a sale or transfer occurs as a result of issuers being merged, combined, spun off, affected by, or engaging in any similar transaction during a calendar year.

Recommendation:

- **AHIP urges the Departments finalize a rule that includes a good faith safe harbor for mergers and acquisitions of new lines of business should all data not be retained by the previous entity or supplied to the acquiring entity.** Additionally, we recommend that entities acquired also be required to report the air ambulance data. We look forward to the Department's guidance illustrating these examples.

C. Submission of Claims Level Data

The No Surprises Act requires plans and issuers to submit claims data for air ambulance services. As a practical matter, we caution that the data submitted will be a very large file as the data instructions require reporting by group and by claim line and urge consideration of a streamlined method for capturing data and uploading the required data.

R*ecommendations:*

- **Emergent vs. non-emergent claims:** Clarification is needed as to how HHS intends to define an emergent vs. non-emergent claim, including specifications as to which diagnostic or billing codes will be considered emergent vs. non-emergent. Plans use CPT and HCPCS codes that delineate emergent vs. non-emergent and would prefer uniformity between the code systems' definitions of emergent vs. non-emergent and the final rule.

- **Definition of Rural and Urban Areas:** Clarification is requested as to the standard intended to be used to define rural vs. urban areas, in particular its application on the reporting forms. The field no longer exists on the reporting form provided in the PRA template, which includes reference to a zip code.

- **Aircraft Type:** A good faith safe harbor is requested for instances where the transport entity does not provide necessary information, such as the type of aircraft used, and some information would only be known by the air ambulance provider.

- **Program Type**: The report requests a specific data element–whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska. Today air ambulance providers generally do not include this information in their claims submission and health plans do not require this information in order to process the claim. We recommend the agencies solely rely upon providers of air ambulance services to report this information.

- **Reason for Denial:** Both plans and issuers as well as air ambulance providers must provide claims adjudication information including whether a claim was paid or denied, the denial reason, and appeal outcome. The Paperwork Reduction Act package indicates that plans and issuers are to provide a denial reason code and this information is also to be included in the public report issued by HHS. AHIP recommends that HHS define a list of "reasons for denial" for uniformity purposes. There are a wide range of reasons a claim may be denied, including insurance affordability, lack of accurate or complete information submitted by the provider, duplicate claims, claims that are denied but ultimately approved (e.g., because information was missing or submitted incorrectly by the provider), denials due to inaccurate claims coding, denials because another payer (e.g., Medicare) is the primary payer and must process first. Issuers may approach such scenarios differently, which often reflect administrative processes or systems build, rather than coverage policy. For example, one issuer may pend a claim when additional information or documentation is needed while another issuer may deny the claim but subsequently approve the claim when it is resubmitted with accurate, complete information. Because there is variation across issuers administrative and systems processes as well as variation in claims denial reporting processes (i.e., qualified health plan transparency in coverage information) have encountered significant challenges resulting from lack of clear, standard definitions and requirements.

D. Public Report

The statue requires HHS, in consultation with the U.S. Department of Transportation, to produce a comprehensive public report analyzing data points not collected as part of the requirements listed above. These analyses include: an assessment of the average charges for air ambulance services; amounts paid by plans and issuers to providers of air ambulance services; amounts paid out-of-pocket by consumers; the frequency of patient balance billing; and the frequency of claims appeals made by providers of air ambulance services to plans and issuers.

Recommendations:

- **AHIP recommends that HHS define a list of "reasons for denial" for uniformity purposes.** We urge caution in describing denial reasons as definitions of what constitutes a claim denial would be quite complex. An overly broad reporting requirement would result in reporting claim denial rates that aren't representative of actual denials. As described above, some of the most common reasons for claims denials include insurance eligibility, duplicate claims, claims denied but ultimately approved (e.g., because information was missing or submitted incorrectly by the provider), denials due to inaccurate claims coding, denials because another payer (e.g., Medicare) is the primary payer and must process first. Public reporting requirements should focus on the result for the patient—whether the service is ultimately covered—rather than denials that reflect internal administrative or systems practices. Thus, claims that are ultimately paid should not be required to be reported as denied claims. Doing so would align with NAIC Market Conduct Annual Statement (MCAS) requirements, which excludes claims that were ultimately paid.

- **We recommend removing cost-sharing information from the public report as this information would not generally be readily available in HHS releases detailed data files.** In lieu of this approach, HHS could provide the public with general trends around cost-sharing for air ambulance services.

E. Group Health Plan Reporting

With respect to the requirement that group health plans are to report required information to HHS, the proposed rules note that nothing prevents a self-insured group health plan from contracting with another party, such as a third-party administrator, to report the required information.

Recommendation:

- To avoid unnecessary duplication and to streamline the process, AHIP recommends the Departments require reporting from one entity with responsibility for claims data and to designate the third-party administrator as that entity.

F. Applicability to Excepted Benefits and Treatment of Expatriate Plans

Plans report some ambiguity with respect to whether reporting requirements apply to HIPAA Excepted Benefits and we therefore urge the Departments to expressly clarify that plans consisting solely of Excepted Benefits are exempt from these requirements and to similarly expressly exempt expatriate health plans.

II. Reporting Requirements Regarding Air Ambulance Services for Providers of Air Ambulance Services (45 CFR 149.460)

AHIP believes the information collection proposed will be valuable in understanding air ambulance transports and the impact of the No Surprises Act on patients receiving care and transportation by these providers and supports these requirements as reasonable.

III. Requirements Related to Reporting and Disclosure – Disclosure of Agent and Broker Compensation to Individuals in Individual Health Insurance Coverage or Short-term, Limited Duration Insurance (45 CFR 148.410)

A. Disclosure Requirements

HHS proposes minimum standards for health insurance issuers offering individual health insurance coverage or short-term limited duration insurance for disclosure to a potential or existing policyholder, including the amount of direct and indirect compensation provided to an agent or broker associated with enrolling the policy holder in individual health insurance coverage or short-term limited duration insurance.

Recommendations:

AHIP supports HHS' approach to provide flexibility and reduce administrative burden by allowing plans to incorporate agent and broker compensation disclosure with enrollment materials, permitting electronic disclosures, and not specifying a format for commission schedules or other documentation. HHS should not require disclosure of compensation information on other forms of documentation confirming enrollment. We offer the following additional recommendations for consideration:

- **Maintain maximum flexibility for plans to allow for accurate disclosure of complex broker compensation structures.** AHIP supports HHS' proposal to allow plan flexibility to describe thresholds for indirect compensation, such as bonuses. HHS should maintain maximum flexibility for plans that allow for disclosure of complex or variable compensation structures, such as ranges, formulas, or other general descriptions that accurately describe compensation to consumers.

- **Clarify that in-house agents employed by health plans are exempt from disclosure requirements.** Health plans employ agents to assist with the sale of insurance contracts, and these agents receive a typical salary for their work. This job description does not meet the definition of "services" or "brokerage services" and an employee's salary does not meet the definition of "compensation" requiring disclosure. Therefore, HHS should exempt in-house agents from health plan disclosure requirements under Section 202, similar to previous Department of Labor guidance related to pension plan disclosures.

- **Exempt student health coverage from broker compensation disclosure and reporting requirements.** While student health coverage is considered individual health insurance coverage, it is unique because this coverage is provided as an agreement between a higher education institution and a health insurance issuer. Unlike other forms of individual health insurance coverage, student health coverage does not include direct sales action between agents or brokers and students. HHS should clarify that student health coverage is excluded from broker compensation and disclosure reporting requirements.

- **Confirm disclosure and reporting requirements do not apply to excepted benefits.** Many plans offer coverage for products like long-term care or disability that are considered excepted benefits. Section 202(c) added § 2746 to the PHSA, which imposes certain disclosure and reporting requirements on health insurance issuers with respect to health insurance coverage and short-term limited duration insurance coverage regarding compensation provided to agents and brokers. These disclosure requirements apply in the context of individual market health insurance coverage. HHS should explicitly confirm that broker compensation disclosure requirements do not apply to excepted benefits described by PHSA § 2791(c). This is because PHSA § 2763 provides that the "requirements of this part," which includes PHSA § 2746, do not apply to excepted benefits where certain conditions are met.

- **Create a safe harbor for calculation errors and give plans the ability to modify after disclosure or reporting.** As previously mentioned, broker compensation structures are complex and variable. Along with disclosure and reporting flexibility, plans should have a specified timeframe to correct errors in disclosure or revise previous reporting to ensure continued accuracy. HHS should establish a safe harbor for calculation errors where plans can correct broker compensation disclosure or reporting without penalty.

B. Reporting Requirements

HHS proposes data collection, reporting requirements, and submission timeline for issuers to submit annual reporting reflecting compensation arrangements between agents and brokers and health insurance issuers.

Recommendation:

- **Finalize reporting timeline as proposed.** AHIP supports HHS' proposed reporting timeline of the last business day of July of the calendar year following the applicable reporting period. Establishing a submission deadline that does not coincide with the Exchange open enrollment period will reduce conflict with existing plan operations. HHS should finalize this timeline as proposed.

C. Applicability
HHS proposes that these requirements apply to contracts executed between an agent or broker and a health insurance issuer offering individual health insurance coverage or short-term limited duration insurance on or after December 27, 2021, with a temporary policy of relaxed enforcement between December 27, 2021 and January 1, 2022.

Recommendation:

- **Delay Section 202 requirements to plan years beginning on or after January 1, 2023 and provide good faith safe harbor for enforcement.** HHS should delay broker compensation requirements to plan years beginning on or after January 1, 2023 and provide a good faith safe harbor for enforcement. While AHIP appreciates HHS' option to exercise discretion to adopt a temporary policy of relaxed enforcement on a case-by-case basis for the December 27, 2021 through January 1, 2022 reporting period, plans do not have enough time to implement information technology changes in time for the proposed deadline. Since a rule is not likely to be finalized until November or December of 2021, plans will be unable to update plan materials and provide necessary documentation to agents and brokers to accurately report compensation amounts for the 2022 plan year.

  Plans need additional time to locate and track data elements required by the proposed rule, work with intermediary organizations to obtain compensation information, establish new programs and systems, train staff, agents and brokers, harmonize existing state requirements and agent and broker agreements, and develop new or revise existing materials and notices. In some cases, these materials and notices have been filed and approved by state regulators and must be sent to enrollees by statutory timelines, which will not allow for inclusion of additional disclosures. A delay of at least one year to plan years beginning on or after January 1, 2023 with a good faith safe harbor for enforcement will enable plans to make necessary updates, provide accurate consumer disclosures, and come into compliance with the law.

IV. CMS Enforcement of Group and Individual Insurance Market and Provider and Facility Requirements (45 CFR Part 150)

A. Definitions (45 CFR 150.103)
HHS proposes to add definitions related to enforcement against providers and facilities.

Recommendation:

- **AHIP supports these definitions** and urges clarity that the definition of health care "provider" should include nurse practitioners and physician assistants operating as licensed health care professionals in their State.

B. Request for Extension (45 CFR 150.309)
HHS is proposing to remove references to "30 days" to request an extension and clarifying that a responsible entity may request an extension when it cannot prepare a response or provide the requested information to HHS by the deadline provided in the notice under 45 CFR 150.307, and that failure to respond by the initial deadline provided in the notice or an extended deadline granted by HHS may result in the imposition of a civil money penalty based upon the complaint or other information alleging or indicating a violation of PHSA requirements.

HHS also proposes to codify examples of what would be considered "good cause" for failure to timely respond, including but not limited to, situations when a responsible entity indicates that it has limited staffing resources to prepare a response, or when a responsible entity requests clarification from HHS regarding its request for information.

Recommendation:

- **We urge HHS not to remove the 30-day period for responding to notices or to request an extension.** We suggest additional examples of what constitutes "good cause," including, but not limited to situations when the notice is directed to the inappropriate contact at the group health plan or health insurance issuer.

C. Basis for Initiating an Investigation; Injunctive Relief (45 CFR 150.503)
We are concerned that the language proposed by HHS would create new investigatory authority that exceeds the parameters of the No Surprises Act, resulting in duplicative enforcement with state Departments of Insurance. The Proposed Rules' permit HHS to determine whether to initiate an investigation or a market-conduct examination (MCE) based on receiving information indicating that a group health plan or health insurance issuer may have failed to meet a PHSA requirement or, alternatively, conduct a random MCE to assess compliance with any provision of the PHSA. The language used is vague and raises concerns that future regulatory authority could be exercised without sufficient notice to parties.

The structure proposed, particularly if it is applicable to every state, would result in parallel enforcement by state and federal authorities for the same conduct. This may be a simple matter of clarifying the application to select states where HHS has primary enforcement authority rather than a nationwide scope. It is critical that the process for investigations and enforcement of potential violations of law is administratively simple, when possible, and clear as to which governmental entity bears responsibility for enforcement.

Recommendations:

- **With respect to these proposed rules, AHIP urges the Departments to limit the scope of the rules to enforcement of the No Surprises Act or other sections within the same title of the Consolidated Appropriations Act (CAA).** Should HHS believe new investigatory

and enforcement authority is necessary under the PHSA, separate rulemaking should be noticed on that topic.

- **We urge the Departments to complete an economic assessment of the impact of this change in enforcement approach.** It is unclear from the language in this NPRM whether that is the intention; no cost or economic analysis has been completed for the proposed new MCEs, which are expressly distinguished in the NPRM from investigations, and therefore Administrative Procedures Act requirements to avoid arbitrary rulemaking have not been satisfied.

  Related to costs, we ask HHS, in final rulemaking, to establish and clarify projected enforcement costs outlined in less detail in the Preamble. For example, the Preamble refers to "CMS [conducting] approximately 200 investigations per month, for a total of 2,400 investigations per year, starting in 2022" but it is unclear whether the use of the word "investigation" refers solely to investigations or MCEs and investigations.[1] We infer from the Preamble that "investigations" refer to actions in response to alleged, potential violations of the PHSA, rather than random or targeted MCEs, but this unclear. The projected costs seem to envision enforcement only of the specific provisions of the CAA, including the No Surprises Act, referenced in these Proposed Rules, but there is a lack of clarity in the rules as proposed that could lead to an interpretation that all MCEs were part of the cost estimate.

- **Clarify whether CMS is seeking to initiate investigations and exercise primary enforcement authority beyond the states where HHS has primary enforcement authority under the Public Health Service Act.** HHS enforcement authority has historically been limited to those states – currently numbering four – that notify the federal government they are not going to enforce (or otherwise fail to substantially enforce) requirements of the PHSA. We read the proposed rules as most likely limited to those four states but recognize there is confusion as to whether the enforcement authority proposed could be viewed as nationwide and therefore urge HHS to clarify that enforcement rules under the CAA do not extend beyond those states where HHS has primary enforcement authority.

D. Market Conduct Examinations (45 CFR 150.313)

With respect to proposed changes to the rules for Market Conduct Examinations (MCEs), we are concerned that codifying current MCE practices and procedures will not allow for the flexibility necessary in dealing with the unique circumstances of each audit.

[1] 86 FR 51766

Recommendation:

- Should HHS codify the MCE practices and procedures as proposed, AHIP strongly recommends that:
  1. HHS permit issuers to designate a single point of contact to which MCE notices should be sent. Notices are not always sent to the same individual at large companies, and in the absence of a designation, it may take several days or longer to make their way to the appropriate contact
  2. HHS add other examples of "good cause" for failure to respond to notice of an MCE including, but not limited to, situations when the notice is directed to the inappropriate contact at the plan/issuer

E. Determining the Amount of Penalty—Aggravating Circumstances (45 CFR 150.321)
HHS proposes to specify that an entity's failure to cooperate with an investigation or MCE would be considered an aggravating circumstance for purposes of determining the aggregate amount of penalty.

Recommendation:

- We are concerned that the penalty for aggravating circumstances could be arbitrarily applied and recommend: 1) HHS specify what constitutes a "failure to cooperate" and 2) HHS provide for a process that allows issuers to request review/appeal of the assessment by a neutral third party not involved in the original decision to assess the penalty for aggravating circumstances. The process should allow issuers to appeal the determination that there was a failure to respond to take into account circumstances where an issuer may fail to respond simply because the notice was directed to the inappropriate contact at the company.

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
C 202.450.8218
ahip.org

Matthew Eyles
President & Chief Executive Officer

September 3, 2021

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Marty Walsh
Secretary of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Director Kiran Ahuja
Office of Personnel Management
1900 E Street, NW
Washington, D.C. 20415

Submitted via the Federal Rulemaking Web Portal: http://www.regulations.gov

RE: Requirements Related to Surprise Billing; Part I – AHIP Comments

Dear Secretary Yellen, Secretary Becerra, Secretary Walsh, and Director Ahuja:

No American should worry about receiving a surprise medical bill and the financial harm that can result. That is why AHIP remains eager to engage with the Administration as well as other health care stakeholders– including employers, providers, facilities, state governments, and consumers – to ensure the No Surprises Act is implemented in an efficient and effective manner. We pledge our partnership in this process.

We appreciate the opportunity to respond the Interim Final Rule with Comment issued by the U.S. Departments of Health and Human Services, Treasury, Labor and the Office of Personnel Management ("the Departments"), "Requirements Related to Surprise Billing; Part I" ("the IFC"), published July 13, 2021 in the Federal Register (86 FR 36872).

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. We strongly supported legislative efforts to ban the practice of surprise medical billing. This egregious business model went on for far too long and eroded Americans' confidence in our health care system while harming the financial security of millions of families each year.

These interim final rules are a crucial step towards ensuring surprise medical bills are part of our history, not our future. The IFC is a thoughtful and reasonable approach to address the care scenarios where surprise bills should be prohibited, the determination of a consumer's cost-sharing obligation, the methodology for the Qualifying Payment Amount (QPA), and the process for lodging complaints with respect to compliance with the No Surprises Act. The regulations as

detailed in the IFC establish comprehensive protections for consumers in a wide array of care settings while going to great lengths to ensure consumer cost-sharing, often determined through the QPA, can be equitably determined. We offer comments on aspects of the IFC, including a series of technical comments and recommendations on how to ensure that health plans and issuers are best able to implement the No Surprises Act and that consumers are fully protected on January 1, 2022.

We join you in the shared goals of strong protections for patients and consumers, minimal operational challenges, reduced health care costs, increased provider participation in health plan networks, and avoidance of unintended consequences for consumers, providers, and the health care system. American consumers and patients are counting on us to get this right. We look forward to engaging with the Departments throughout the coming years to do just that.

Sincerely,

Matthew Eyles

Matthew Eyles
President & Chief Executive Officer

Attachment

Attachment
Detailed AHIP Comments on IFC

Ensuring Successful Implementation & Timelines
The law requires consumers to be protected from receiving surprise medical bills beginning January 1, 2022. We are fully supportive of that requirement and agree that consumers should NOT receive surprise medical bills beginning on that date while health insurance issuers work behind the scenes with providers and facilities to comply with these new requirements.

Need for Good Faith Safe Harbor
We do, however, have significant concerns about whether health plans have sufficient lead time and regulatory clarity to implement and operationalize many of the non-consumer facing portions of these and subsequent regulations. We ask that there be a good faith safe harbor in place to implement those provisions of the law through 2023.

We appreciate the actions taken with Affordable Care Act FAQ 49 in August 2020 and recommend similar good faith safe harbors, including that non-enforcement of some provisions extend to certain surprise billing sections of the Consolidated Appropriations Act of 2020 (CAA).[1] Health plans and issuers have responsibility for developing work streams; updating information technology; creating forms, notices, and other communications; training employees; and other operational measures necessary to effectuate obligations in the IFC. This is occurring at the same time as many inter-related requirements, including the transparency in coverage final rule, interoperability rules and new identification cards.

The following aspects of the IFC will require flexibility for orderly implementation. We urge the Departments to implement a good faith safe harbor or other similar mechanism to allow health plans and issuers to come into compliance.

- **Qualifying Payment Amount (QPA) Methodology:** The methodology detailed in the IFC, which we believe is reasonably constructed, will take more time than three months to operationalize. There are too many outstanding implementation questions that require answers in short order: What constitutes a contracted rate? From where to pull contracted rates within a geographic region? How is the proper median identified? How should the cost-sharing for enrollees be calculated and communicated? What paperwork is necessary to facilitate accurate communications with contracted providers, facilities, employers and enrollees? Once these questions are answered, the task itself of calculating QPAs will be very time consuming. Each health care service and supply code requires a separate calculation by each geographic area and market segment. Once this information is calculated, it will need to be tested for accuracy and loaded into the claims processing systems for calculation of the member's cost-sharing. We urge the Departments to provide a good faith safe harbor related to the QPA calculation. Under the safe harbor, plans and issuers should be permitted to adjust cost-sharing in favor of the enrollee as these processes are implemented and the QPA methodology is refined.

[1] FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, FAQs. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

- **Notice/Consent Transmittals between Issuers and Non-Participating Providers:** The necessary infrastructure does not yet exist for non-participating providers or facilities to transmit required notice and consent forms or information to health insurance issuers when one of their patient's waives balance billing protections. This communication is especially critical in ensuring the health plan or issuer is aware which post-stabilization services are treated as emergency services and able to calculate the correct consumer cost-sharing.

- **Independent Dispute Resolution (IDR) Costs and Pricing for 2022:** Health insurance providers and third-party administrators must first model anticipated costs for clients and convey the impact of new requirements to clients for self-funded plans and price appropriately for fully-insured contracts. Without the final IDR regulations, issuers will not know how the process will work or what costs will be involved. Additional lead time is necessary prior to the start of a calendar-based plan year.

- **Forms and Required Filings:** Many policy forms that must be filed for each plan year need to be finalized and approved by state regulators. This is not feasible prior to plan years beginning on or after January 1, 2022, given the status of rulemaking related to surprise billing. This is an example where a good faith safe harbor until 2023 would recognize health plans and issuers need additional time to submit updated policy forms.

- **Issues with Staggered Compliance:** We note that the requirements of the No Surprises Act apply to plan years beginning on or after January 1, 2022, and many plans will renew in mid-year 2021 and prior to January 2022. As a result, some enrollees will be in plans not subject to many No Surprises Act requirements, but providers will be nonetheless subject to their requirements. For these plans, issuers are unclear what information must be communicated to non-calendar year plan enrollees about the No Surprises Act before the end of 2021. The staggered dates also impact consumers, as we expect confusion from those enrolled in plans that do not renew until after January 1st.

Necessary Partnership for Operational Success – Multi-Stakeholder Working Group

Due to the number, extent, and complexity of technical implementation challenges created by the No Surprises Act, we recommend the Departments create an operations working group of health care stakeholders to discuss the operational challenges and how to address them as quickly as possible. This working group could include representatives from health insurance plans and issuers, third-party administrators, health care providers, facilities, billing and coding administrators, state regulators, and consumer groups, to identify issues such as coding and communication obstacles and identify actionable methods for incorporating requirements of these and forthcoming final rules into business operations. Throughout our recommendations on the IFC, we seek clarity on regulations as drafted and identify operational challenges that may prevent sound policy from being implemented as intended; this multi-stakeholder operations working group could discuss the best way to address these operational challenges.

Preventing Surprise Medical Bills for Emergency Services

Emergency departments have historically led to a significant portion of all surprise medical bills. When emergency medical care is required, the last thing any patient wants to think about is whether each and every provider treating them participates in their health insurance network.

Ending surprise medical bills for emergency services is a top priority for our members. To ensure this is achieved properly and smoothly, the final regulations must make clear what constitutes emergency services, including post-stabilization care, and what items or services are subject to the non-emergency services requirements or are outside the scope of the No Surprises Act. Final rules should create a bright line between emergency and non-emergency services, with a specific and well-defined cut-off, particularly given language in the Preamble that indicates emergency services include care after the member is stabilized and as part of outpatient observation or inpatient/outpatient stay.[2]

We are concerned that the existing regulatory definitions cannot readily be coded into routine health insurance claims and are subjective depending on the determination of the attending physician. To address, we recommend the Departments clarify: 1) which facility types can provide emergency services under these regulations, and 2) clearly limit the scope of post-stabilization services to avoid opportunities for misuse by providers. Our comments also address the need for clarity around prior authorization requirements and operational concerns with implementation.

First, we recommend the Departments define the facility types and care settings where emergency services are provided to ensure there is a clear distinction between emergency and non-emergency services. Emergency services are provided at hospital emergency departments and freestanding emergency departments. Emergency services are not provided at urgent care facilities, retail clinics, or ambulatory surgical centers. Given the conduct of some emergency medicine staffing firms that were the source of the significant rise in surprise medical bills in recent years, we have concerns that some actors could exploit the expanded definitions of what is included in emergency services. Avoiding the possibility of existing primary and urgent care providers or facilities adding emergency services or coding care as emergency services for the purposes of increasing their reimbursement is clearly in the public interest. It is also consistent with the legislative intent of the No Surprises Act, which is to protect patients when they lack a meaningful choice in where to seek care or who will treat them. Including locations where an individual patient does have a choice would not align with the legislative intent and lead to unintended consequences that could increase costs for patients, consumers, businesses and taxpayers.

Second, important clarifications are needed to ensure a clear bright-line distinction for what constitutes post-stabilization so as not to include all inpatient services provided in an emergency department. The notice and consent procedures for post-stabilization services must not become a loophole for circumventing the consumer protections of the No Surprises Act. As such, the Departments sought comment on the standards for determining a reasonable travel distance. We believe a reasonable travel distance standard should take into account the difficulty in arriving at the new facility given physical and other limitations that may be present. We strongly urge the Departments to create clear standards for determining a patient's ability to

[2] See 86 FR 36,880: "... emergency services include any additional items and services that are covered under a plan or coverage and furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items and services are furnished) after a participant, beneficiary, or enrollee is stabilized and **as part of outpatient observation or an inpatient or outpatient stay** with respect to the visit in which the other emergency services are furnished." (Emphasis added).

travel that can be applied independent of the treating or attending physician. Placing the sole discretion for determining a patient's fitness and ability to travel on the same provider that may create a financial conflict of interest that runs counter to legislative intent and creates opportunities for abuse. Permitting only the treating physician to make the determination on post-stabilization care based on non-emergency transport to an in-network facility is likely to add costs to providing care. Additionally, clarity is requested as to how the availability of air medical transport would factor into this determination given the regulations only reference nonmedical transportation or nonemergency transportation.

The distinction is also necessary for claims processing. Without changes to the current electronic transaction standards (including HIPAA claims submission standard (837) and electronic remittance advice (835) and corresponding operating rules), plans would often be unaware of whether a claim is being submitted as an emergency services claim. New requirements on health care providers will be necessary, as out-of-network providers and facilities will need to add information to claim forms designating whether a claim is an emergency services claim.

In addition, the IFC addresses the role of prior authorization for emergency services. Given the expanded definition of emergency services to include post-stabilization services provided as part of outpatient observation or inpatient stay, we believe it is important that regulations distinguish between prior authorization and medical necessity reviews. Medical necessity reviews are an integral part of determining whether outpatient observation of inpatient stay is appropriate for a patient. The intent of the law is to prevent a patient from receiving a surprise medical bill for emergency services, which the existing prohibition on prior authorization addresses. However, in the Preamble, in discussing the limits on prior authorization for care, the Departments state that:

> "this provision does not permit plans and issuers that cover emergency services to deny benefits for a participant, beneficiary or enrollee with an emergency medical condition that receives emergency services, based on a general plan exclusion that would apply to items and services other than emergency services."[3]

We do not believe the intent of this clarification is to prohibit the denial of coverage of items and services that are not medically necessary, but the language is so broadly worded that some could interpret it that way because non-medically necessary services (e.g., circumstances in which inpatient stays are determined to be not medically necessary in favor of outpatient observation) could be seen as plan exclusions. We recommend the Departments clarify that this is the case.

Clean Claims and Initial Payments to Providers and Facilities

We support the approach in the IFC with respect to the initial payment that must be paid by health plans and issuers to out-of-network providers and facilities. The No Surprises Act does not prescribe a minimum initial payment, and we strongly support maintaining this in regulation. There is no maximum payment amount imposed upon the IDR process. Functionally imposing a minimum that is not included in the statute would create an inappropriate imbalance that would invariably increase health care costs. We believe the market should continue to set rates for health care services and items, not the IDR entities or federal regulations. The IFC preserves that process while correcting the underlying market failure, which will benefit the public.

[3] See 86 FR 36,880

The initial payment, or notice of denial of payment, to non-participating providers or facilities is required only after a final, "clean" claim is submitted to the plan or issuer. We believe it essential for future rulemaking to reiterate that the timetable only begins with receipt of a clean claim with all necessary information, as articulated in this IFC. We support the requirement that the standard be the claim has all information necessary to process the claim.

We recommend future rulemaking clarify that health plans and issuers remain able to negotiate with non-participating providers prior to sending an initial payment. Additionally, due to the requirement that timetables begin with receipt of a clean claim, we recommend the Departments define "clean claim" as "a properly completed billing instrument, paper or electronic, including required health claim attachments and for facility providers consists of the UB-04 as adopted by the National Uniform Billing Committee."

Related to the initial payment rules, the IFC acknowledges that timeframes for post-service claims and appeals and the initial payment/denial deadline may not align. The rules note the distinction between an adverse benefit determination (ABD), which is subject to ERISA claims procedures or internal appeals, and a denial of payment or an initial payment that is less than the billed amount, which may be disputed through the IDR process. We strongly support keeping ABD appeals separate from the IDR process, ensuring the IDR process remains focused on disputes regarding the amount paid by the plan for items and services that fall under the No Surprises Act.

Health insurance plans and issuers need in-network health care providers to report to them the facility at which they are performing the services to determine if the provider is providing treatment at a non-participating facility. This is not a current HIPAA requirement and would lead to a claim being rejected as not a final, clean claim. If the location is left null, plans have very limited insight into the service location of the provider and are unable to configure billing when an out-of-network provider treats an enrollee at a participating facility. This is a critical operational and reporting challenge that must be rectified before the full processes for resolving disputes can move forward under the final rules.

Role of State Law and Preemption of State Laws

Smooth implementation of the new surprise billing protections requires the ability to easily identify what circumstances qualify as a specified state law that would apply and when the No Surprises Act shall govern. We request more detailed guidance on the matter to avoid confusion among regulators, providers, and plans.

We recommend that regulations clarify that when any item or service in a care scenario would be subject to the federal regulatory scheme of the No Surprises Act, the entirety of the payment dispute for that visit is subject to federal rules. As much as possible, health plans and issuers wish to avoid the increased costs, slow processing, and consumer confusion arising from navigating multiple state laws governing the same visit when the dispute could be settled according to the No Surprises Act.

Generally, state laws apply to the issuer of the policy or sponsor of the plan; however, some states extend the applicability of their balance billing laws extraterritorially to state residents, regardless of where the policy is issued. This variation in state applicability adds complexity to determining when state law or federal law applies. More importantly, not all state laws prescribing out-of-network payment and surprise billing protections extend to providers.

We recommend the Departments follow models they have utilized for other purposes, such as the compilation of benchmark plan information for essential health benefits requirements under the Affordable Care Act, and work with states to provide issuers with an annual list of whether state or federal law governs with respect to a particular instance. This is especially apparent when consumer cost-sharing is implicated. For example, a state law may apply to the dispute resolution process but not the consumer's cost sharing amount, or the state law may address the amount the issuer pays the provider but not the amount that is the basis of the member's cost sharing. These inconsistencies must be reconciled and require clear federal rules to determine how issuers are to make decisions based on whether the federal or state law applies to a particular determination.

Clarification is also needed when determining the recognized amount when there is a specified state law without a prescriptive payment methodology, such as when the applicable state law directs open negotiation and the possibility of independent dispute resolution. The IFC states that the recognized amount should be based upon the state specified law as applicable. However, such a directive does not cleanly align with the overarching idea that a consumer's cost sharing should not be impacted by the final amount determined through arbitration. We believe the best solution is using QPA in these situations.

Guidance will also be necessary to address unique circumstances where state laws create an exception to the general rule detailed in final regulations. For example, some states (Massachusetts and Vermont) have merged insurance markets for the individual and small group markets; guidance on how to calculate QPAs under these circumstances is necessary.

Qualified Payment Amount Methodology

AHIP's primary considerations in analyzing the methodology for determining QPAs under the final rules were whether the methodology would protect consumers from unnecessarily high costs, whether the process would be administratively feasible, and whether the QPAs would reasonably reflect local market rates. We believe all criteria are satisfied by the approach taken in the IFC but reiterate that the systems necessary to implement this methodology cannot be in place to ensure the QPAs are accurately calculated and communicated beginning January 1, 2022. Further, we note several instances where unique circumstances, such as contracting approaches, that deviate from the general course of business will need to be addressed in future rulemaking or guidance.

Definition of Insurance Market for Self-insured Group Health Plans

We urge the Departments to define "insurance market" for self-insured group health plans to include all self-insured group health plans for which a third-party administrator (TPA) has a contractual obligation to administer. The TPA should, in turn, acquire responsibility for calculating each QPA for their self-insured clients that sponsor group health plans. We continue to believe that QPAs should be calculated on behalf of all self-insured group health plans based

upon all self-insured business in a geographic area. We recognize the IFC includes the option for a group health plan sponsor to elect that their TPA determine the QPA for all clients and believe that sponsor-level calculations will increase costs and compliance burdens and future rulemaking should establish these calculations as the responsibility of the TPA.

Requiring the calculation of a separate QPA for each group health plan sponsor would exponentially increase the operational complexity of the QPA, as each TPA would be required to calculate and maintain a vast number of QPAs for each client. Furthermore, TPAs would likely find it impossible to calculate QPAs for any clients that they have added since January 31, 2019, without access to the proprietary contracts of the prior TPA upon which the QPA must be calculated. In the future, if a group health plan sponsor were to change their TPA (which happens routinely), the new administrator would not be able to calculate or substantiate the QPA without referencing proprietary contracts of a competitor.

Given this operational complexity, AHIP recommends that future rulemaking establish or guidance clarify that, for items or services provided to an enrollee in a self-insured health plan by an out-of-network provider subject to the provisions of the Act, TPAs should calculate the QPA on behalf of all self-insured clients with whom they contract within a geographic region. This is consistent with the statute, which defines the health insurance market for self-insured group health plans to include other-self-insured health plans.

Monitoring by Fiduciaries
The Departments should not impose any additional burdens upon administering entities that perform ministerial QPA calculations only where group health plans have decided to opt in beyond the substantial requirements in this regulation. However, if the Departments determine that group health plans, as fiduciaries, need additional information in order to appropriately monitor compliance by administering entities calculating QPAs on their behalf, we recommend that, upon request by a group health plan, it is sufficient for the administering entities to make available to the health plans the same information already required to be shared with nonparticipating providers and facilities with the initial payment or notice of denial of payment or upon request under 45 CFR 149.140(d).

To the extent the Departments determine that imposing additional burdens on group health plans and their administrators are warranted because group health plans, as fiduciaries, must have information that goes beyond what must already be assembled and provided to providers, such information should be limited to a standard description of the methodology used in the administrating entity's ministerial calculation of the QPA and should not include the potentially voluminous underlying confidential data or other details. This information, combined with the Departments' existing audit authority under the statute, is sufficient to address any concerns about monitoring how terms of the plan and these rules are met.

Finally, the Departments should recognize a safe harbor for group health plans and their administrators that the aforementioned information is sufficient for purposes of any need of a group health plan, as a fiduciary, to obtain information on the calculation of the QPA from its administering entity for monitoring purposes.

Calculation Based on Facility Type
Comments were solicited with respect to whether QPAs should be calculated separately for different types of emergency facilities. We support the approach in the IFC that requires a different median contracted rate for hospital emergency departments and free-standing emergency facilities; we do not support an alternate approach to this calculation at this time. This should be the case regardless of whether the plan varies the payment rate based upon facility type. Free-standing emergency facilities do not incur the same overhead costs, have the same level of certification, or typically treat the same range of conditions as hospital emergency departments. Codes will not communicate to a plan or issuer at which type of facility an item or service was provided. We recommend the Departments clarify that claims transmittals from non-participating providers must include a notation for the site of service.

Geographic Regions for Air Ambulance Services
We support the IFC's approach to calculating the QPA for air ambulance services. The geographic region used for an air ambulance service is determined based upon the point of pick-up. Clarification is needed that when calculating the median contracted rate, all air ambulance service providers that regularly serve any point within a geographic region are to be included. Particularly for fixed-wing air ambulance services, an aircraft may frequently be based in another state or geographic region from which they travel to pick up patients in other areas. To accurately reflect the cost of contracted air ambulance services, the QPA should reflect the rates of all contracted air ambulance providers serving the geographic region, not just those that happen to have bases in the region. We agree there is no need to differentiate between independent non-hospital providers and hospital-based providers who provide emergency air medical services.

Same or Similar Item or Service
For some procedural code modifiers, such as those for additional surgeries, it may not be practical to calculate a separate QPA for the code-modifier combination. We recommend that rules allow health plans and issuers to calculate a median contracted rate for the service code and apply that modifier as a business rule, in a manner consistent with the methodology for calculation of unit-based services.

Varied Payment Bases and Facility Reimbursement Schemes
Many plans contract for items or services using varied payment bases that make the standard methodology for calculating a median of contracted rates not feasible. Among others, these methods include per diem and percent of billed charges. Further, we request clarification that health plans and issuers are permitted to use claims data to deconstruct facility reimbursement schemes which are based on case rates, DRGs, and groupers. That would allow issuers to base the facility QPAs on more facility contracts and be more representative of market rates.

Market Segments
It is in the best interest of the consumer that QPAs be calculated based on the contracted rates that most closely reflect what participating providers with their plan are paid. We recommend the Departments clarify that plans and issuers may calculate QPAs based not only on contracted rates within an insurance market in a given geographic region, but separate QPAs for each

network type, such as PPO plans within a particular market in a region. This will help avoid inaccurate or inflationary cost-sharing determinations.

New Service Codes
The Departments sought comment on the process for identifying reasonably- related codes for new services. There are a very large number of service codes created or modified since January 31, 2019. Identifying a reasonably-related code for each is a tremendous operational burden for plans and issuers. For items and services furnished in 2022 for which issuers have a sufficient number of contracts as of January 31, 2021, it is more feasible to use a median contracted rate as of that date, adjusted by the percentage increase in CPI-U from 2020 to 2021.

New Plans
It is important that new health plans are permitted to transition to calculating QPAs using median contracted rates during the first year in which the plan possesses sufficient information. As currently written in the rules, new plans would be reliant on databases or All-Payer Claims Databases (APCDs). Without the ability to move away from databases and APCDs, there is diminished incentive to build cost efficient networks, as plans and issuers are being held to a payment standard they do not control. Without an update to the methodology for new plans, we are concerned that there will be far fewer issuer entrants into new markets, which hurts consumers through reduced competition.

Insufficient Information
With respect to scenarios where a plan or issuer lacks sufficient information to calculate the median contracted rate and must instead rely on a third-party database, we recommend the Departments require greater transparency from database vendors or the entity maintaining the database information. Issuers will be required to share the identity of the third-party database with non-participating providers upon request. As a result, an issuer should be equipped to answer questions from the non-participating provider to aid in resolving disputes outside of IDR. Forms of transparency could include a requirement to publicly disclose the volume of claims data used to calculate the median in-network allowed amount, their information sources and whether any imputed data is used.

Information Sharing Between Plans and Providers
We recommend that health insurance providers have the option to direct providers to an online website or portal to initiate open negotiations in lieu of an email address and telephone number. This would ensure that health insurance providers are able to implement these requirements as efficiently and accurately as possible and, in turn, reduce administrative costs that are passed along to consumers in premiums. Additionally, with respect to the DOL model notice, it requires health plans and issuers to include the QPA and other information with the payment, but there is no place on the 835 HIPAA transaction to do so. We support measures to automate information shared through standard transactions to the greatest extent practicable.

Provider Consolidation
The Departments sought comment on the impact of large, consolidated health care systems on contracted rates and the impact of those rates on prices and the QPA. Provider consolidation has been widespread and escalating in recent years, resulting in increased leverage for providers in

negotiations with issuers.[4] This has long exerted upward pressure on prices and premiums. The Departments should be mindful of this market dynamic and take steps to mitigate the effects of provider consolidation to the greatest extent possible because of its potential to increase consumer cost-sharing as a result of higher QPAs in very concentrated markets.

Opt-in for Self-insured Plans to State Laws
The opt-in for self-insured group health plans introduces additional complexity into an already complex set of requirements with little evidence of a desire by many self-insured plan sponsors to opt-in to state laws. Preserving ERISA preemption and giving stakeholders clarity on which governmental entities have oversight jurisdiction are important to ensure the public is protected when questions of compliance arise. We recommend that the opt-in be removed in future rulemaking and that the Departments disallow opt-ins for providers or health plans.

Non-fee-for-service Arrangements
We support the approach taken by the Departments to provide for the determination of the QPA when payment arrangements and contracted amounts are not based on fee-for-service. The rules recognize that incentive-based payments to providers are an important tool for attracting and retaining high-quality, high-value providers to participate in robust health insurance networks and those incentive payments should not factor in the QPA. The approach taken for these arrangements, notably relying on internal methodologies of the plans and issuers who negotiated the contracts, should help encourage future shifts away from fee-for-service billing. It can also serve as a model for unique contracting circumstances, such as those discussed below involving rental agreements, successive discounts, and chargemaster based contracts.

Rented Networks and Unique or Single Instance Contracting
We support the approach taken with regard to single case agreements whereby they are included in the definition of participating facility with respect to a single individual's care but not part of the QPA calculation. However, the Departments noted that many plans and issuers rent provider networks or otherwise contract with third parties to manage provider networks and sought comment on whether additional guidance or special rules are needed on how to define a contract in this situation and how to define the same for single case agreements.

For many health insurance providers, the network they rented on January 31, 2019, is not the same network or even the same contracting entity from which they rent provider networks today; therefore, the contracted rates are quite different and the provider networks vary substantially. Further, the current contracting entity would not have insight into the contracted rates from years prior owned by a different company.

We seek clarification on how health insurance plans and issuers are to determine contracted rates for QPA purposes when the contracting entity providing the rental network has changed from the calculation year. For practical purposes, plans and issuers will likely have to determine their QPAs based on contracted rates currently in effect at the time of QPA determination from the entity that is providing the rented network that year. Plans report that in many circumstances, nationwide rented network codes will be very difficult to compile and would require compiling

[4] https://www.ahip.org/how-hospital-consolidation-hurts-americans/, August 26, 2021.

an out-of-network fee schedule for each of the 384 metropolitan statistical areas (MSAs) nationwide.

The uncertainty about what constitutes a new geographic region is of particular concern for smaller and local health plans. How should a "geographic region" be defined when determining whether the plan or issuer had sufficient presence in the region as of January 31, 2019? Plans and issuers require clarification on whether that value should be entered as the MSA, all MSAs in a particular state, or the census division.

Health insurance providers have reported contracting methods that do not always align with the binary of "participating vs. non-participating." Agreements with providers are often more nuanced than merely: (i) incorporating a provider in a contract for a single instance, or (ii) for a broader all-encompassing in-network participation arrangement. One such example is the use of standing discount agreements, distinct from single case agreements and in-network participation arrangements, with providers who do not participate in a particular network recognized by the plan, issuer, or the underlying terms of coverage for application of in-network benefit levels and cost-sharing. Plans and issuers also have some out-of-network discount arrangements that are not ad hoc/single case. The discounted arrangement may not cause the provider to be treated as in-network, and indeed in some cases, the provider may be out-of-network for some networks and coverages and not for others. For example, a provider may be in-network for PPO, but out-of-network for a narrower PPO network where a separate standing discount contract applies (as an example only, for services provided in an emergency).

We recommend that when a provider is out-of-network for a given plan or coverage but has a standing discount arrangement that these "standing discount" arrangements with providers not be considered "contracted rates" and not factor into calculating median contracted rates for purposes of a QPA. In addition, while the IFC requires issuers to incorporate contracted rates associated with rental networks into the QPA calculations, we recommend future rulemaking or subsequent guidance clarify that contracted rates for rented or rental networks are only to be included in QPA calculations if those providers participate a network that a plan, issuer, or underlying terms of coverage recognize for application of in-network benefit levels and cost-sharing.

Chargemaster-based Contracting
Some health plans and issuers use a "percent of billed charges" contract model, particularly for rental networks, where hospitals have different rates for the same code depending on what specialty area within the hospital provided the service. As all hospitals construct their chargemasters differently, insurers do not have insight into the level of detail that would be necessary to enter contracted rates for QPA calculation purposes, as the rate fluctuates. We recommend future rulemaking address unique contracting scenarios and allow the rates for a particular code at a facility, when based on a percentage billed model, to use all amounts paid within a facility for a code within a set amount of time, to identify the contracted rate for QPA purposes.

Indexing
We believe the indexing of contracted rate amounts in perpetuity for QPA calculation purposes risks inflating costs for consumers in the future. In future rulemaking after adequate experience

with implementation by all parties, we recommend the Departments gather public input on when it is appropriate to re-index contracted rates for purposes of the QPA calculation.

Notice and Consent to be Balance Billed
We agree there are few circumstances where an informed patient would willingly consent to receive a balance bill. Notice to consumers should be abundantly clear and in plain language and terms that spell out what the consumer would be consenting to and what costs they would incur by signing. We believe federal and state regulators should closely monitor use and potential misuse of written notice/consent forms by providers and facilities to ensure that they are not being used as a loophole to continue to balance bill. We also support guardrails to ensure providers do not obtain consent retroactively.

The Departments should develop information sharing requirements and oversight mechanisms for providers when patients consent to be balance billed. The notice and consent exemption should not be an open door to providers to misuse information obtained from health insurance plans. Health plans must promptly be provided an electronic copy of the consent document when a provider obtains it so the plan can accurately determine the enrollee's financial obligation. In addition, oversight mechanisms should include processes for resolving any disputes between providers and patients on whether notice was sufficient and/or consent was given, including a mechanism for notifying health plans of the final resolution of disputes.

Under the final rules, for written notice and informed consent to be balance billed for emergency services, the provider or facility must notify the plan or issuer when transmitting the bill for items and services for which consent has been received, either on the bill or in a separate document. We recommend the notice be provided to the plan or issuer on a timely basis, meaning within 24 hours. With respect to services provided by non-participating providers at participating facilities, AHIP encourages the Departments to require that providers and facilities indicate on the claim submission whether each item or service is subject to balance billing provisions and whether the patient has provided written consent to be balance billed for that item or service. We recommend that the Departments consider whether a currently-available field on the HIPAA Transaction Form 837 can be repurposed to capture this information. A "check the box" type designation should suffice; however this will require significant lead time to implement and would not be ready by January 1, 2022.

Complaint Processes
We recommend the Departments establish the tri-Departments as joint authorities responsible for fielding and responding to complaints regarding possible violations of QPA calculation requirements. A review team from the three agencies should be established to review complaints received via a hotline, email, regular mail, or website. The statement of compliance health plans and issuers send detailing their QPA methodology should include information on how providers or facility staff may submit a complaint. The process for submitting complaints would be relayed to providers on the required information sharing disclosure about the QPA calculation. This process should be sufficient to provide confidence in the appropriate deference that the rule grants to health plans and health insurance issuers in the QPA determination, as the sole entities with insight into the total of contracted rates for an item or service and to provide a statutorily

required guardrail to help ensure good faith compliance with the process for determining the QPA.

Health insurance providers seek clarification on what constitutes an oral complaint under the final rules. While the rules make clear these complaints are to be directed to HHS, some threshold requirement of formality is needed to ensure not every inquiry contained in call, email, or letter constitutes a formal complaint under the regulations.

Scope and Definition of a Visit

The Departments sought comment on the definition and scope of a "visit." We believe patients should be broadly protected and that loophole opportunities should not be created where providers could exploit uncertainty about the common understanding of a health care visit in order to increase revenue by discouraging patients from seeking in-network care when available and appropriate.

We recommend the Departments clarify the definition of a "visit" includes only those items and services provided at the facility or ordered at the facility. We recognize that many providers, particularly in rural areas, may engage in telemedicine consultations or order off-site laboratory work, which should be considered part of the same treatment visit. Otherwise, items and services ordered and furnished after discharge should not fall within that category. Further, final regulations should clarify that when a patient is discharged or transferred to another facility, the emergency and the visit have ended.

Laboratory services require further clarifying rules on the scope of a visit, namely when lab work is reviewed at a participating laboratory by a non-participating provider. Patients should be protected based on the reasonable understanding that work performed at an in-network lab would all be in-network, much as the No Surprises Act was passed to align with the common understanding that treatment by providers at a participating hospital will be covered as in-network services.

Other Provisions and Comments Solicited

All-Payer Claims Databases (APCDs)

Under the interim final rules, state APCDs are always eligible third-party databases for QPA calculation purposes. We have concerns that APCDs are not accessible in the way envisioned by the IFC. It can take several months to apply for, obtain approval, and actually receive the data from an APCD. We recommend the Departments encourage States to develop an expedited process to enable carriers to access APCD data for the purpose of determining the QPA for new plans or coverage. We also support transparency in the database fee structures.

Application to Indemnity Products

The Preamble addresses how certain provisions of the final rules apply to indemnity products.[5] AHIP recommends the Departments include in future rulemaking a definition of indemnity products that aligns with the NAIC model act definition: "a health benefit plan that does not require a person to use, or creates incentives including financial incentives, for a person to use

[5] 86 FR 36,904

health care providers managed, owned, under contract with, or employed with the health carrier." An indemnity plan does not include plans that are otherwise excepted benefits.

Definition of Provider
The IFC defines "physician or health care provider" while other regulations and the Preamble refer to a "physician or other health care provider." We urge utilization of the latter for uniformity, clarity, and accuracy.

Unique Plan Designs and Expatriate Plans
The Departments sought comment as to whether there are any other plans with unique benefit designs that should be exempt from all or some of these interim final rules.[6] The IFC defines a "physician or health care provider" subject to the No Surprises Act and implementing regulations as "a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law…" Our interpretation of this language is that plans, to the extent they offer benefits outside the United States (e.g., expatriate health plans), are exempt from requirements under the final rules.

We ask for clarification and urge exemption from the provisions of the IFC as they relate to items and services furnished outside of the United States as many requirements apply only to health care providers who satisfy that definition, including advance EOBs, cost estimates, and identification cards. Subjecting offshore providers to these requirements would lead to consumer confusion and reporting burdens that would hinder international business. Information on identification cards directed at U.S.-based providers would be confusing to international providers, leading to confusion for consumers. For reporting, the added complication of segregating claims incurred in the U.S. from those incurred elsewhere would be a burden to expatriate health plans and create an unlevel playing field with international companies not subject to the same rules and we urge their exemption from these requirements.

[6] 86 FR 36904

The No Surprises Act & Federal Independent Dispute Resolution (IDR): Health Insurance Provider Experience and Recommendations

July 2023

Introduction

In December 2020, Congress passed the No Surprises Act (NSA) on a bipartisan vote. The NSA prohibits out-of-network health care providers from billing patients more than their in-network cost-sharing when a patient receives emergency services, air ambulance transportation, or is treated by an out-of-network provider at an in-network hospital. Consumer protections took effect for health insurance coverage and group health plans with effective dates on or after January 1, 2022. In April 2022, the Federal Independent Dispute Resolution (IDR) process began, allowing health care providers and facilities who do not accept the initial payment from a group health plan or issuer to dispute the payment before an IDR Entity.

Methodology

AHIP collected data and feedback on the IDR process from health insurance providers nationwide to assess their experience with the Federal IDR process from the beginning of the process until March 2023. Respondents included a mix of large national and medium-sized regional plans. AHIP received responses from nine (9) health insurance providers representing 120 million commercial enrollees, accounting for the majority of national commercial health plan enrollment. During this time, the October 2021 interim final rule directing how IDR Entities are to consider factors for payment determinations, including the Qualifying Payment Amount (QPA), was vacated and the Tri-Departments (Labor, HHS, and Treasury) issued a new Final Rule with minimal guidelines for IDR Entities. AHIP conducted this research to supplement the most recent Status Update from the Tri-Departments, provide experiential data in connection with AHIP's amicus briefing in ongoing litigation, and inform recommendations to the Tri-Departments on how best to improve the implementation of the NSA and IDR.

Results

Most payment disputes between health care providers and health insurance providers were resolved without the IDR process

- Health insurance providers reported that in nearly 9 in 10 disputes – 88% – their initial payment offers were accepted by providers without entering an open negotiation period.
- For disputes that entered an open negotiation period, 37% were resolved without pursuing IDR.
- While all responding health insurance providers based their initial payment amounts on Qualifying Payment Amounts (QPA), several health insurance providers considered other factors, such as geographic area and market segment, in addition to the QPA. The initial payment amounts remained steady throughout the last year
- Additional data received indicates out-of-network claims covered by the NSA proceed through the process as follows:

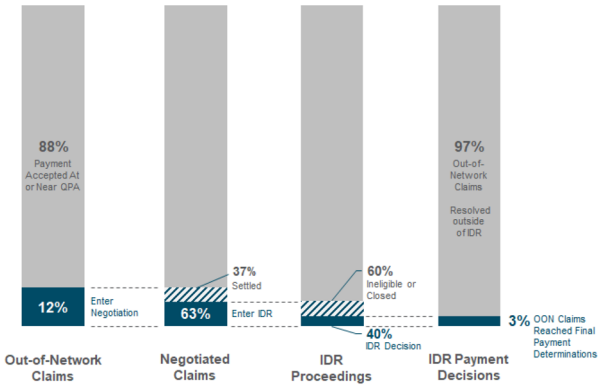

Fig. 1: Percentage Of NSA-Eligible Claims by Outcome
(Source: June 2023 AHIP Data Request)

Health insurance provider experience with IDR entities varies widely

- The average payment amount was about 143% of QPA. Payments were generally lower in cases where health insurance providers prevailed and substantially higher in cases where providers prevailed.
- Most health insurance providers noted substantial degree of variability between different IDR entities with regards to payment amounts and the share of disputes where entities found in favor of the responding party.

Air ambulance disputes are clear outliers

- Every responding health insurance provider noted their experience in disputes with air ambulance providers differed substantially from their experience with other providers. In general, air ambulance providers were able to prevail in IDR disputes in almost all cases and were typically awarded much higher payments (more than double the QPA).

Impact of the IDR process on network participation is mixed

- While it remains too soon to assess broader trends, there are early signs that some providers and facilities that had previously opted to remain out of network are now entering into networks.
- Several health insurance providers reported that they saw an increasing interest from some providers to participate in network. They used their IDR payment determinations as a starting point in their contract negotiations.
- In contrast, other health insurance providers felt that out of network providers were less likely to participate in network because they could receive higher payments through the arbitration process.

IDR entities take longer than 30 days to issue determinations

- On average, IDR entities took 62 days to issue determinations. Health insurance providers pointed to the high volume of cases, and especially high volume of ineligible submissions, as primary causes of delays in the process.

The costs of IDR process are substantial

- Two large health insurance providers reported spending, on average, over $3 million on staff hired specifically to process IDR disputes.
- These costs are in addition to the costs for project management, negotiators, reporting, finance, and additional support positions needed to complete all steps required during the IDR Process.

High volume ineligible cases and unactionable written explanations are the biggest pain points in the IDR process

- Health insurance providers consistently pointed to the high volume of ineligible cases as the primary cause of both the significant delay and higher than expected costs of the IDR process.
- Many providers failed to vet their cases before submitting them to IDR to ensure that the cases were NSA eligible. Claims wrongly submitted to the Federal IDR included claims payable by Medicaid or Medicare, claims subject to preemptory state mandates or otherwise outside of scope of the NSA.
- Some providers engaged in what one plan called “provider claim dumps”, which it referred to as the practice of “indiscriminately sending a payer its entire accounts receivable without putting in the work to select the claims that are eligible under the NSA,” often with the help of third-party billing companies. Consequently, health insurance providers
- must devote substantial staffing and IT resources to sorting through the ineligible cases.
- Similarly, health insurance providers consistently pointed out that written explanations for IDR determinations were too generic and vague to be actionable. The explanations did not provide sufficient detail to explain the reasons behind the IDR entity’s ruling. Consequently, health insurance providers had little guidance on how to improve their offers and ensure that fewer cases would proceed to IDR in the future.

Other issues commonly mentioned by health insurance providers

IDR Process and Entity Challenges

- Challenging the validity of QPA in determinations: Some IDR entities challenge health insurance providers’ QPA calculations. Health insurance providers note that the IDR process is not an appropriate forum to debate the validity of QPA calculations, which is expressly prohibited by the No Surprises Act.
- IDR entity delays: IDR entities often take a long time to respond to health insurance providers on dispute-related issues, causing substantial delays in the process. Conversely, IDR entities often set unrealistic deadlines for health insurance providers to respond to requests for additional information.
- Variation among IDR entities: There is a considerable variation among IDR entities in terms of process (forms, letters, determinations); invoicing and refund processes, and communication styles. Some IDR entities send communications via secure email making it time consuming and difficult to access.
- No tracking or reporting capabilities: Health insurance providers currently lack the ability to check the status of a dispute and track its progress through the Federal IDR portal. Similarly, health insurance providers have no ability to generate reports through the

portal on their active disputes, which would be useful for health insurance providers and providers to better communicate, reconcile disputes, and ensure timely payment.
- No process for challenging IDR Entity or eligibility errors: Health insurance providers have no mechanism to challenge the eligibility of a dispute once a payment determination is issued.

Provider-driven Challenges in the IDR Process

- Incorrect payer contact information: Providers often list incorrect contact information for the plan when submitting a dispute or batched disputes through the IDR process. This leads to disputes proceeding without the plan's involvement and time-consuming delays.
- No way to address obvious errors: If a dispute is submitted to IDR with incorrect billing codes, or other obvious errors, there is currently no process to fix it quickly. These cases clog up the system and cause additional delays.

Recommendations for Action by the Departments

Reducing Ineligible Claims for Dispute

- The Departments should urge standards developers to create a field to identify the line of business for a surprise billing claim.
- The Federal IDR portal should automatically reject Notices of IDR Initiation submitted after the deadline.
- The portal should add functionality for an automatic screener for eligibility, rather than merely a prompt, based on the CMS State Enforcement Letters.
- A process should be defined to dispute a payment determination issued for a claim found to be ineligible under the No Surprises Act.
- Require initiating parties to upload the Remittance Advice document to the portal, which would identify Remittance Advice Remark Codes (RARCs) for determining eligibility.
- Convene stakeholders to discuss updated RARCs specific to No Surprises Act eligibility.
- Create a voluntary directory for health insurance providers to submit contact information through the Federal IDR Portal.

Improving Consistency and Transparency Among IDR Entities

- Develop a single training manual for all IDR Entities and require more stringent and intensive live training for staff of the IDR Entities.
- Develop materials to inform IDR Entities on the considerations, including the role of the QPA under the rules, as well as reiterating that any prohibited factors must not be part of an inquiry by the IDR Entity.
- Consider directing disputes for certain claim types, such as by provider specialty or similar codes, to an IDR Entity specifically trained for reviewing those types of claims.
- Require complete and accurate completion of a uniform, written explanation template for IDR Entities to detail written explanations of payment determinations that clearly explains how the QPA and additional considerations factored in the decision.
- Continually review IDR Entities for conflicts of interest and demonstrations of bias.

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
C 202.450.8218
ahip.org

Matthew Eyles
President & Chief Executive Officer

December 6, 2021

The Honorable Janet Yellen
Secretary of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Marty Walsh
Secretary of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Director Kiran Ahuja
Office of Personnel Management
1900 E Street, NW
Washington, D.C. 20415

Submitted via the Federal Rulemaking Web Portal: http://www.regulations.gov

RE: Interim Final Rules with Comment Period: "Requirements Related to Surprise Billing; Part II" (RIN 1210-AB00)

Dear Secretary Yellen, Secretary Becerra, Secretary Walsh, and Director Ahuja:

I write on behalf of AHIP to offer comments in response to the Interim Final Rule with Comment Period (IFC) entitled "Requirements Related to Surprise Billing; Part II" issued by the Departments of Health and Human Services, Labor, and the Treasury, and the Office of Personnel Management ("the Departments"), published October 7, 2021, in the Federal Register.

No one should worry about returning from the hospital to a surprise medical bill. For decades, millions of consumers each year have experienced financial hardship, even bankruptcy, from receiving a surprise medical bill from an out-of-network doctor they did not select. Surprise billing escalated in recent years as hospitals consolidated, private equity firms took over physician staffing groups, and thousands of hospital-based providers made a business model out of not participating in health plan networks and charging patients much higher prices. The practice represented a market failure that not only resulted in millions of people receiving surprise bills, it increased health care costs for everyone.

The interim final rules from the Departments are a critical step toward ensuring that, beginning January 1, 2022, surprise medical bills are a relic of our past. AHIP strongly supported Congressional efforts to ban surprise medical billing and recognize what was enacted was a compromise after numerous years of debate. And today, we firmly support the approach the Departments take to protect patients through these interim final rules. **The interim final rules go a long way toward addressing the underlying market failure and will help achieve the predicted premium savings intended by the No Surprises Act.**

Consumers' best interests are served by these rules and the full patient protections taking effect January 1, 2022. That is why it is very disappointing the Texas Medical Association and the

Association of Air Medical Services have filed lawsuits to vacate portions of the rules. The qualifying payment amount (QPA) is central to the law and the sections of the rules providing direction for the IDR process cannot be separated from the entirety of the approach to protect patients from surprise medical bills. As we detail in our comments, AHIP strongly supports the approach taken, including the necessary use of interim final rules with comment periods, to ensure the statutory effective date could be met.

In the enclosed comments, AHIP:

- details our support for the use of these interim final rules;
- offers technical feedback on the surprise billing and air ambulance billing independent; dispute resolution (IDR) processes;
- explains our legal reasoning on the payment determination requirements in the rules; and
- reacts to the new requirements for external review.

When more high-quality health care providers participate in health plan networks, patients receive better, more coordinated health care at lower costs. And they do not worry about surprise bills. AHIP and our members believe the underlying market failure can be corrected when more health care providers, particularly hospital-based physicians, participate in commercial health plan networks that serve more than 200 million individuals. More in-network care means the requirements of the No Surprises Act need not be triggered, including the need to resolve payment disputes through IDR. By creating a regulatory scheme that makes IDR efficient and predictable, while substantially reducing the likelihood of providers or facilities gaming the system for unjustifiably high out-of-network rates, the Departments are discouraging unnecessary IDR while encouraging greater network participation. The approach taken in the interim final rules is a clear win for hardworking people.

The interim final rules also closely preserve the intent and purpose of the No Surprises Act and will help achieve the budgetary savings estimated by the Congressional Budget Office. Consumers will be protected from surprise medical bills while having more access to in-network health care providers. The law and these implementing rules achieve higher quality care and lower health care costs.

Consumers deserve control and choice over their coverage and care, and no one should receive a surprise medical bill for care they did not choose. AHIP and our member health insurance providers look forward to continuing to engage with the Administration as these patient protections take effect, the online portal launches, and the era of surprise medical billing comes to an end.

Sincerely,

Matthew Eyles

President & Chief Executive Officer

Attachment
AHIP Detailed Comments on Requirements Related to Surprise Billing; Part II

AHIP's comments on the interim final rules are organized into the following sections:

I. Support for the Administration's Approach to Payment Determinations for a Qualified IDR Item or Service
II. Independent Dispute Resolution Process: Technical & Operational Considerations
III. Independent Dispute Resolution Process for Providers of Air Ambulance Services
IV. Internal Claims and Appeals and External Review Processes
V. Patient-Provider Dispute Resolution; Protection for Uninsured Individuals
VI. Other Miscellaneous Comments

I. Support for the Administration's Approach to Payment Determinations for a Qualified IDR Item or Service

A. Public Policy Interests Require Clear Direction to Certified IDR Entities (CIDRE) on How to Consider the QPA and Additional Circumstances

The process for parties to submit offers and have a payment determination made by a certified IDR entity, as well as the considerations in determination by the certified IDR entity, are detailed in the IFC with great clarity and, together, represent sound public policy. The approach ensures all credible, relevant information is adequately heard by the certified IDR entity and thoroughly accounts for the nuances of paying for health care in the United States. It levels the playing field in the dispute in a way that should discourage misuse and abuse of IDR processes, streamline and encourage efficiency in resolving disputes, and help correct the underlying market failure that led to Congress taking action by anchoring payment determinations to locally negotiated market rates for qualified items or services, rather than billed charges.

The totality of these rules is such that the savings for taxpayers estimated by the Congressional Budget Office (CBO) can be realized. The CBO has projected that the No Surprises Act will reduce private health plan premiums by 0.5%-1% on average and reduce the Federal deficit by $17 billion over 10 years.[1] These estimates were based on the assumption by CBO that the consideration of the QPA in the IDR process would have an anchoring effect. Representative Frank Pallone (Chair, Energy & Commerce Committee) and Senator Patty Murray (Chair, Health, Education, Labor & Pensions Committee), key bicameral leaders in passing the No Surprises Act wrote as much earlier this year: "[t]his estimate was provided based on the assumption and understanding by CBO that the QPA is central to the IDR determination, above all other factors."[2]

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[1] https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf
[2] Letter from Rep. Frank Pallone, Jr. and Sen. Patty Murray to Secretary Becerra, Secretary Yellen, and Secretary Walsh (Oct. 20, 2021) at https://www.help.senate.gov/imo/media/doc/Pallone%20Murray%20No%20Surprises%20Act%20IFR%20Comment%20Ltr%2010.20.212.pdf (Pallone-Murray Letter)

Similarly, Representatives Bobby Scott and Virginia Foxx, the Chair and Ranking Member of the House Education and Labor Committee, have affirmed their committee intended the QPA to have a central role in order to achieve lower health care costs. In a recent letter to the Departments, Scott and Foxx wrote: "the IFR properly finds that the QPA should be the primary factor considered by IDR entities."[3] The bipartisan leaders specifically point to the plain language of the law and the role of the QPA in lowering premiums: "The thoroughness of the law's treatment of the QPA reflects the importance placed on it and also ensures that the standard is fairly and transparently applied during the IDR process. In addition to comporting with the plain language of the statute, the approach adopted by the IFR is consistent with Congress's bipartisan goal of lowering premiums and preventing inflation in health care spending." **The conclusion is clear, and leaders agree: These rules will help people pay less for health care.**

In determining which offer to select, the CIDRE must consider the QPA, credible information requested by the CIDRE, and additional information submitted by a party, so long as the information is credible and clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate. Contrary to some news reports, nothing in the IFC requires a CIDRE to default to selection of the QPA or the offer closest to it. The rules mandate all credible information be reviewed and expressly envision the breadth of information expected to be presented, which includes, but is not limited to, the QPA. We believe this balanced approach is both legally supported by the statute and in the clear and best interests of public policy.

The QPA represents a reasonable, market-based rate. Payment determinations that favor market rates will encourage greater participation in health plan networks. "The No Surprises Act directs the Departments to establish through rulemaking the methodology that a group health plan or health insurance issuer offering group or individual health insurance coverage must use to determine the QPA."[4] The first interim final rule implementing the No Surprises Act establishes that "for a given item or service, the QPA is the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation."

Fundamental to the question a CIDRE must decide is what the out-of-network provider or facility would be fairly paid for the item or service provided in a functioning market. The QPA is a fair representation of what the market rate is for a given item or service provided in the same geographic region. We wholeheartedly agree with the Departments, as stated in the Preamble to these interim final rules, that the QPA "represents a reasonable market-based payment for relevant items and services." It is a product of contracted rates negotiated by other providers in the same specialty with that health plan or health insurance issuer. We know it is a fair rate paid

[3] https://edlabor.house.gov/imo/media/doc/chairman_scott__ranking_member_foxx_re_surprise_billing_protections.pdf
[4] Requirements Related to Surprise Billing; Part I. Preamble. July 13, 2021.

to a specialty provider for that specific item or service because it is what is paid to their colleagues in the same region, and their colleagues had full ability to negotiate the terms of their contract with the health plan. The Departments say as much in the Preamble, noting "[t]he QPA is generally based on the median of contracted rates, and these contracted rates are established through arms-length negotiations between providers and facilities and plans and issuers (or their service providers)."

As the Departments also acknowledge, anchoring out-of-network rates close to the QPA will encourage predictability of IDR, which can help avoid the need for IDR altogether. One way to avoid the need for IDR is if providers and facilities are in-network with (or participating with) health plan and health insurance networks. When there is predictability that reimbursement amounts following IDR will be close to median contracted rates, without significant possibility of a windfall for certain providers, more providers will have financial incentive to participate in health plan networks. More participating providers is good for patients, consumers, and providers – indeed for the entire health care system. Provider networks are a key tool for delivering the right balance of quality, affordability, and choice for consumers. Health insurance providers use high-value provider networks to reduce premiums and promote more affordable coverage for consumers. Health insurance providers evaluate doctors and hospitals for quality and safety performance before including them in a network. This involves ensuring that facilities and providers meet patient safety goals and credentialing standards. In fact, performance on quality measures and patient outcomes is the key part of criteria used for provider selection and inclusion in a plan's network—including high-value network plans.

Increasing participation in health plan networks is central to the operation of health insurance providers and plan administrators. A large, robust network of participating providers is the essence of the product offered by commercial health plans. A large network of participating providers is in the public interest, as more consumers will have affordable, high-quality care from doctors they know to participate in their health plan. Growing network participation is in the interest of health care providers that will have readier access to a larger pool of patients and guaranteed payments from health plans that are also better able to incentivize value-based care and pay providers for performance and value rather than fee-for-service.

Experience has demonstrated that when surprise billing laws require reimbursement for out-of-network care based on contracted rates, more hospital-based providers join health plan networks. In the nation's largest insurance market – California – the state legislature passed AB 72, which took effect July 1, 2017. The California law is distinguishable from the Federal No Surprises Act; it relies on a benchmark payment to out-of-network providers of either the average contracted rate or 125% of the Medicare reimbursement rate and there is no option for independent dispute resolution. At the Federal level, Congress decided not to rely solely on a benchmark payment approach and instead allows for disputes to include an open negotiation period and option for independent dispute resolution. But the California model demonstrates how reducing or eliminating the financial incentive to remain out of network -- by steering out-of-network reimbursements toward local, contracted rates -- drives more hospital-based providers in-network.

That is exactly what happened in the years following AB 72 taking effect. Among health insurance provider networks between 2017 and 2019, the total number of in-network physicians increased 16%, with growth seen in every hospital-based specialty[5]: 10% growth in emergency medicine, 1% in pathology, 18% in anesthesiology, and 26% in diagnostic radiology. Objective, market-based standards for reimbursement encourage more health care providers to participate in health plan networks.

The No Surprises Act was enacted to protect consumers from receiving surprise out-of-network bills. A key related goal of the Act was to increase participation in health plan networks, not to increase disputes between health care payers and providers. In issuing the first interim final rule on requirements related to surprise billing, the Administration stated in a press release that "Thanks to the Biden-Harris Administration and bipartisan congressional support, HHS, Labor, Treasury, and OPM are promulgating rules that will protect consumers from financial ruin simply because they could not ask for an in-network provider during their treatment."[6] With more health care providers, particularly hospital-based providers being in-network with health plans, consumers are protected because they will be able to ask for an in-network provider. Because of the presumption articulated by the Departments with respect to the QPA, the financial incentives point away from the business model of remaining out-of-network and towards participation in health plan networks.

The QPA is a detailed calculation set by law with its methodology detailed in regulation. Guiding payment determinations based on objective standards required by law developed by the Departments will foster predictability, stability, and equity in the IDR process. The QPA methodology is detailed at length in 26 CFR 54.9816-6T, 29 CFR 2590.716-6, and 45 CFR 149.140. The Departments developed the QPA methodology following a thorough process which included input from the public and affected stakeholders. It is an objective and quantifiable standard, which is essential as a guide and form of measurement for an otherwise entirely subjective and new process. Without an objective standard as a guide for the certified IDR entities, the question of how out-of-network providers are to be compensated becomes a highly subjective decision where arbitrators contracted through certified IDR entities must guess and the predictability of IDR becomes scattershot. These interim final rules readily acknowledge that the offer closest to the QPA will not always be the appropriate out-of-network rate, and there will be circumstances where the nuance of treatment or unique aspects of a local market may dictate a higher or lower reimbursement rate. The CIDRE is required to take that information into account. The rules merely guide the CIDRE as to how that information is to be evaluated. It would defy common sense to require entities to adjudicate disputed payments while offering no standards or criteria for those entities to base their decisions, particularly in a brand-new dispute resolution system.

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[5] https://www.ajmc.com/view/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did
[6] https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise-medical-bills

The interim final rules provide clear direction around how to consider the additional circumstances that are part of the statute. While Congress spent several pages of the No Surprises Act detailing the QPA, including a directive to the Departments to issue rulemaking on the QPA methodology, section 103 of the Act gives but a paragraph listing the "Additional Circumstances" to be considered in IDR. It makes sense, therefore, that the Departments in both the Preamble and regulations, go into great detail as to how these additional circumstances are to be evaluated. The process for evaluating additional circumstances is thorough and fair, as detailed in 26 CFR 54.9816–8T(c)(4)(iii)(B) through (D), 29 CFR 2590.716–8(c)(4)(iii)(B) through (D), and 45 CFR 149.510(c)(4)(iii)(B) through (D).

Many of the "additional circumstances" retread the same ground that has already been considered in setting the QPA, as each of those are accounted for in determining contracted rates. It would be redundant to consider them twice, absent cause or an anomaly. For example, billing codes and their modifiers already account for severity and acuity. The level of training, experience, or quality outcomes increase contracted rates for providers, which are the input unit for the QPA calculation. Market shares of both parties negotiating contracted rates influence the rates, which then become part of the QPA calculation.

The Departments readily acknowledge that many of the additional circumstances are already accounted for in the QPA and therefore the emphasis on credible information about the additional circumstances demonstrating a material difference is appropriate to ensure that reimbursements are not unnecessarily inflated. A prime example of why this makes sense is articulated in the IFC when the Departments write about how to evaluate the level of training or experience of a provider, saying that to choose an offer higher than the one closest to the QPA simply because the provider is more experienced "would lead to an increase in prices without a valid reason and does not align with the goals of the No Surprises Act." The Departments take the view that deviating substantially from the QPA requires a valid reason supported by credible information. We agree. The use of a rebuttable presumption, rather than a hardline directive, strikes an appropriate balance between predictable efficiency and ensuring all sides are heard.

Avoiding subjectivity and random results is more than an abstract goal, as predictability of IDR translates to cost-savings for consumers and taxpayers. The Departments explain this in the Preamble to these interim final rules:

> "Anchoring the determination of the out-of-network rate to the QPA will increase the predictability of IDR outcomes, which may encourage parties to reach an agreement outside of the Federal IDR process to avoid the administrative costs, and will aid in reducing prices that may have been inflated due to the practice of surprise billing prior to the No Surprises Act. Finally, anchoring the determination to the QPA will help limit the indirect impact on participants, beneficiaries, and enrollees that would occur from higher out-of-network rates if plans and issuers were to pass higher costs on to individuals in the form of increases in premiums."

We firmly agree and urge the Departments to include the policy rationale behind the interim final rules, particularly as it relates to the guidance for payment determination, in sub-regulatory guidance and/or training materials when certifying IDR entities. The emphasis on the qualifying payment amount, while mandating consideration of other credible information, is more than a balanced approach that is good public policy; it is the appropriate interpretation of the No Surprises Act by the Departments with the expertise and charge to issue rules.

B. Statutory Construction and the Role of the Qualifying Payment Amount

The Departments correctly interpret the No Surprises Act to center the QPA in the IDR process. The IFC explains that "when selecting an offer, a certified IDR entity must look first to the QPA, as it represents a reasonable market-based payment for relevant items and services, and then to other considerations. This presumption that the QPA is the appropriate out-of-network rate can be rebutted by presentation of credible information about additional circumstances…"[7] This presumption reflects the best interpretation of the No Surprises Act, in line with its text, structure, and purpose.

To "ascertain[] the plain meaning of the statute," the Departments have properly considered "the particular statutory language at issue, as well as the language and design of the statute as a whole."[8]

The governing statutory provision indicates that the QPA is the presumptive appropriate out-of-network rate. The QPA is enumerated in its own subclause of Section 2799A–1(c)(5)(C)(i),[9] listed first and separately from all other considerations. The rest of the factors are described in a separate paragraph and are termed "additional" considerations, making clear that they are supplementary. Moreover, the certified IDR entity's consideration of these "additional" items is subject to constraints: certain aspects cannot be considered, Section 2799A–1(c)(5)(D), and an IDR may be conducted without the parties submitting any additional considerations at all, Section 2799A–1(c)(5)(B)(ii). As the Chair of the Senate's Health, Education, Labor, and Pensions Committee and the Chair of the House's Committee on Energy and Commerce explained, the No Surprises Act "designates the QPA as the only factor that must be submitted and considered without qualification in every dispute under consideration by the IDR entity."[10]

Examining the IDR considerations "in their context and with a view to their place in the overall statutory scheme,"[11] reinforces the QPA's presumptive role. The No Surprises Act has detailed rules for calculating the QPA, Section 2799A–1(a)(3)(E), whereas the "additional circumstances,"

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[7] 86 FR 55,996
[8] *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988).
[9] The No Surprises Act made parallel amendments to provisions of the Public Health Service ("PHS") Act, the Employee Retirement Income Security Act ("ERISA"), and the Internal Revenue Code. The citations herein are to the portion of the No Surprises Act that amend the Public Health Service Act, Pub. L. No. 78-410.
[10] *See* Pallone-Murray Letter at 2 Letter from Rep. Frank Pallone, Jr. and Sen. Patty Murray to Secretary Becerra, Secretary Yellen, and Secretary Walsh (Oct. 20, 2021) at 2.
[11] *FDA v. Brown & Williamson Tobacco Corp.*, 529 U. S. 120, 133 (2000).

are amorphous and not defined by the statute. Several statutory provisions indicate that the QPA is centerpiece of the No Surprises Act. First, Congress required the Departments to make the QPA the subject of their first rulemaking, and the Departments did so following a thorough process, considering extensive stakeholder input to issue a detailed QPA methodology by regulation. Second, the QPA is subject to several audit requirements. Section 2799A–1(a)(2)(A). Third, the Act makes the QPA the benchmark against which IDR results are measured and reported. *See* 2799A–1(c)(7)(A), 2799A–1(c)(7)(B)(iii)-(iv).

Finally, the broader statutory design and purpose confirm the QPA's anchoring role. "A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme … because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law."[12] The QPA will almost always serve as the "recognized amount" that is the basis for cost-sharing for services subject to the Federal IDR process, Section 2799A–1(a)(3)(H). This indicates that Congress considered the QPA to be a reasonable out-of-network rate.[13] Presuming that the QPA is the appropriate out-of-network rate avoids substantial divergence between patient cost-sharing and the out-of-network rate paid by the patient's health plan. Furthermore, the No Surprises Act emphasizes the importance of "encouraging the efficiency (including minimizing costs) of the IDR process." Section 2799A–1(c)(3)(A). Anchoring the IDR determination to the QPA serves this purpose; a free-floating fact-intensive IDR inquiry does not.[14] Consistent with the statute, the IFC recognizes that the QPA will not always be the appropriate out-of-network rate.

Under the IFC, if there is credible information of additional circumstances that establish the QPA is materially different from the out-of-network rate, then the certified IDR entity may depart from the QPA presumption.[15] This permits the certified IDR entity to address any credible concerns about special circumstances, without creating a wholly unbounded "additional circumstances" inquiry that would likely increase consumers' costs, contrary to the purpose of the Act.

II. Independent Dispute Resolution Process: Technical & Operational Considerations

As noted above, AHIP supports the process the Departments have detailed for group health plans, health insurance issuers, health care providers, and health care facilities to initiate and resolve disputes over out-of-network payment rates in scenarios covered by the No Surprises Act. Furthermore, we support the use of an online portal to facilitate resolution of these disputes. In our comments, we detail below additional technical and operational considerations in implementing the IFC.

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[12] *King v. Burwell*, 576 U.S. 473, 492 (2015) (internal quotation marks and citation omitted).
[13] *See* Pallone-Murray Letter at 2 ("[T]he QPA, which reflects standard market rates arrived at through private contract negotiations, represents a reasonable rate for services in a vast majority of cases.").
[14] *See* Pallone-Murray Letter at 3 ("Reducing the administrative costs of the IDR process and minimizing the frequency of IDR was also a shared goal of the Committees of jurisdiction that considered surprise billing legislation.").
[15] 86 FR 55,997-98.

A. Technical Considerations

As the Departments complete the technical design and implementation of the IDR process, we recommend the Departments address the following issues to ensure streamlined implementation of the new processes and requirements:

- **Identification of Patient-Enrollee:** For both the Open Negotiation Notice and Notice of IDR Initiation, as well as throughout the dispute resolution process, health insurance providers and issuers will require additional information not currently in the template or envisioned in the rules to properly identify the individual enrollee for whom payment for out-of-network medical care is at issue in the dispute. Quickly identifying the items and services under dispute will be critical with the short timeframes laid out in the No Surprises Act and additional information will help avoid confusion, extra communications, and additional administrative expenses. At a minimum, health insurance providers will need to be informed of the following information to accurately identify the specific items and services under dispute:
    - Claim number
    - Provider First & Last Name (professional providers)
    - Provider Group Name (professional providers)
    - Facility Name (facility providers)
    - Provider NPI
    - Plan name
    - Member First and Last Name

  This information should be on any notice or initiation forms, as well as in their companion format in the portal.

- **Support for Electronic Notices and Avoidance of Electronic and Paper Mail:** The IDR initiation and process through payment determination is best completed entirely through the web portal CMS intends to launch effective January 1, 2022. The process can and should be as automated and streamlined as possible, thus we support the use of solely electronic notices. As part of that streamlining, we strongly urge the Departments to require parties in dispute resolution to rely solely on electronic transmissions and avoid use of paper mail entirely, and, as much as possible, avoid use of electronic mail. Instead, all communication, accountability for deadlines, and notifications throughout the IDR process should be recorded and transmitted through the online portal. Avoiding paper mail helps address a concern as to what would constitute a timely submission under the rules, such as the date of postmark versus date of receipt. Paper mail is difficult to track, could be lost, is slow, and is inefficient. While e-mail surely avoids many of the pitfalls of traditional, paper mail, we are concerned that e-mail transmissions may get lost or an insufficient record of receipt could result. E-mail clients often lack necessary encryption or privacy protections. Using the portal as the sole means of transmitting and communicating information as part of the IDR process will minimize the opportunity for errant communications that delay and disrupt the process and permit the

parties to minimize the administrative resources that must be devoted to participating in the IDR process, which ultimately are reflected in provider charges and issuer premiums. It would also help protect patients' right to privacy by minimizing the opportunities for inadvertent disclosure of individually identifiable health information.

Further, no one wants a dispute transmission going to a recipient's spam folder or delayed because an employee is out of the office. This would be especially important for the communication between the parties relating to the selection of the certified IDR entity, because there is a short 3-day timeframe to conduct those negotiations, and emails are easily missed or opened late. In developing and refining the online portal, we ask that the Departments convene a stakeholder group of health insurance providers, providers, and facilities to provide input and feedback on additional functionality to ensure that the portal effectively reduces administrative burdens and costs while protecting sensitive information. AHIP has already had a number of productive conversations with Tri-Department staff on this and looks forward to continuing to engage on ways to develop the most user-friendly and functional portal possible. As part of this additional functionality, we recommend the Departments use a tracking feature to ensure that parties are notified throughout the dispute process as to the status of the dispute, including whether and when submissions are received, how many days remain until the next deadline, and other milestone information to confirm the process is moving forward in accordance with regulations.

- **Establishment of Clear Accountability for Deadlines and Ramifications if Deadlines Are Not Met:** Throughout the statute and implementing regulations, there are clear timeframes for how long parties have to proceed through each step in the open negotiation and dispute resolution process. We urge the Departments to ensure these deadlines are adhered to and parties subject to them have both notice of and accountability to any required deadlines. To aid in this, further clarity would be beneficial as to when, precisely, timeframes begin and cease to toll, how the online portal will reflect such and notify parties, and what shall result if parties miss a deadline. We recommend that the portal, as part of the tracking component mentioned above, be the official timekeeper with respect to required deadlines and that the portal be used to notify parties when a deadline approaches. We further recommend the Departments, through rulemaking, make clear that should a party fail to satisfy a deadline requirement, absent a demonstration of good cause, the dispute process cease.

- **Effects of Determination:** Under the Federal IDR process, determinations made by a certified IDR entity are binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity. We support this decision as necessary to effectuate consumer protections inherent elsewhere in the No Surprises Act.

- **Conflicts of Interest for Certified IDR Entities:** While the conflict-of-interest protections outlined by the Departments account for many of the potential conflicts that could arise between a CIDRE (or the individual arbitrator) and a party to IDR, we would also request that CIDRE personnel assigned to the dispute must not have been affiliated with a party to the

disputed, or an employee or agent of such a party, within 3 years (supplanting the 1-year threshold outlined in the IFC). We also ask the Departments to clarify that its proposed definition of "material financial relationship" would cover situations where there is common ownership of an IDR entity and an IDR participant (e.g., where a private equity firm owns a 5% stake in both a physician practice and an IDR entity).

- **Costs of IDR Process:** The approach to fee schedules CMS establishes in Technical Guidance 2021-01 for Federal independent dispute resolution adheres to the principle, which AHIP supports, that fees be enough to discourage overuse of IDR, but not so exorbitant as to have a likelihood of inflating health care costs. We also seek clarification that if a dispute is determined to be ineligible for the Federal IDR process, the initiating entity is deemed to have not prevailed in the dispute and is responsible for paying the Certified IDR Entity Fee.

B. Batching of Claims

AHIP supports the approach taken with respect to resolving similar claim disputes between the same parties during the same time period as part of a batched review is a prudent method of achieving the statutory goal of efficiency. In particular, we applaud the Departments for recognizing the central role of the QPA as articulated by Congress and requiring certified IDR entities to review each QPA submitted with a claim as part of a batched dispute.

We offer the following recommendations on ways to further avoid abuse or misuse of the option to batch claims for dispute, while promoting efficiency of the IDR process.

The Departments should clarify whether an initiating party must batch items from previous 30 days for the same or similar item or service, or whether they can choose between batching and initiating multiple IDR proceedings. AHIP supports guardrails to prevent providers or facilities from abusing batching, but we also want to avoid providers having the ability to initiate multiple IDR proceedings for the same or similar item or service simultaneously, when the dispute could be properly batched. For example, while a party that initiates IDR cannot initiate another IDR proceeding with the same party over the same or similar item or service during the 90 days following a final determination, it is conceivable a provider could initiate multiple IDR proceedings with the same issuer for the same or similar item or service before a determination for the first IDR proceeding is complete.

For example, if an issuer has ten instances of a member receiving a specific service from one provider over the past 30 days, the provider could initiate ten different IDR proceedings, so long as the open negotiation period of each terminates before the determination is completed in the first proceeding. This seems to run counter to the intent of the batching provisions in the statute. One way to address this may be that the prohibition on initiating another IDR proceeding could begin on the date of the notification of IDR, rather than the date of determination, or clarity around whether claims that can be properly batched must be batched together.

Additionally, we urge the Departments to clarify that the use of "the same group health plan" in reference to a dispute being eligible for batching refers to the plan sponsor, not administrator, of a group health plan. This would be the plain text reading of "group health plan" as it is defined in both ERISA and the PHSA, but due to the widespread use of third-party administrators, including many AHIP members, we believe greater clarity is required to ensure that "same parties" does not encompass any plan administered by the same entity administering the group health plan covering the individual who received out-of-network items or services.

We recommend the Departments require a common nexus among batched claims. In most instances, claims batched together will, presumably, come from the same location. However, disputes may arise between parties (providers and payers) that serve broad geographies. Such situations could result in bundling of claims that are in unrelated geographies with completely different sets of providers. The provider and payer could also have very different market power in those different geographies. Given the fees proposed for the batched process, we assume permissive batching of otherwise unrelated claims was not intended. Therefore, we urge the Departments to clarify that in addition to having a common payer and provider, that there be additional related connections among the claims (e.g., delivered in the same geographic region).

Finally, AHIP would like the Departments to reconsider the ability of claims from health insurance products with very different networks and reimbursements to be batched together. Under the terms of the IFC, an individual market HMO and a large employer PPO could be considered the same health insurance issuer and therefore the same party for batching. The distinctions between these products, networks, and contracted rates would not lend themselves to the efficiencies envisioned and would likely place undue burdens on the IDR entities.

C. Specified State Law and State Balance Billing Procedures

One area of significant uncertainty for health insurance providers and issuers preparing for patient protections to take effect January 1, 2022, is around the procedure for determining whether a specified state law applies to a claim and how the web portal will function when it is unclear whether a dispute should be determined by the Federal process or state process. Similarly, plans have raised the concern about the impact on deadlines should a dispute be filed before the incorrect jurisdiction.

Absent a default to the Federal requirements as a good faith compliance standard, clear guidance from state and Federal regulators is needed to ensure proper implementation by both providers and health insurance providers. The Departments' August 2021 state enforcement inquiry will undoubtedly be helpful in determining the applicability of a specified state law.[16] However, if responses by states to the enforcement inquiry cannot be published, we recommend a crosswalk be created between the Federal and state laws, providing clear direction to stakeholders as to which states meet the standards for compliance under all facets of the No Surprises Act.

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[16] https://www.cms.gov/files/document/caa-state-enforcement-survey.pdf

On a practical level, this will need to be incorporated into the Federal web portal. We ask for guidance as to how the portal will make a determination as to the applicability of Federal vs. state law and clarity as to how a party raises a jurisdictional challenge, as well as the impact on deadlines if a dispute is submitted to the wrong jurisdiction.

III. Independent Dispute Resolution Process for Providers of Air Ambulance Services

AHIP supports the approach the Departments take in these interim final rules with respect to independent dispute resolution for out-of-network providers of air ambulance services. Our comments in Section I (Support for the Administration's Approach to Payment Determinations for a Qualified IDR Item or Service) similarly apply to dispute resolution and payment determinations for out-of-network air ambulance services.

For far too long, air ambulance transportation was a leading cause of surprise bills, and these out-of-network bills were among the most financially devastating for hardworking families. As with other out-of-network disputes, the principle that the regulatory scheme should encourage more in-network providers very much applies to air ambulance services. These rules will help fix a longstanding market failure that allowed very few air ambulance service providers to choose to participate in health plan networks. The rules will help rein in out-of-control reimbursements and subject inflated rates to traditional market forces, to the benefit of consumers.

IV. Internal Claims and Appeals and External Review Processes

The IFC applies requirements for state and Federal external review processes and related notice requirements to grandfathered health plans or coverage with respect to adverse benefit determinations involving items and services within the scope of the requirements for out-of-network emergency services, nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. AHIP supports this change as a common-sense policy adaption to ensure consumers in all group health plans and individual health insurance coverage have the same ability to seek review of adverse benefit determinations related to their rights under the No Surprises Act. We offer the following recommendations and requests to aid implementation of this section of the rules:

- **External Review Template and Model Notices:** The template for the Federal external review process will need to be updated to reflect the opportunity for enrollees in grandfathered health plans to seek review of select adverse benefit determinations, as external review requirements do not currently apply at all to grandfathered health plans. For the same reason, a model notice of external review rights would need to be developed for use by grandfathered health plans.

- **External Review of Ability to Provide Consent:** The interim final rules require plans to make available external review when disputes arise regarding the patient's ability to provide informed consent to receive out-of-network services. Under the first interim final rule, issuers and group health plans are required to defer to the treating physician's judgement regarding a patient's ability to provide informed consent. This is because the issuer or health plan was not involved in this determination and would not have information or documentation beyond the treating physician's notice that would inform the dispute. Furthermore, we believe that responsibility for making the patient whole after an incorrect determination of ability to provide informed consent, including the payment of any cost-sharing differential, should lie with the provider that made that determination.

- **Expedited External Review of Urgent Claims:** These interim final rules require grandfathered health plans to make available external review for any adverse benefit determination related to cost-sharing and surprise billing protections under the No Surprises Act. The text of the rule is unclear as to whether any adverse benefit determination could be deemed urgent and therefore eligible for expedited external review, even in a grandfathered plan. We request clarity from the Departments as to whether there are any standards for whether an adverse benefit determination is considered "urgent" under these interim final rules.

- **State External Review Processes:** The IFC extends the applicability of state external review processes to the select adverse benefit determinations that stem from scenarios covered by the No Surprises Act, but neither the statute nor the rules themselves modify state definitions of adverse benefit determinations. Clarity is requested as to how individuals enrolled in coverage subject to a state external review process should proceed if the state does not recognize the same adverse benefit determinations as those being defined by these rules.

V. Patient-Provider Dispute Resolution; Protection for Uninsured Individuals

AHIP applauds the Administration for including extensive protections for uninsured individuals. Everyone deserves affordable health coverage and high-quality health care. Health insurance providers are committed to achieving the goal of getting more people covered by high-quality and affordable health insurance coverage. Until such time, however, hospital-based providers should not have license to impose artificially inflated bills on those without health coverage.

We believe the requirement to furnish a good faith estimate and the establishment of patient-provider dispute resolution process will help protect uninsured individuals from being forced to pay billed charges. In the rule, HHS notes that a good faith estimate is similarly required when out-of-network providers or facilities seek informed consent from an individual to be balance billed. While HHS encourages providers to use similar considerations for both estimates whenever possible, we recommend HHS either require in future rulemaking or clearly establish in guidance that, in practice, good faith estimates furnished in both circumstances should be the same.

With respect to the definition of "self-pay" individuals, we recommend future clarification in guidance that an individual covered by Medicare, Medicaid, CHIP, or TRICARE are not considered self-pay individuals solely by reason of not being enrolled in a group health plan or commercial health insurance coverage. While these programs are expressly excluded from the No Surprises Act, as balance billing was already prohibited, this clarification can help avoid unnecessary production of good faith estimates.

Additionally, we note that there will likely be insured patients who could be considered self-pay following a review of their benefits. If an individual's health plan contract does not cover the specified item or service a provider is offering, they may require the same good faith estimate as someone who is not enrolled in any group health plan or commercial health insurance coverage. In future rulemaking, we recommend the Departments address the need for this inquiry into the terms of coverage to precede the requirements for furnishing a good faith estimate.

VI. Miscellaneous Comments

A. Definitions of Single Case Agreements

The interim final rules establish definitions for "participating health care facility," "participating emergency facility," and "participating provider." Definitions for participating facilities include reference to single-case agreements with health insurance providers that the definition for participating provider does not include. The definitions for the former state: "A single case agreement between an emergency facility [or health care facility] and a plan or issuer that is used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement."

One reading of the definition of participating provider, therefore, would logically follow that every claim from a health care *provider* with a single-case agreement with a plan or issuer must be treated as a No Surprises Act claim, while claims from a *facility* with a single-case agreement would be treated as a participating network claim. We recommend future rulemaking clarify that a provider with a single-case agreement is a participating provider for the purposes of that instant claim.

B. Use of an Interim Final Rule with Comment Period

The Departments appropriately exercised their statutory authority to proceed via an Interim Final Rule with Comment Period. The Public Health Service Act allows the Secretary of Health and Human Services to "promulgate any interim final rules as the Secretary determines are appropriate."[17] The Internal Revenue Code and ERISA grant the same authority to the

[17] 42 U.S.C. §300gg–92 (PHSA Section 2792).

Secretaries of the Treasury and Labor, respectively.[18] This statutory authority supports that the Departments had good cause to adopt an interim final rule.[19] The Departments were required by Congress to first promulgate a rule regarding the QPA methodology, and reasonably gathered the stakeholder feedback from that rulemaking before proceeding with this one. The Departments have been diligent in gathering information and preparing for this rulemaking; the complex undertaking of setting up an entirely new dispute resolution system simply takes time.[20] The Departments appropriately judged it impossible to complete notice and comment with enough time for the IDR process to go into effect by January 1, 2022.[21]

For the No Surprises Act to work, the IDR process must be functional by this statutory deadline. Functionality is not merely a matter of having regulations on the books; the regulated entities, including plans, issuers, and potential IDR entities, must have time to implement the regulations. As explained in the IFC, the rules require a host of regulated entities to follow detailed processes and potentially make changes to benefit designs, which often must be made in advance of plan/policy years.[22]

Furthermore, IDR entities will need to be established, prepare documentation, and apply for certification well in advance of when the first IDR request is submitted. IDR entity staff will need to be trained on the new requirements. In short, the regulations must be extant well in advance of 2022 to allow time for implementation by January 1, 2022. The Departments appropriately proceeded through an Interim Final Rule to ensure that the necessary IDR infrastructure can be implemented by the congressionally mandated start date.

C. Early Adoption of the Advanced Explanation of Benefits (EOB)

An advanced EOB will provide enrollees a personalized estimate of their out-of-pocket costs in advance of a scheduled service. Alongside enrollee cost calculators available from health insurance providers, advanced EOBs will provide patients an additional tool to understand and anticipate their potential health care costs before a service or procedure. We appreciate that the administration recognizes the importance of data standards for communication between providers and facilities and plans and issuers to make implementation a success and support deferred enforcement pending future rulemaking and standard development. The Departments seek comment on whether there are ways to leverage the Transparency in Coverage requirements, including whether there are ways for plans and issuers to provide the information required in the

[18] 26 U.S.C. § 9833; 29 U.S.C. § 1191c (ERISA Section 734).
[19] *Coalition for Parity v. Sebelius*, 709 F. Supp. 2d 10, 20 (D.D.C. 2010) ("[T]hat Congress has specifically authorized the Secretaries to promulgate interim final rules provides support towards a finding of 'good cause' to proceed without notice and comment.").
[20] *Methodist Hosp. v. Shalala*, 38 F.3d 1225, 1236 (D.C. Cir. 1994).
[21] *See id.* (dispensing with prior comment is "permitted where congressional deadlines are very tight and where the statute is particularly complicated").
[22] 86 FR 56,044

Transparency in Coverage final rules to participants, beneficiaries, and enrollees during plan or policy years beginning in 2022.[23]

A 2019 AHIP survey found that three-quarters of its commercial health insurance providers currently offer a cost estimator tool to their 120 million covered lives.[24] These tools allow covered individuals to request an estimate of out-of-pocket costs for covered items and services. Beginning in 2022, many insured individuals may be able to use existing cost calculator tools to obtain an estimate of their out-of-pocket costs for certain covered items and services. However, it is important to note that not all consumers currently have access to a cost calculator and not all existing cost calculator tools offer the same information. For example, a 2019 AHIP survey found these tools offer a median of 526 items and services, ranging from less than 100 to 1600.

While health insurance providers are committed to meeting the deadlines for enrollee cost calculators, we urge the Departments to focus on the current implementation date of January 1, 2023. Not all current cost calculator tools provide every data element required under the Transparency in Coverage final rule, such as information on medical management requirements. Issuers are working to develop new calculators or update existing tools by the January 1, 2023 implementation date. In the August FAQ on Implementing the ACA and No Surprises Act, CMS acknowledged that issuers have been working toward this date and opted to not enforce the earlier No Surprises Act requirement for a cost calculator tool.[25] Thus, while some issuers may be able to deliver cost-sharing estimates via existing cost calculator tools in 2022, HHS should not implement a new requirement that they do so. We recommend consumers use available tools to obtain an estimate of their out-of-pocket costs but acknowledge these resources are not yet available to all insured individuals.

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[23] 86 FR 55,984
[24] AHIP Survey on Price Transparency Tools. December 5-31, 2019.
[25] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

December 21, 2022

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and
Insurance Oversight
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Lisa Gomez
Assistant Secretary
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, D.C. 20210

Ms. Carol Weiser
Benefits Tax Counsel
U.S. Department of the Treasury
1500 Constitution Avenue NW
Washington, D.C. 20220

Dear Dr. Montz, Assistant Secretary Gomez, and Ms. Weiser:

I am writing regarding the ongoing implementation of the *No Surprises Act*, which is on track to have prevented surprise medical bills for consumers in 12 million out-of-network health care claims during the first year the law has been in effect.[1] At AHIP, our member health insurance providers continue to prioritize these consumer protections and seek public policy solutions that put consumers first while working to reduce health care costs for working families.

AHIP and our member health insurance providers recognize the important roles Congress intended for median contracted rates when they established the Qualifying Payment Amount (QPA) for the dual purposes of determining consumer-cost sharing for covered items and services and guiding payment determinations under the Federal IDR Process. AHIP supports the Tri-Agencies approach to the QPA methodological issues.

The most recent lawsuit from the Texas Medical Association, however, makes various allegations to challenge the QPA methodology established in the July 2021 Interim Final Rules (IFR) "Requirements Related to Surprise Billing; Part I." One issue raised in this lawsuit – allegations that the QPA calculation includes "ghost rates" runs the risk of undermining public confidence in the QPA and potentially misleading the court. This would be unacceptable. We urge swift action by the Tri-Agencies to make clear that what TMA misleadingly refers to as

[1] https://www.ahip.org/news/press-releases/new-study-no-surprises-act-protects-9-million-americans-from-surprise-medical-bills

"ghost rates" – reported as $0 rates – are not to be included in QPA calculations. Only rates for items and services for which a contractual agreement exists between a provider, facility, or air ambulance service provider, and a plan or issuer should be included in the calculation.

On August 19, 2022, the Departments of Health and Human Services, Labor, and the Treasury ("Departments") published "FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55" ("FAQs Part 55").[2] Here the Departments addressed questions about how plans and issuers are required to calculate a median contracted rate under the *No Surprises Act*, which is an essential step in determining a QPA for a covered item or service. In particular, the Departments included, at Q14 in FAQs Part 55, the following question:

> Under the No Surprises Act and its implementing regulations, are plans and issuers required to calculate a median contracted rate separately for each provider specialty, if the plan's or issuer's contracted rates for service codes vary based on provider specialty (as a result of the plan's or issuer's contracting process)?

In answering Q14, the Departments added a footnote (Fn. 29) that included substantive guidance on whether a fee schedule amount of $0 is to be included in calculating a median contracted rate. In Fn. 29, the Departments state:

> The Departments have been informed that some plans and issuers enter $0 in their fee schedule for covered items and services that a provider or facility is not equipped to furnish. In the Departments' view, $0 does not represent a contracted rate in these cases. Therefore, plans and issuers should not include $0 amounts in calculating median contracted rates.

Under the *No Surprises Act* and 45 CFR 149.140, the QPA for a given item or service is generally the median contracted rate on January 31, 2019 for the same or similar item or service, increased for inflation. The contracted rate is the total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator (TPA) or pharmacy benefit manager (PBM). Interim final rules published in July 2021 detail how plans or issuers are to account for non-fee-for-service contractual arrangements when different types of contracting models are utilized. In these circumstances, a plan or issuer is to use an "underlying fee schedule or derived amount" to "convert each of their non-fee-for-service contracts into fee-for-service

[2] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf

arrangements for purposes of calculating the median contracted rate."[3] Together, these directives make clear that all recognized contracted rates for an item or service, and only recognized contracted rates, are to be included in the QPA calculation, subject to the parameters in the July 2021 interim final rules and subsequent guidance.

AHIP supports further clarification, including in future rulemaking, that $0 rates are not part of the QPA calculation.

Trust and confidence by the public and health care stakeholders – including health insurance providers, health care providers, facilities, and providers of air ambulance services – is paramount in ensuring the durability of the *No Surprises Act* so that nobody again worries that an emergency or hospital visit will result in a costly surprise medical bill. We look forward to continuing to work with the Departments to ensure faithful implementation of this law in a way that lowers health care costs for consumers.

Sincerely,

Jeanette Thornton
Executive Vice President, Policy & Strategy
AHIP

[3] "Requirements Related to Surprise Billing; Part I" 86 FR 36893

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

September 26, 2022

James Butikofer
Office of Research and Analysis
U.S. Department of Labor, Employee Benefits Security Administration
Washington, DC 20210
Via Electronic Delivery

RE: **Paperwork Reduction Act Comments on ICRs included in Final Rules on Requirements Related to Surprise Billing (OMB Control Number: 1210–0169)**
AHIP Comments

Dear Mr. Butikofer:

AHIP[1] appreciates the opportunity to provide comments in accordance with the Paperwork Reduction Act (PRA) on changes to the Information Collection Requirements (ICRs) for OMB Control Number 1210-0169, affecting surprise medical billing. Due to the substantive policy implications raised by including new information on the above-referenced OMB Control Number, we also use this letter to detail recommendations to the Departments of Labor, Health and Human Services, and the Treasury ("Departments") regarding the underlying regulatory changes in the Final Rules "Requirements Related to Surprise Billing" published August 25, 2022 (87 FR 52618).

No American should ever face a surprise medical bill that can lead to financial ruin. We strongly supported Congressional efforts to ban the egregious practice of surprise medical billing and have stood with the Administration as Interim Final Rules were challenged in court, complicating and delaying implementation of the Independent Dispute Resolution (IDR) process under the No Surprises Act. By way of these comments, we offer our constructive input on the mechanics of implementing the No Surprises Act and developing an IDR process that advances our shared goals of more affordable and higher quality health care, as well as to increase the number of participating providers and facilities so surprise bills need not arise in the first place.

In the attached comments, we address the challenges with the new requirements related to "downcoded" claims and how the Departments' approach could result in the unintended consequence of more providers leaving health plan networks, less efficient and cost-effective care, and costly operational burdens. Additionally, we emphasize the need for enforcement and

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

accountability when it comes to the written decision requirement for Certified IDR Entities included in the August 2022 Final Rules.

We look forward to continuing engagement with the Departments and other health care stakeholders to ensure the No Surprises Act is implemented in an efficient manner that lowers health care costs, while ensuring patients are protected from surprise medical bills.

Sincerely,

Adam Beck
Vice President, Employer Health Policy & Initiatives

Attachment: AHIP Detailed Comments

A. ICRs Regarding Additional Information to Be Shared with the Initial Payment or Notice of Denial of Payment

Existing regulations implementing the No Surprises Act have required responding parties in a payment dispute to transmit certain information along with an initial payment or denial of payment to an out-of-network facility, provider, or air ambulance service provider. Under the August 2022 Final Rules, the Departments will now require additional information to be communicated by a plan or issuer to an initiating party. The Final Rules include a definition of "downcoding" and "require additional information about the QPA that must be provided with an initial payment or notice of denial of payment, without a provider, facility, or provider of air ambulance services having to make a request for this information, in cases in which the plan or issuer has downcoded the billed claim." While we believe providers, facilities, and air ambulance service providers should have as much relevant information as is material to the out-of-network claim and any subsequent dispute, we would like to address specific elements of the new requirements related to information about downcoding that present operational challenges for health plans and issuers.

The definition of "downcoding" is ambiguous, not standard industry practice, and counter to the intent of the No Surprises Act.

We are concerned about the definition of "downcoding"[2] the Departments have added to federal regulation. As currently written, due to ambiguity, the term could be construed broadly so as to encompass actions that fall outside the scope of this rule. Further, downcoding as described by this definition does not align with industry coding practices and would result in substantive policy effects counter to the intent of the No Surprises Act. Plans and issuers as a matter of industry practice routinely make corrections to coding selections in order to reflect clinical accuracy and simplify billing. The Departments should clarify these coding practices are not included in the definition of "downcoding."

The definition is ambiguous with respect to what constitutes an "alteration by a plan or issuer," such as in circumstances where a provider or facility bills for codes that are tangential to the service provided and not expected to be paid, where a provider or facility lists a code that is clearly inaccurate or inappropriate, or if alteration includes removal of an extraneous code. Adjustments to claims codes as described by the Departments as "downcoding" are in practice most often used to better reflect accurate coding based on national coding guidelines. In many circumstances, guidelines call for a code that was included in a billed claim to be removed or

[2] "The alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider, facility, or provider of air ambulance services."

disregarded as a courtesy to the provider. For example, many bundled procedures include codes that are tangential to the service actually being billed, but note services delivered as part of the procedure. The current definition would prove unworkable in many billing circumstances routinely encountered by health plans and issuers. Additional clarity as to how the definition applies in actual coding situations would be necessary to avoid much of the delay and confusion that has already been caused as a result of the high volume of IDR requests.

There are specific industry practices where the definition of "downcoding" as currently written would not align. As an example, in cases of multiple radiology, multiple diagnostic imaging procedures are performed by the same provider or provider group on the same date of service during the same patient encounter. It is standard practice for plans operating in all markets, public and commercial, to subject these services to Multiple Procedure Payment Reduction (MPPR) rules that affect the codes paid. There are also "Add-On Codes." An add-on-code is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An add-on code is rarely eligible for payment if it's the only procedure reported by a provider. These coding procedures save consumers and taxpayers money, avoid redundant charges, and also make the process administratively simpler for providers. The blanket requirement to display additional information about downcoding at the time of initial payment or denial disincentivizes health plans and issuers to continue these practices.

Industry standard practices should control, as they are objective, well-established, and universally accepted. A provider has no means of ascertaining why an item or service code reflects something different from what their billing department submitted on a claim. Industry standard coding, however, can be ascertained, and indeed that information could be requested by the Certified IDR Entity (CIDRE). As discussed below, substantively changing a code requires review of medical records by a clinical team, which under this scheme would put a CIDRE in the position of exercising clinical judgment, a practice that would be inappropriate under the No Surprises Act.

The inclusion of additional information in such a wide range of circumstances also poses substantive policy concerns that we believe go beyond the Congressional intent of the role of CIDREs. The task of the CIDRE is to "determine which offer best reflects the appropriate out-of-network rate, provided the information relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination." We are concerned that providing QPAs for items or services not at issue, or for alternate circumstances--including code amounts that do not align with standard billing practices--would create unnecessary confusion for the CIDRE and may lead to payment determinations that do not reflect the appropriate out-of-network rate. For example, take a common scenario where a provider chooses to bill for individual laboratory tests rather than a panel of labs. It is standard industry practice to bill for the panel – because this is considered correct coding and is more

efficient and cost-effective than billing for separate individual lab tests. The CIDRE should see the QPA for the code representing the panel of tests because it corrects a coding error and is what the plan would actually pay. For the plan to share a series of QPAs for each individual lab test that would be require the plan to pay based on coding errors, driving costs higher and causing unnecessary confusion. This is not an instance of downcoding, however this situation would satisfy the definition of downcoding as currently written, while causing confusion and potentially inflating health care costs. Should a CIDRE be frequently seeing QPAs for codes that a plan does not consider payable, the CIDRE would likely end up factoring this otherwise extraneous data into their consideration, essentially making payment determinations based on inflated cost data. If this were to occur, one of the primary purposes of the No Surprises Act begins to unravel, as incentives to enter into network contracts with issuers would disappear.

Separate from the ICR under the PRA, we strongly urge the Departments to reconsider the underlying policy rationale for this new definition and whether the public interest would be served by this new requirement.

The implementation timeline for including additional information related to downcoding is not practical.

The timeline established by the Departments for conveying additional information about downcoding would be extremely difficult for plans and issuers to satisfy and we ask for greater flexibility over a longer time horizon to adjust to new requirements. In discussing the applicability of these final rules, the Departments recognize that system updates to incorporate the new information requirements regarding downcoding into standard payment systems would be difficult to quickly achieve. The Preamble texts states "Plans and issuers may use reasonable methods to provide this additional disclosure with the initial payment or notice of denial of payment while plan or issuer systems and procedures are updated to provide the additional notice in a more streamlined and automated manner." While this acknowledgment is appreciated, in practice it has meant plans must create a short-term process that is quite administratively burdensome while simultaneously developing a longer-term automated process. Particularly in light of our aforementioned comments regarding the need to reevaluate the definition of "downcoding" we ask the Departments, at a minimum, to delay the implementation timeline. Alternatively, during an interim period until all rules are final and in effect, initiating parties could request information about adjusted claims as part of the Open Negotiation process. It is important to note this process routinely takes place between issuers and providers, where providers request additional information about claims adjustments.

Health plans use electronic systems to analyze claims and determine whether a coding adjustment is appropriate, and then automatically triggers payment for the specified amount once the claim code is determined. With the mandate laid out in the recent Final Rules, health plans must now find some automated solution that allows both the original and the downcoded QPA,

as well as a rationale, in the same system, while distinguishing one from the other for payment purposes. This implementation process remains unclear, as these systems do not yet exist, and therefore the late October timeline established in the Final Rules poses immense, if not impossible, challenges.

Displaying additional information on remittance forms creates unnecessary complexity that does not serve the public interest.

The requirement to include additional information about "downcoded" claims means that new information must be displayed on a remittance advice form, or "remit" that is sent with an initial payment or denial of payment. Currently, standard claims formats do not allow easy incorporation of the additional requirements of the No Surprises Act. While the coding information can be incorporated onto a remittance, it will be cluttered. We are concerned that simply appending the additional information onto existing remits will create a more confusing and complex report that would not provide facilities, providers, or CIDREs with valuable information as the Departments intend.

There are ways of communicating information about downcoding to providers and facilities when such an action takes place. However, the remittance form is likely not the best place to do so. We ask the Departments to convene interested stakeholders in creating an approach to more effectively transmit information related to downcoding, and any other No Surprises Act data, in a way that reduces administrative burden, minimizes complexity, and provides useable information.

Certified IDR Entities are prohibited from exercising medical judgment.

The Final Rules now call on plans and issuers to relay two Qualifying Payment Amounts, which would then be available to a CIDRE. This creates substantive challenges for the CIDREs. As a matter of policy, we do not believe hypothetical information should be relayed and the burden of a plan calculating not only the actual QPA but also an alternative one creates substantial complexity that likely does not serve a clear public interest. Beyond the complexity, this requirement calls on a CIDRE to exercise judgment as to which code would have been most appropriate for the item or service. This is a matter of medical judgment requiring clinical expertise not possessed or expected to be possessed by the CIDRE. In the preamble to final rules issued in 2015 relating to internal appeals and external review, the Departments also clarified that issues related to how a claim is coded may also involve medical judgment because "[m]edical judgment is necessary to determine whether the correct code was used in the patient's case."[3] Under the August 2022 Final Rules on Surprise Billing, a CIDRE is now tasked with determining which codes – those billed or those paid – reflect the appropriate out-of-

[3] 76 FR 37207, 37216 (June 10, 2011)

network rate for a patient's case. This is a matter of medical judgment. In the Preamble to the Interim Final Rules published on October 7, 2021, the Departments clearly barred CIDREs from exercising such a role: "The Departments clarify that it is not the role of the certified IDR entity to determine whether the QPA has been calculated by the plan or issuer correctly, to make determinations of medical necessity, or review denials of coverage."

If a plan does alter a code or modifier due to the code submitted being inappropriate or inapplicable to the clinical services provided, the plan does not view this as downcoding, but rather correcting the code. Similarly, if a plan amends or removes a code modifier, such as modifiers indicating patient acuity, that determination is made by clinicians reviewing the patient history and medical records, and that medical judgment should not be supplanted by an arbitrator as a layperson. Under the Final Rules, the CIDRE would be tasked with determining which code or modifier was clinically appropriate. This is clearly outside the CIDRE's domain or regulatory instruction.

B. ICRs Regarding the Certified IDR Entity's Payment Determination Written Decision in the Federal IDR Process for Nonparticipating Providers or Nonparticipating Emergency Facilities
&
C. ICRs Regarding the Certified IDR Entity's Payment Determination Written Decision in the Federal IDR Process for Nonparticipating Providers of Air Ambulance Services

The Departments should clarify enforcement of the written decision requirement and provide parties with recourse for noncompliant Certified IDR Entities.

The changes proposed to requirements for a Certified IDR Entity's written decision regarding a payment determination are at issue in the second and third ICRs included with the August 2022 Final Rules. In contrast to the requirement for additional information about downcoding, these requirements place a burden on the CIDRE, rather than a plan or issuer, and therefore our comments are more limited and focus on the need for enforcement of these requirements. We support the Departments' enhanced requirement under the August 2022 Final Rules for CIDREs to include an explanation of the additional information considered to make a determination as to the appropriate out-of-network rate, including the weight given to the QPA and any additional credible information submitted, as well as the requirement to include an explanation as to why any additional information considered was not reflected in the QPA. We note that the experience of health plans and issuers in the first several months of the Federal IDR Process has revealed a patchwork approach with respect to how CIDREs conduct their payment determinations. We are concerned about a lack of uniformity as to the written decision requirement and the absence of any clear enforcement policy.

Therefore, we urge the Departments to issue clear guidance to Certified IDR Entities on the form, manner, timing, and importance of the written decision, and to detail penalties or other enforcement mechanisms available within your authority to ensure this requirement is not viewed as a mere suggestion. Should CIDREs be found to not be in compliance with this expanded requirement, parties are owed some recourse, such as a process for triggering a review by the Departments and halting further payment determinations by the noncompliant CIDRE until the matter is resolved. The written explanation will be invaluable to all parties involved and help the Departments going forward to evaluate not just the outcomes of payment determinations, but the rationales for them, and ensure a more efficient and transparent process in the future.

PUBLIC SUBMISSIONS FOR THE RECORD

THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

STATEMENT FOR THE RECORD BY

THE ERISA INDUSTRY COMMITTEE (ERIC)

TO THE

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS

"HEARING ON REDUCED CARE FOR PATIENTS: FALLOUT FROM FLAWED IMPLEMENTATION OF SURPRISE MEDICAL BILLING PROTECTIONS"

September 19, 2023

Chairman Smith, Ranking Member Neal, and Members of the Committee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled *"Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections,"* examining the implementation of key patient protections enacted by the *No Surprises Act (NSA)* nearly three years ago. **We appreciate the Committee's continued interest in protecting patients from surprise medical bills, and urge Congress both to support the Administration's implementation of the *NSA* as Congress intended, and to extend protections to ground ambulance providers.**

ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under ERISA's protection from a patchwork of different and conflicting state and local laws, in addition to federal law.

Americans engage with an ERIC member company many times a day, such as when they drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage or snack, use cosmetics, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, or go shopping.

ERIC member companies offer comprehensive health benefits to attract and retain employees, to be competitive for human capital, to improve health and productivity, and to provide peace of mind. Large employers, like ERIC member companies, roll up their sleeves to improve how health care is delivered in communities across the country. They do this by developing value-driven and coordinated care programs, implementing employee wellness programs, providing transparency tools, and a myriad of other innovations that improve quality, reduce costs, and drive value for working families. These efforts often use networks to guide our employees and their family members to providers of higher quality and lower cost. Surprise billing undermines all of this and fundamentally frustrates the goals of providing quality, affordable employer-sponsored health benefits.

The plan sponsors that ERIC represents offer primarily self-funded health insurance to their plan beneficiaries – employees, their families, and often retirees as well. ERIC members generally contract with a third-party administrator (TPA), such as a large health insurance company, and that TPA develops networks, administers claims, and negotiates reimbursement rates on behalf of the plan sponsor. However, it is the plan sponsor that ultimately pays claims, and is liable for the costs of the plan, regardless of whether those costs are covered by premiums, or exceeded, in a given year. Ultimately, ERIC member companies pay about 75 percent of health care costs on behalf of their plan beneficiaries.

ERIC supports market-based solutions, and rejects policy proposals that rely on government fiat. However, it is widely accepted among free-market economists and others that in the case of market failures, it is incumbent upon a functioning government to develop and enforce guardrails and structures to facilitate free and fair exchange. While the *No Surprises Act* did not take the same approach as that advocated by many in the employer community, we believe it was a necessary intervention into a failing market, and that its design and implementation ultimately will solve this market failure.

ERIC is proud to see that the *NSA* is working, and has protected Americans from nearly nine million surprise medical bills in the first nine months of implementation.[1] However, with the law continuously being challenged within the legal system, patient protections from surprise billing are under attack. Recently, the Texas Medical Association (TMA) in its third lawsuit against the Administration contested the methodology used to calculate the qualified payment amount (QPA) and other independent dispute resolution (IDR) processes implemented under the *NSA*. The U.S. District Court for the Eastern District of Texas held that many of the challenged regulatory provisions stand in conflict with the legislative terms of the *NSA,* and should therefore be vacated. ERIC and other organizations disappointed with the decision believe the statute as written by Congress and scored by the non-partisan Congressional Budget Office (CBO) clearly established the QPA as the primary consideration for arbitrators when determining the final payment for out-of-network care.

Congress was promised vast savings from the *NSA* when they voted in favor of the legislation. The CBO's QPA-driven analysis estimated savings of more than $17 billion over ten years. Because their analysis of the legislation found that the QPA would be the primary factor for determining final payments, CBO states that "*in most affected markets in most years, smaller payments to some providers would reduce premiums by between 0.5 percent and 1 percent*."[2] These savings would allow employer-sponsored plans to expand or enhance benefits for employees. Leading policy experts have also made clear that achieving the cost-savings intended by the *NSA* is possible only by maintaining the QPA as the primary and overriding consideration for final payment determinations during the IDR process[3]. It is evident that providers are eroding these savings and market-based mechanisms through the legal system, at the expense of consumers, employers, and taxpayers, and these ongoing legal challenges put patients at risk of unsustainable costs and unreasonable payments.

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[1] "No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022" AHIP https://ahiporg-production.s3.amazonaws.com/documents/202211_IP_Surprise_Billing.pdf

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

[3] Matthew Fiedler, Benedic Ippolito, Loren Adler. "'Equal weighting' is a poor framework for arbitration decisions." USC-Brookings Schaeffer on Health Policy. June 24, 2021. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/06/24/equal-weighting-is-a-poor-framework-for-arbitration-decisions-under-the-no-surprises-act

While employers across the country have already begun to calculate QPAs and execute IDR cases in accordance with the agency regulations at issue, the Court's ruling threatens to shut down all IDR processes until further guidance on QPA calculation is released. This reality stands to throw the entire areas of compliance and administration into chaos, as employers are unsure whether they must update every single QPA calculated to date, or even whether concluded IDR cases and payments need to be reassessed as a result. Numerous publications have outlined provider advocacy before this committee and others, wherein provider and hospital groups have complained that IDR is moving too slowly, while at the same time those same advocates are taking legal action designed specifically to halt IDR and require the rewriting of economically significant regulations.

The QPA ensures fair market payment and is the only market-based, quantified reference that should be used. It uses rates that are averaged at the contract level between providers and payers, specifically utilizing locally negotiated rates that reflect the market conditions where care was provided. It also minimizes the use of outside resources such as databases like state all-payer claims databases (APCDs) and avoids referring to the usual and customary charges. The use of the QPA during the IDR process originally required that the certified IDR entity must begin with the presumption that the QPA is the appropriate out-of-network rate for the qualified IDR item or service under consideration, and that the IDR entity must select the offer closest to the QPA, unless the certified IDR entity determines that credible information submitted by either party clearly demonstrates that the QPA is "materially different" from the appropriate out-of-network rate. Providers that demanded greater out-of-network rates than what other providers in the market have agreed to, would have the burden of justifying the rates that go against current market standards. Now that the QPA is challenged, patients are at increased exposure to out-of-pocket medical expenses, and providers are incentivized to charge unreasonable rates, in hope of an IDR windfall.

The volume and unpredictability of IDR cases are not sustainable for the government, the IDR entities, or the taxpayers, who will bear the cost of frequent disputes and unreasonable payments. Between April 15, 2022, and March 31, 2023, disputing parties initiated over 334,000 disputes through the federal arbitration portal – nearly 14 times greater than the Departments initially estimated.[4] This overwhelming amount of claims being disputed through IDR leaves employers and health plans struggling to keep up with the myriad disputes, sometimes thousands of claims at once, to which they must respond. This activity takes time and resources away from providing high-value health benefits to enrollees. If the *NSA* rules are continually attacked and further weakened, the IDR volume will likely become even more unsustainable, and consumer health care costs will become more unaffordable.

Worse, as many employer groups feared would take place, and expressed to this committee and others during the legislative debate that led to the *No Surprises Act*, the majority of IDR cases are indeed being brought by a small number of provider groups, most of whom are deeply involved with Wall Street private equity funds.[5] These private equity funds have made a calculated decision to use IDR as a revenue generation mechanism, not as a means of last resort, and are no doubt using algorithms and AI to mass-identify claims by code and payer in order to mass-generate IDR claims. This committee's urgent attention is needed to address this issue.

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[4] https://stopsurprisebillingnow.com/wp-content/uploads/2023/06/Hill_CASMB-One-Pager-June-2023-final.pdf
[5] Partial Report on the Independent Dispute Resolution (IDR) Process October 1 – December 31, 2022 https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/partial-report-on-the-idr-process-10-01-2022-to-12-31-2022.pdf

The *NSA* as passed into law and implemented provides important tools to help decrease costs for employer-sponsored health plans and beneficiaries alike. If providers are successful in their lawsuits against the rule, patients will bear the burden and experience higher health care costs. **ERIC urges Congress to protect patients from unfair surprise medical bills and lower health care costs by supporting the *NSA*'s full implementation.**

ERIC also encourages Congress to extend the *NSA* to apply to ground ambulances. While Congress has protected patients from balance bills at hospitals and from air ambulances, patients may already be bankrupted by their ground ambulance bill before arriving at the hospital. A 2023 study published in Health Affairs found that 28 percent of commercially insured emergency ground ambulance transports resulted in a surprise medical bill from 2014 to 2017.[6] Surprise medical billing from ambulances is still occurring today and must be addressed to fully protect patients.

We note that some medical transportation providers have opposed Congressional efforts to protect patients from their surprise bills. Ground ambulance providers have suggested that because they are subject to state law, federal surprise billing restrictions should not apply. ERIC notes that all health care providers are subject to various state laws, and that the participation of ground ambulance providers in interstate commerce (through services provided to patients and group health plans) clearly subjects them to federal jurisdiction – and that federal law can and should supersede any possibly conflicting state laws in this limited area of out-of-network billing practices. States and localities have imposed regulation on ambulances in light of a lack of consistent policy from the federal government; now is the opportunity to create a streamlined set of rules, thus eliminating the need for much of this inconsistent regulation.

Conclusion

In conclusion, thank you for this opportunity to share our views with the Committee. The ERISA Industry Committee and our member companies are committed to protecting patients' access to care, ensuring fair provider compensation, and doing so without driving up health insurance costs.

[6] Adler, Loren "Ground Ambulance Billing and Prices Differ by Ownership Structure" Health Affairs. Volume 42, Number 2 https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00738

American College of Radiology™

September 27, 2023

The Honorable Jason Smith
Chairman
House Ways & Means Committee
1100 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Ways & Means Committee
1100 Longworth House Office Building
Washington, D.C. 20515

Re: Hearing on Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections

Dear Chairman Smith and Ranking Member Neal:

The American College of Radiology (ACR®) appreciates the opportunity to provide written comments in response to the Committee's September 19, 2023, hearing on *Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections.* We thank the committee for continuing to ensure that the No Surprises Act (NSA) is implemented as Congress intended when passed in 2020.

ACR supports the goal of the NSA to protect patients from surprise medical bills for care received by out of network providers. However, regulatory challenges have plagued physician practices attempting to utilize the Independent Dispute Resolution (IDR) process created through passage of the NSA. These comments highlight key challenges for radiologists— access to the IDR process, batching, and reasonable and timely payment, and we offer potential solutions.

Batching Restrictions and Financial Challenges

The NSA permits multiple qualified IDR services to be "batched" in a single IDR process "*for purposes of encouraging efficiency (including minimizing costs) of the IDR process.*"[1] However, the rules setting forth batching parameters published in the Interim Final Rule, *Requirements Related to Surprise Billing; Part II*[2] ("October 2021 Rule"), do not achieve this objective—they do the opposite. The October 2021 Rule imposes the following restrictions on batching: (1) the services must be billed by a clinician with the same National Provider Identifier or Taxpayer Identification Number; (2) payment for the services must be made by the same plan or issuer; (3) the services are billed under the same service code (or a comparable code under a different procedural code system); and (4) the services must be furnished within the same 30-business-day period (or the same 90-calendar-day cooling off period, if applicable).[3]

The October 2021 Rule defines batching parameters so narrowly that it creates a financial hardship for physicians and operational dysfunction for the IDR process. Further, the current regulations are so restrictive that "batching" is almost non-existent for radiologists. On average, a batch is only two charges. Smaller batch sizes necessitate submission of a larger number of disputes, which impose

[1] 42 U.S.C. § 300gg–111(c)(3) (emphasis added). The NSA amended three statutes with identical provisions: the Publish Health Service Act ("PHSA"), the Employee Retirement Income Security Act ("ERISA"), and the Internal Revenue Code ("IRC"). For ease of reference, this letter cites to the PHSA provisions.
[2] 86 Fed. Reg. 55,980 (Oct. 7, 2021).
[3] 45 C.F.R. § 149.510(c)(3)(i).

HEADQUARTERS
1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900

significant administrative costs and greater IDR fees. This is not the robust batching process that Congress intended, and it has created a system that is overwhelmed and unsustainable— claims "on hold" for an indeterminant length of time and independent dispute resolution entities (IDREs) unable to meet the deadlines set forth in the NSA.

In what has become a vicious cycle, these delays further exacerbate the financial hardship imposed by participation in the IDR process. The delays mean that clinicians often must wait nearly 220 days for payment, which does not include the additional mandatory 90-day cooling-off period following a decision. The IDR fees are held for months in escrow while IDR proceedings remain in limbo. In 2022, radiologists in two practices we spoke with paid more than $290,300 and $193,100, respectively, in IDRE fees for cases that are past the deadline for a payment determination. Making matters worse, IDREs are allowed to accrue interest on the funds they hold in trust or escrow for parties participating in IDR, with no requirement to include accrued interest with the returned fees.[4] Providers lose the time value of the money they pay, compounding the financial expense of participating in IDR. Moreover, even when a provider prevails in IDR, payors are not paying when required and are sometimes paying only a fraction of what the IDRE awarded. And because IDRE payment determinations have no precedential effect, plans typically persist in underpaying even after they lose in IDR. As a result, as soon as the cooling-off period is complete, practices are forced back into the IDR process to request reasonable reimbursement for claims substantially similar to those on which they previously prevailed.

Fees

Along with the restrictions placed on batching, the IDR fees have been especially frustrating for radiologists trying to participate in the IDR process. Under initial guidance, the administrative fee was set to $50 and the IDRE fees up to $670. Then, the IDR administrative increased from $50 to $350[5], along with an increase in the IDRE fees (up to more than $1200), with less than a two-week warning to physician practices. Most radiology claims are for less than $50, with the vast majority below $100. Almost none are $350 or more. Thus, without broader batching rules, radiology cannot access IDR in a cost-efficient manner.

The Centers for Medicare and Medicaid Services (CMS) announced on August 11 the repeal of a 600% increase to its fee to file a dispute under the NSA. This action is in response to the latest ruling by the U.S. District Court for the Eastern District of Texas in a suit brought against the federal government by the Texas Medical Association, Texas Radiological Society, Houston Radiology Associated and others, that charged the government's fee increase and batching rule violated federal law. ACR, along with the American College of Emergency Physicians (ACEP) and the American Society of Anesthesiologists (ASA), filed an amicus brief in support of the lawsuit (known as "TMA IV"). ACR was pleased to learn of this result but to make matters even more complicated, new guidance has been issued regarding the IDR fees.

On September 20, 2023, the U.S. Departments of the Treasury, Labor, and Health and Human Services issued a new proposed rule, outlining a new fee structure for the IDR process. The proposed new

[4] 86 Fed. Reg. 55,980, 56,005 (Oct. 7, 2021).
[5] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf

administrative fee, which is required to be paid by both providers and payers entering the IDR process, is $150 beginning January 1, 2024. This triples the $50 fee which CMS reverted to following the TMA IV court decision and is still not workable for radiologists. The proposed fees for batches have also increased and the larger the batch, the higher the fee. In the proposed rule, the departments also indicate that the final administrative fee may differ from the proposed $150, if additional data becomes available between the publication of the proposed and final rules. They also propose to allow the fee to be updated more or less frequently than annually using the rulemaking process. This makes financial planning for physician practices nearly impossible and further exemplifies why IDR is still not accessible for radiologists under this new proposal. The chart below illustrates the evolution of the fees for the IDR process.

	2022	2023 (January 1-August 2)	2023 (August 3-December 31)	2024 (Proposed)
Administrative Fee	$50.00	$350.00	$50.00	$150.00
IDR Entity Fee Range - Single	$200-500	$200-700	$200-700	$200-840
IDR Entity Fee Range - Batch	$268-670	$268-938	$268-938	$268-1,173
Large Batch Add-On Fee	N/A	21-50 items: 110% of batch fee 51-80 items: 120% of batch fee 81 or more: 130% of batch fee	21-50 items: 110% of batch fee 51-80 items: 120% of batch fee 81 or more: 130% of batch fee	Fixed fee between $75-250 for every additional 25 line items.

Even before the increase in IDR fees, batching requirements were so narrow that clinicians would often need to pay more to participate than the dispute was worth. For example, for CPT 71045 (X-ray exam chest 1 view) Medicare pays an average of $9. With the current batching requirements, radiologists would be able to batch only two charges for CPT 71045 for one Employer Group Health Plan furnished within the same 30-business-day service period. The total batch value per Medicare payment would be $18. This is one of the most frequently billed CPT codes by radiologists, and by the narrowly defined batching requirements, it is cost prohibitive to participate in the IDR process, resulting in massive underpayments. The newly proposed guidance on fees also deters physicians from batching based on the higher fees for larger batches. While ACR understands new guidance will be issued by the departments about batching, we recommend Congress provide strict oversight to ensure the rules do not disincentivize physicians from accessing the IDR process.

The financial impact on radiology practices is just one challenge resulting from implementation of the NSA. Patient care is also suffering. Radiology is facing a national labor force shortage, which has been compounded by ongoing Medicare reimbursement cuts, stresses from the pandemic and macroeconomic factors such as inflation. In turn, medical groups are struggling to provide care and in many cases are reducing their services. ACR is aware of radiology practices terminating relationships

with hospitals that they are no longer able to serve, leaving the hospital scrambling to provide patch coverage.

Recommendations:

- HHS should allow clinicians to batch qualified IDR items and services under the same category of service codes rather than restricting batches to only those claims with the same service code. HHS should allow clinicians to batch qualified IDR items and services paid within the same 90 days of payments, rather than limiting the time window to 30 business days of service.[6]
- Any future rulemaking involving IDR fees should take into consideration the average amount of an actual claim to ensure that the fees are not cost prohibitive for practices attempting to utilize the IDR process.
- The IDR fees should remain a standard amount and only be updated through the rulemaking process. Fees should not deter batching.

Lack of Transparency and Disclosure of Information

Federal vs. State IDR Process

Another issue with batching is determining whether an IDR claim falls under state or federal jurisdiction. Ideally, a patient's insurance card should include sufficient information needed for determining jurisdiction. Without this information, it is unclear if a claim is one that is covered under the federal or state process. Since the insurers have failed to provide this information, physicians often have difficulty availing themselves of the IDR process. As a result, if a batch of claims contains even one claim that falls under the jurisdiction of the other system, federal or state, the entire batch is rejected. This causes delays and adds to the administrative burden.

Qualified Payment Amount (QPA)

In many instances, the initial payment or notice of denial sent to the provider by the insurer does not include all the required information. In some cases, the qualifying payment amount (QPA) for the item or service billed is not being clearly identified, and a certifying statement is missing that affirms that the QPA was calculated properly and that it serves as the recognized amount for the purposes of calculating patient cost-sharing. This lack of information makes it difficult for providers, and eventually for certified IDREs, to determine whether a claim is eligible for the federal IDR process.

Additionally, the QPA methodology finalized by the agencies is leading to artificially low QPAs that do not reflect market-rates. It was designed to limit cost-sharing liabilities and is not a market-based indicator of appropriate payment for an item or service. There are also reports of insurers miscalculating the QPA, leading to QPAs even lower than what proper adherence to the methodology would dictate.

Last month, in a separate court ruling, the U.S. District Court for the Eastern District of Texas agreed with the plaintiffs, the Texas Medical Association, that the government was incorrectly permitting insurers to use a faulty methodology when calculating their median in-network rate, also known as the qualifying payment amount (QPA). ACR, along with ACEP and ASA, also filed an amicus brief in support of this

[6] The NSA permits the Departments to craft a rule with an "alternative period" to "encourage procedural efficiency and minimize health plan and provider administrative costs." 42 U.S.C. § 300gg-111(c)(3)(A)(iv).

litigation (known as "TMA III"). The court agreed that the methodology the insurers employed in calculating the QPA was tilting the arbitration process in the insurers' favor. The court overturned several regulatory provisions related to the QPA calculation, including those that enabled insurers to include in the calculation of QPAs contracted rates for services that physicians do not provide, known as "ghost rates." Although the government may still appeal, if the decision stands, this ruling will bring the law back in line with what Congress intended for the NSA.

Unfortunately, because of the court ruling, HHS put a hold on the IDR process, putting physician practices in limbo. However, the hold was partially lifted with an announcement by CMS on September 21, 2023, instructing IDR entities to resume processing disputes submitted on or before the Aug. 3 court ruling. The frequent disruptions in the IDR process have also added to physicians' frustration and the backlog in claims that await IDR decisions. However, ACR enthusiastically awaits new guidance around the QPA.

Recommendations:

- HHS should require that the plan type be disclosed at the time of the initial payment or notice of denial, as this information is not available on a patient's insurance ID card. This will help providers determine which dispute resolution process applies.
- HHS should require insurers to use the Remittance Advice Remark Codes (RARCs) when providing the required disclosures that accompany the initial payment or notice of denial. This will give providers the necessary information to assess patient responsibility amounts and reduce the need to initiate payment disputes, as well as provide IDREs with dispositive information about whether a particular claim is eligible for the federal IDR process.
- Increase transparency around calculation of the QPA. HHS should require insurers to disclose the methodology used to calculate the QPA for an out-of-network claim, so that providers are confident it is calculated correctly and in line with the regulatory requirements.
- Require public reporting/audits of IDR process, including QPAs.
- Reopen the IDR process and instruct arbitrators to disregard qualified payment amount calculations until a rule that complies with the court's decision is published.

Lack of Timely Payment and Communication

Many physicians have reported the extremely troubling trend of insurers' failure to pay what they owe if an IDRE finds in favor of the provider. Insurers are simply not paying the amount owed within the required 30-day period, if at all, despite numerous attempts by providers to collect the payment they are entitled to under the terms of the arbitration.

If a provider does not reach resolution with the insurer during the 30-day open negotiation period, a claim is submitted through IDR portal. However, once the dispute is submitted, there is no way to check the status of that dispute in the portal. This results in an extremely high number of email communications from insurers to providers. The emails cover a range of topics including IDRE selection, requests for additional information, fee requests, offer links, and determinations from IDREs. This is

entirely too many separate communications regarding one dispute and creates additional administrative burden on practices.

Recommendations

- HHS should enforce required timely payments. Insurers who are not paying what they owe to a provider after the IDR process is complete must be penalized and forced to compensate the provider for the total amount owed plus interest.
- A uniform electronic payment process should be in place. Certified IDREs should have a uniform process established to collect all the IDR fees and refund the winning party the certified IDR entity fee.
- HHS should consider incorporating the open negotiations process into the IDR portal. Doing so could help both insurers and providers better track what claims are entering the dispute resolution process and when the 30-day open negotiations process begins. The updated portal should clearly include the contact information for all the key contacts involved in the dispute. Finally, it should formalize the process and provide additional data to HHS about compliance or non-compliance.

Thank you for your time and commitment to ensuring the NSA is implemented as Congress intended. We appreciate the opportunity to outline radiology's concerns related to the NSA and provide potential solutions to help improve the IDR process. If you have any question, please contact ACR Director of Government Affairs, Ashley Walton.

Sincerely,

Sincerely,

Cynthia R. Moran
Executive Vice President
American College of Radiology

HEADQUARTERS
1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900

October 3, 2023

Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth HOB
Washington D.C. 20515
WMSubmission@mail.house.gov

RE: Request for Comments for September 19, 2023 Hearing on Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections

Dear Chairman Smith:

SpecialtyCare is a healthcare provider of perfusion and intraoperative neuromonitoring (IONM) throughout the United States. We are writing specifically with regard to our IONM service line. SpecialtyCare is the largest provider of IONM in the United States. Our clinicians and neurologists support over 110,000 spine and brain surgeries a year across 42 states. All our services are performed in the operating room where our patients are at their most vulnerable. They are unconscious and relying 100% on the surgical team (of which we are a part) to get them through the surgery safely.

Our IONM service line is a combination of in network and out of network. For three years, we have been pursuing a strategy of trying to increase our in-network footprint with health plans and issuers ("Insurers") because that is best for our patients and our hospital and surgeon clients. Unfortunately, the Insurers have not shared the same vision. Most of our requests for in-network contracts have either been rejected with a "take it or leave it" rate that is far below the fair market value rates that are being developed through the IDR process or, in the case of one major insurer, they told us that they make more money with us being out of network.

OVERVIEW

We had great optimism for the process laid out by the No Surprises Act ("NSA") and believed it would help bridge this gap. After its implementation, we saw Insurers unilaterally decreasing initial payments and increasing their number of zero pays. As a result, SpecialtyCare has been forced to be an active participant in the federal IDR process implemented under the NSA. Despite the strangled implementation, we have been highly successful at winning decisions with our most recent win rates exceeding 80% on the merits; unfortunately, all the time and cost invested to win is for naught because Insurers just do not pay decisions timely. Nothing in the NSA requires them to pay, and the longer they hold funds for investment before paying them out, the better their profits. Meanwhile, the days outstanding for our receivables from date of

service has **more than tripled** creating extensive working capital constraints that will eventually impact the critical care that we provide to people when they are most vulnerable. The remainder of this letter sets forth the critical issues that we see with the NSA and provides our data supporting our assertions.

ISSUES AND PRESENTATION

We appreciate the opportunity to offer our views on various issues addressed at the Hearing on Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections held by the Ways and Means Committee on September 19, 2023.

This comment letter addresses four main issues related to the implementation of the NSA: (1) delays in payment from Insurers following certified IDR entities' written payment determinations; (2) the lack of interest from Insurers regarding the negotiation of in-network contracts; (3) the utility of batching claims for items and services based on an episode of care as opposed to individual service codes; and (4) delays in written payment determinations by some certified IDR entities.

1. Delays in Payment from Insurers following Certified IDR Entities' Written Payment Determinations

Congress intended for the NSA to provide an efficient process for healthcare providers and Insurers to resolve payment disputes and for healthcare providers to collect reasonable compensation for their services. Accordingly, under the NSA, an Insurer must make any additional payment it owes to a provider under an IDR entity's written payment determination no later than 30 calendar days from the date the certified IDR entity issues its written payment determination. 42 U.S.C. § 300gg-111 (c)(6).[1]

Unfortunately, the vast majority of Insurers have failed to pay in accordance with the NSA's 30-calendar-day requirement. Only 31% of our decisions are paid within the 30-day timeframe. As of the date of this letter, 85% of Insurers against whom we have won decisions have past due amounts, and **96%** of our IDR awarded amount is more than 30-days past due (60 days from decision) and remains unpaid. For those of our decisions that have been paid, Insurers have taken, on average, 178 days from the date of the written payment determination to provide us with additional payment. Before the NSA took effect, SpecialtyCare typically received payment within 105 days from the date of service. With the NSA now in effect, that number has increased to 446 days. The slow pace of IDRs processing decisions is challenging, but it could be managed if providers were paid timely for the decisions they win. However, the rate of decisions

[1] As this Committee is aware, the NSA made triplicate amendments to the provisions of the Public Health Service ("PHS") Act, the Employee Retirement Income Security Act ("ERISA"), and the Internal Revenue Code ("IRC"). The versions of the NSA enacted into ERISA and the IRC are the same in all material respects as the codification in the PHS Act, so this comment letter cites the PHS Act provisions only for ease of reference.

being rendered is meaningless because providers will be choked out of business well before they see their decisions paid, even if the decision rate is improved.

We see this as a direct result of the lack of an express enforcement mechanism in the NSA upon which healthcare providers can rely when Insurers fail to pay IDR decision awards. It is possible that litigation is a means of collection, but that is more time and more cost to be incurred by SpecialtyCare and any other provider. SpecialtyCare has already incurred additional expense and administrative burdens by having to send demand letters for the additional payments to which we are legally entitled. We have emails and spreadsheets from payers expressly stating that they owe the additional payment on the decisions, yet months go by without them paying. Our next step is incurring the costs of litigation with no clear means of recouping those costs. Meanwhile, the Insurers, which are professional litigators with voluminous lawyers on staff, withhold the payments with impunity.

2. Lack of Interest from Insurers Regarding the Negotiation of In-Network Contracts

While many debate the veracity of the Insurer's QPA calculations, the Departments' regulations implementing the NSA have permitted Insurers to make initial payments to providers for any amount the Insurer chooses regardless of whether it bears any relationship to the QPA. In 2019, the base year for the NSA, our average payment for the out-of-network portion of our service line was $1,402 per surgery. For 2022, it was $1,037 per surgical procedure. For 2023 year to date, it is $684. Since inception of the NSA, we are winning at an average rate of $1,791 per procedure. Even when we lose, we are receiving incremental awards because the Insurers are consistently offering more in IDR than what they initially paid. We have been able to negotiate five additional in network agreements since the inception of the NSA with five small payers at rates consistent with our 2019 rates. From our perspective, between rates and the costs of the IDR, there should be room for two reasonable parties to find an in-network arrangement that works for both sides. However, when we offer these rates to the larger Insurers the highest rate counteroffered by any of them was $765 per procedure. A 46% decrease from the 2019 rate. Even more challenging is that 53% of the Insurers to whom we have sent offers have not responded at all despite our continued follow ups. This forces us to rely entirely on the NSA IDR process, which benefits Insurers because of the delay and gives no incentive to Insurers to negotiate in good faith for in-network contracts.

As an example of our experience, on May 31, 2023, a 13-year-old female suffering from scoliosis underwent a six-hour spine correction surgery affecting 12 levels of her spine for which SpecialtyCare provided neuromonitoring for five hours by a Board-certified Neurologist. The Insurer's initial payment was $97, and it has paid nothing further to date. While this is one instance, we have thousands of examples of these extreme and egregious payment determinations by the Insurers.

3. The Utility of Batching Disputes Based on an Episode of Care as Opposed to Individual Service Codes

The Departments' flawed batching regulations, which required IDR disputes to be batched separately based on individual service codes, has resulted in significant financial burden for providers, like SpecialtyCare, who have been required to submit multiple IDR disputes for one single patient encounter. Although the United States District Court for the Eastern District of Texas recently vacated the Departments batching regulations in *Texas Medical Association, et al. v. Dep't of Health and Human Servs., et al.*, No. 6:23-cv-00059 (Aug. 3, 2023), the damage has been done. The Departments' batching requirements significantly increased the amount SpecialtyCare had to pay in IDR entity fees and administrative fees. These increased fees also made it financially impractical (and unfeasible) for us to pursue our right to dispute certain line items. For decades, the "episode of care" has been the fundamental reference point for healthcare services provision and billing. Why the Departments' would choose to deviate from what everyone in the healthcare industry, from clinicians to administrators, sees as the fundamental reference point is a mystery to us. To use CPT codes for batching instead of "episode of care" is analogous to comparing threads instead of comparing sweaters. The providers are unduly burdened by the batching and the Insurers' systems are not capable of timely re-adjudicating a claim by CPT code.

A closely related idiosyncrasy in the Departments' framework is that the provider has to identify in their IDR notice whether a plan is fully insured or self-funded as a batching criteria. To be part of the IDR process, the provider is out of network, so the provider has no access to any of the plan details of the Insured. The only source of information for the provider is the 835 data and the explanation of benefits (EOB). The Insurer is not required to disclose in either the 835 or the EOB whether the plan is fully insured or self-funded. We interact with over 1,200 payers and less than ten we have found so far provide this information in the 835 data or on the EOB. Consequently, providers are having batches dismissed from the process simply because they do not have the information to know whether a plan is fully insured or self-funded, when the Insurer has that information at its fingertips.

SpecialtyCare provides the Insurers' claim numbers on their notice so the Insurer can easily track to the underlying plan information. Even the claim number process has become a game because Insurers are now changing their claim numbers between the Open Negotiation Notice (ONN) submission and the IDR notice of arbitration. The typical scenario is the Insurer pays a very low initial payment amount. The EOB at this point is the initial adverse determination that triggers the ONN process. We send an ONN. They typically do not respond at all. We submit a Notice of IDR. Insurers will then sometimes pay an extra $10 or other de minimis amount and issue a re-adjudicated EOB with a different claim number. We then go through the arbitration process using the initial EOB claim number (because that is what the statutes says), the Insurer objects stating that the claim number is incorrect because the number changed on the re-adjudicated EOB. This causes massive amounts of work for the IDRs and the providers to track back through the actions of the Insurer.

4. Delays in Written Payment Determinations by Some Certified IDR Entities

Under the NSA, within 30 days from being selected, the certified IDR entity must select which one of the parties' offers it determines best represents the reasonable amount of reimbursement for the items/services in dispute. 42 U.S.C. § 300gg-111(c)(5)(A). There are specific certified IDR entities that regularly fail to comply with this requirement. As a result, SpecialtyCare has submitted many disputes that remain pending in the IDR process for months on end.

SpecialtyCare has submitted a total of 11,831 disputes to IDR. Out of those disputes, only 1,891 (approximately 16%) have been fully adjudicated, and 7,208 (approximately 61%) are still pending. Of the 7,208, 4,879 are awaiting action by the IDR to request payment and/or notice from the IDR that it is open to receive submission materials. The remaining 2,732 disputes have been closed (approximately 23%), usually through settlement with the Insurer.

We are grateful for the ability to share our thoughts, and we appreciate your continued attention to ensuring that the NSA is implemented in a manner that treats healthcare providers fairly and in accordance with Congress's intentional and thoughtful design.

Sincerely,

SpecialtyCare

/s John G. Arena

John G. Arena
Chief Legal Officer
On behalf of:

SpecialtyCare, Inc
Remote Neuromonitoring Physicians, PC
Sentient Physicians PC
3 Maryland Farms, Suite 200
Brentwood, TN 37027
Phone: 800-3458-4565
Fax: 888-959-4082

American Society of Anesthesiologists®

1061 American Lane | Schaumburg, IL 60173-4973 | (847) 825-5586
905 16th Street N.W., Suite 400 | Washington, D.C. 20006 | (202) 289-2222

Statement of Michael Champeau, MD

President
American Society of Anesthesiologists

House Ways and Means Committee

Hearing on Reduced Care for Patients:
Fallout From Flawed Implementation of
Surprise Medical Billing Protections

September 19, 2023

Chairman Smith and Ranking Member Neal,

On behalf of the members of the American Society of Anesthesiologists (ASA), thank you for this hearing to examine the implementation of the No Surprises Act (NSA). We appreciate the Committee's ongoing efforts to ensure that the work of the relevant federal departments is in compliance with the statutory language of the law.

We commend this committee for its leadership in developing the NSA. The committee served a key role in crafting a law that successfully protects patients from surprise medical bills and improves transparency within the health care system. A third major component of the NSA – the creation of a functional dispute resolution system – is the focus of my statement today.

We believe significant opportunities exist for Congress to give renewed attention to the Independent Dispute Resolution (IDR) process, a mechanism intended to fairly resolve payment disputes between payers and physicians. We believe that there is currently an imbalance in the implementation of this part of the law. This imbalance benefits payers while creating profound financial challenges for anesthesiology practices across the country, especially small- and medium-sized, community-based practices. We urge the Committee and Congress to continue to work to fix the independent dispute resolution (IDR) process and to ensure that the law is implemented as Congress intended.

We have identified the three key challenges facing our members, briefly described each, and provided specific recommendations to address the challenges, which include:

1) **Overly restrictive "batching" rules and guidance.**
2) **Unreasonable insurer-calculated QPAs and "ghost" rates.**
3) **Lack of timely payments from payers to physician practices that prevail in the IDR process.**

Overly restrictive "batching" rules and guidance

One of the most vexing issues faced by anesthesiologists is the flawed batching rules and guidance. Current agency guidance[1] continues a highly inefficient policy that limits the batching of anesthesia claims for a given practitioner/issuer pair to the same service facility and CPT code. This approach is extremely expensive for anesthesiologists' practices and hampers the ability of anesthesiologists and IDR entities to efficiently batch large groups of claims. The practices are effectively limited to "micro-batches" of two to three claims. The dozens of "micro-batches" that are required in lieu of larger batches exacerbate current problems related to the high volume of claims submitted to IDR entities. Practices are required to pay an administrative fee and an IDR fee for dozens, if not hundreds of "micro-batches" instead of a single administrative fee and IDR fee for a larger batch. Congressional intent was clearly to permit these larger batches.

Anesthesiology's unique payment methodology and universal dollar-value conversion factor offers the Departments an opportunity to align directly with Congressional intent. The universal contracting practice for anesthesia services between a payer and anesthesiologist centers on a dollar-value anesthesia conversion factor rate, not on the full final payment amount. A payer will contract with an anesthesiologist and/or their group for payment for all anesthesia services

[1] Centers for Medicare and Medicaid Services. (August 2022) Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities. Pg 3.

based upon a single, universal anesthesia conversion factor. Indeed, the subject of any negotiation between a payer and an anesthesiology practice is this conversion factor. Whether the anesthesia service is for a surgical procedure on the head, shoulder, arm, or leg, the payer's in-network universal anesthesia conversion factor is used for all services. While the assigned anesthesia base units (units based upon the complexity of the anesthesia) and time units (captures actual anesthesia time) are variable, the dollar conversion factor is constant. If agreement can be reached on this anesthesia conversion factor, the anesthesiologist/group and the payer will agree to the contract and the group will serve as an in-network entity.

Accordingly, disputes between out-of-network anesthesiologists and payers that require resolution by an IDR entity focus entirely on the insurers' universal anesthesia conversion factor. In the out-of-network scenario, the IDR entities are required to determine the appropriate common dollar conversion factor based on offers from both parties.

ASA believes the most efficient manner to adjudicate the large backlog of pending anesthesia claims is to permit the batching of all anesthesia claims within a given geographic area and that share the same practitioner tax ID number and insurance issuer. Doing so would allow IDR entities to quickly and efficiently resolve all of a payer's out of network anesthesiology claims through a single anesthesia conversion factor-based batch, instead of being forced to resolve many smaller two-to-three claim, CPT-based "micro-batches."

Recommendation: Congress should work to ensure the Departments' rules and guidance align with Congressional intent on batching.

Inaccurate insurer-calculated QPAs and "ghost" payments

ASA is concerned about continued reports of inaccurate QPAs. Some QPAs are unreasonably low and are inconsistent with even a range of reasonable local in-network contracted rates. In some cases, the QPAs are more in line with Medicare payment rates than they are with the local contracted rates. As a result, physicians and their practices are forced to utilize the IDR process in order to be paid appropriately for their services.

One possible driver of inaccurate QPAs is "ghost" rates. "Ghost" rates are contracted non-negotiated payment rates for medical specialties that will rarely or never provide the actual service for which the insurer is calculating the QPA. For example, the contracts of some primary care practices may contain undetected payment rates for anesthesia services, even though the primary care practice will never provide the anesthesia service and the payment rates was never negotiated. Some insurers may include those rates as "contracted" rates for the purposes of calculating the QPA for an anesthesia service. The result is inaccurate QPAs.

A 2022 study on the subject found that "for QPA calculations, including rates for providers who rarely or never provide a service may lead to QPA values that do not reflect payments typically accepted by in-network providers. Using the example of anesthesiology, emergency medicine, and advanced imaging services, the majority of primary care practices have contracted rates for these services that they never or rarely provide and that they do not negotiate with payers." [2]

[2] American Society of Anesthesiologists (August 22, 2022), "Current Insurer Calculation of Qualified Payment Amount for Out-of-Network (OON) Care May Violate No Surprises Act." https://bit.ly/40uJsTM (Accessed 9/25/2023)

The agency has directed payers to halt the use of "ghost" payment rates[3] and $0 rates in calculating QPAs rates.[4]" However, it remains unclear whether payers are complying with this guidance. Neither the government nor physicians have access to the information necessary to "check the math" of the insurer.

Payers' past behavior, whether intentional or inadvertent, should raise concerns within the agency about the accuracy of QPA calculations. Inaccurately low QPA calculations force more claims into the IDR process, adding to the backlog. Because of the importance of an accurate QPA to the NSA process, it is essential that payers' behavior and their calculations be carefully scrutinized.

Recommendation: Congress must hold the Departments accountable for accurate QPA including the performance of statutorily mandated QPA audits.

Lack of timely payments from payers to physician practices that prevail in the IDR process

ASA has received frequent reports of payers failing to make payments to anesthesiologists who have prevailed in the IDR process. By law, once an IDRE has adjudicated a physician/payer dispute and selected the provider's offer as the appropriate payment, the payment due to the physician must be paid no more than 30 calendar days later. Whether intentional or inadvertent, payers are failing to meet the necessary timeline. The lack of a strong mechanism within the NSA to compel payers to make timely post-IDR payments is a significant problem for anesthesiology practices.

Recommendation: Congress should develop and pass legislation to strengthen payer compliance with the statutory payment deadline.

We thank you for your consideration of these recommendations. We believe that, if acted upon, these recommendations will return balance to the implementation of the NSA – balance that was intended by this committee and expected by all the stakeholders.

Manuel Bonilla, ASA's Washington, D.C., representative, can be reached at M.Bonilla@asahq.org or at (202) 436-2644.

[3] Centers for Medicare and Medicaid Services. (August 19, 2022) FAQS About Affordable Care Act and Consolidated Appropriations Act of 2021, Implementation Part 55. Pg 16.
[4] Ibid. Pg 17.

LEUKEMIA & LYMPHOMA SOCIETY®

September 19, 2023

House Ways & Means Committee
10:00AM, 1100 Longworth House Office Building
RE: "Reduced Care for Patients: Fallout from Flawed Implementation of the Surprise Medical Billing Protections"

STATEMENT FOR THE RECORD

The Leukemia & Lymphoma Society's (LLS) mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. We advance that mission by advocating that blood cancer patients have sustainable access to quality, affordable health care and health coverage.

Many of our patients are among the one in six Americans who have received a surprise bill.[i] Numerous studies and media accounts have documented the financial impacts of surprise bills, including devastating out-of-pocket costs for those consumers directly affected and higher premiums for all privately insured consumers.[ii,iii,iv,v,vi,vii,viii,ix] Over time, surprise billing has become a business strategy used by a broad variety of facilities and providers. Of particular concern has been the growth and impact of private equity's use of this practice for financial gain to drive profits for private interests. As a result, LLS has worked alongside state and federal policymakers – including this Committee – to develop solutions to stop this harmful practice that are grounded in evidence and patient experience. We are pleased to have been able to contribute to the No Surprises Act (NSA) which aims to protect patients from surprise bills and inflationary healthcare costs.

LLS celebrated the passage of the NSA and its dual objectives to shield patients from ruinous surprise bills *and* contain individual and systemic costs (including out-of-pocket costs). However, litigation brought by providers has hindered the Administration's ability to smoothly implement the law and simultaneously prevented patients from actualizing the full breadth of the law's benefits. LLS has fought vigorously on behalf of our patients in statehouses, before Congress, and now in the courts.

We are disheartened by the multitude of attacks providers have levied against the NSA in the wake of its passage – all the while claiming they hold patient's interests above their own.[x] Litigation brought by providers has repeatedly eroded regulatory guidance provided by the implementing agencies aimed at limiting out-of-pocket costs for patients and consumers. Still other lawsuits have taken aim at the independent dispute resolution (IDR) process – drastically slowing down processing and payments while threatening to increase premiums for patients. Yet more litigation aims to overturn the entirety of the law and put patients back in immediate danger of receiving surprise bills.

While we acknowledge that issuers and providers have been frustrated by certain aspects of the IDR process, we urge this Committee not to lose sight of the significant ways the NSA has benefited patients and consumers. We support efforts to build upon the Act's successes, including more transparency and swift resolution of payment disputes, without subjecting patients and consumers to higher healthcare costs.

[i] Lopes, L., Kearney, A., Hamel, L., & Brodie, M. (2020, February 28). *Data Note: Public Worries About And Experience With Surprise Medical Bills*. Kaiser Family Foundation. https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/

[ii] Duffy, E., Ly, B., Adler, L., & Trish, E. (2020). Policies to address surprise billing can affect health insurance premiums. *The American Journal of Managed Care, 26*(9), 401–404. https://doi.org/10.37765/ajmc.2020.88491

[iii] Congressional Budget Office. (2021, December). *Estimate for Divisions O Through FF HR 13, Consolidated Appropriations Act of 2021*. CBO. https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

[iv] Adler, L. (2020, December 8). *California saw reduction in out-of-network care from affected specialties after 2017 surprise billing law*. Brookings. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/

[v] HHS. (2020, July). *HHS Secretary's Report on: Addressing Surprise Medical Billing*. ASPE. https://aspe.hhs.gov/sites/default/files/private/pdf/263871/Surprise-Medical-Billing.pdf

[vi]Appelbaum, E., & Batt, R. (2019, September 4). *Private Equity and Surprise Medical Billing*. Institute for New Economic Thinking. https://www.ineteconomics.org/perspectives/blog/private-equity-and-surprise-medical-billing

[vii] Cole, B. (2021, January 5). *Health Lobbyist Spent $75 Million to Kill Surprise Medical Bills Reform*. Newsweek. https://www.newsweek.com/health-lobbyist-spent-75-million-kill-surprise-medical-bills-reform-1559065

[viii] Bluth, R. (2019, September 16). *Investors' Deep-Pocket Push To Defend Surprise Medical Bills*. Kaiser Health News. https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/

[ix]Sanger-Katz, M., Creswell, J., & Abelson, R. (2019, September 16). *Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing.'* The New York Times. https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html

[x]O'Neill Institute, Health Care Litig https://litigationtracker.law.georgetown.edu/issues/no-surprises-act/ https://litigationtracker.law.georgetown.edu/issues/no-surprises-act/ation Tracker. https://litigationtracker.law.georgetown.edu/issues/no-surprises-act/

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

Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

"Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

September 19, 2023

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) writes to share the hospital field's experience with implementation of the No Surprises Act (NSA).

Hospitals and health systems support Congress' approach to protecting patients from unexpected medical bills. The NSA prohibits providers from sending patients certain types of balance bills and ensures that patients' cost-sharing responsibilities are limited to what they would have paid for in-network health care. Once the patient is protected, the provider and health plan are expected to work together to determine appropriate reimbursement. For instances where this approach fails to result in a mutually agreed upon reimbursement amount, Congress established an independent dispute resolution (IDR) process.

While we continue to support the underlying goals of the NSA, implementation of the statute has been uneven from both regulatory and operational perspectives. We appreciate the opportunity to provide feedback to the Committee, as we have previously shared this information with the agencies supervising the NSA — the Centers for Medicare & Medicaid Services, Employee Benefits Security Administration and Department of the Treasury.

OVERVIEW OF THE NSA

The NSA included critical patient protections against unexpected medical bills for certain types of health care services when provided by out-of-network providers. The AHA supports these patient protections. Through various provisions in the law, Congress intended for plans and other payers to appropriately reimburse providers for these services and included an IDR process should negotiations between the two parties fail. Patients are fully removed from this process, and the outcome has no bearing on their cost-sharing obligations. However, this does not mean that the IDR process will not affect patients. **Specifically, inappropriate reimbursement by payers can impact providers' ability to continue offering services or offering them in the timeframe or the quality that patients deserve.** A high-functioning IDR process is crucial for fully realizing the NSA patient protections.

Congress also incorporated the IDR process into the statute to curb inappropriate behavior by both payers and providers. However, the process only functions as a deterrent if both parties know that an unbiased third party will make a timely determination. If the process is weighted in favor of one party, that party has less of an incentive to act fairly in the initial claim billing and reimbursement process. Untimely decisions also limit the deterrent effect, as payers know that providers can only serve patients for a limited time with constrained cash flow. Delaying the reimbursement process can be an effective tactic for dissuading providers from disputing inappropriate payments even when their claims are strong.

Certain policy decisions and implementation challenges have undermined the unbiased and timely nature of the IDR process and contributed to the higher-than-anticipated volume of disputed claims. One of our primary concerns related to the overweighing of the qualifying payment amount (QPA) was validated by the U.S. District Court for the Eastern District of Texas. We continue to urge the regulatory agencies to comply with the court's ruling and refrain from placing any constraints on IDR entities that were not authorized by Congress. In addition, we have identified the following recommendations to improve the open negotiation and IDR process.

POLICY AND OPERATIONAL CHALLENGES AND RECOMMENDATIONS

Regulations Concerning Batching and Bundling of Claims

The agencies have adopted an unworkably narrow definition of "item or service" for

purposes of batching claims for IDR disputes. Effectively, a claim for an episode of care that involves multiple line items on the bill cannot be submitted to the IDR as a single dispute. Take, for example, a claim for an emergency department visit to set a broken leg. This claim may include multiple line items to cover diagnostic scans, supplies, physician time, etc. Under the agencies' regulations, each of these items is its own "item or service" and must be separately adjudicated.[1] As such, these regulations effectively make batching of claims unavailable to facilities, resulting in substantial underpayment of providers as well as increased use of the IDR process.

Following is an example from an AHA member hospital. A hospital billed a health plan for an out-of-network Level 4 emergency visit that include 30 unique "items or services" (per the agencies' definition). The total value of the charges was $68,880. The health plan paid $1,614 on a single line item. Under the current rules, this hospital must evaluate each underpaid line item and determine which to adjudicate. To select one item or service to dispute leaves the hospital significantly underpaid for the totality of services already rendered to a covered patient; but to initiate individual disputes for all unique items and services is extremely costly in terms of both money and time. In this instance, since only one of the items or services were paid, the provider would need to initiate 29 disputes to challenge the full reimbursement for this claim, and the administrative fees alone would have amounted to $10,150, not including the IDR fees.[2] This policy gives payers tremendous opportunity to abuse the system, as they have sole discretion over how to make an initial payment (i.e., whether they pay a single bundled amount, pay on each individual line item or a combination).

Other aspects of the batching rules also are driving the volume of disputes. Specifically, how the agencies have defined payer for purposes of batching severely limits providers' ability to batch like claims together. Under the law, claims may only be batched together if they meet certain conditions, including that the "payment for such items and services is required to be made by the same group health plan or health insurance issuer." Under the agencies' guidance, claims for individuals enrolled in employer-sponsored coverage may only be batched if the coverage is from the same employer. Yet, in most cases, it is the employers' third-party administrators (TPAs) that both determine the initial payment amount and reimburse the provider. In addition, it appears that most TPAs are using the QPA, which they are calculating based on all their TPA business in the same market. The TPA's initial payment is the same regardless of an individuals' employer, and yet providers may not batch these claims. This policy is further complicated as the provider generally does not know which employer the patient is associated with as their insurance card, as well as the remittance, may only indicate the TPA information. This double standard in the definitions disadvantages providers and

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[1] On August 3, 2023, the U.S. District Court for the Eastern District of Texas vacated the batching provisions of the NSA regulations. Further guidance from the agencies is forthcoming.
[2] This claim occurred when the administrative cost per IDR filing was $350.

drives unnecessary utilization of the IDR process, thereby increasing the costs and burden for all parties. We strongly urge the agencies to revise the guidance to allow batching at the TPA level for employer-sponsored insurance (ESI) claims.

Recommendation: Revise the batching and bundling guidance to allow for a more rational process for facilities to dispute inappropriate reimbursement.

Excessive Administrative Fees

The agencies increased the non-refundable administrative fee to $350 from $50 effective Jan. 1, 2023. This 600% increase for initiating an IDR dispute is cost prohibitive for many hospitals and health systems, especially considering how facility claims must be disaggregated per the batching and bundling rules. As noted in the emergency department claim described above, the potential administrative costs for disputing the claim would amount to $10,150 in administrative fees to fully contest the payers' total reimbursement of $1,614 on a claim valued at $68,880. These fees create an inappropriate financial barrier to the IDR process and further tilts the process in payers' favor as they are aware that many providers will be unable to use the process due to the expense. Under a recent court decision challenging the increase, the administrative fee was once again set at $50, but only for claims filed after Aug. 3, 2023. Providers who filed between Jan. 1 and Aug. 3, 2023, will not receive a refund for the fees they have already paid for the dispute process. We encourage the agencies to maintain the lower administrative fee amount.

Recommendation: Continue to maintain the IDR administrative fee at $50, which otherwise makes the IDR process cost prohibitive for many facility claims when coupled with the batching and bundling policies.

Lack of Oversight of QPAs

Congress created the QPA for two purposes: 1) to calculate patient cost-sharing in a timely way, and 2) as a factor for consideration by the IDR entities. However, many health plans are using the QPA to set initial payment determinations, and there are reports from hospitals of payers offering very low rates based on their calculation of the QPA. In some cases, these rates are lower than what Medicare pays. We are unaware of any market for any service in which Medicare consistently pays above commercial rates. On its face, this suggests that some payers are not accurately calculating the QPA, likely by including "ghost rates" in their calculations. "Ghost rates" occur when a provider and plan technically have a dollar value for a service in their contract, but the provider does not offer the service and therefore does not negotiate on the amount. As a result, the rate could be $0 or otherwise low for the service since the reimbursement amount is irrelevant.

We continue to believe that the only way to enable providers to engage in the IDR process on equal footing with the plans, as well as to ensure arbiters have the information they need to make an informed decision, is to require payers to detail their QPA calculations. **Payers should be required to demonstrate to providers they are accurately calculating the QPA.** Otherwise, only one party enters the dispute process with the knowledge of how the QPA was calculated and whether it accurately represents a median contracted rate, while the arbiter and provider are unable to challenge this factor, which the agencies have consistently given outsized importance.

In addition to requiring that payers demonstrate to arbiters and providers that the QPA adheres to federal requirements, **the agencies also should conduct rigorous review of plans' QPA calculations.** More than a year into implementation, no public information has been provided to verify that such audits are occurring. Allowing payers' behavior to go unrestricted is likely contributing to their audacity in underpaying providers. We believe chronic underpayments could impact access to care. QPA oversight should therefore be one of the agencies' highest priorities.

Recommendation: Ensure greater transparency and oversight regarding the calculation of the QPA.

Failure by Health Plans to Negotiate

The NSA includes a 30-day open negotiation period, which we understand Congress intended to be used by providers and health plans to determine reimbursement in the vast majority of out-of-network cases. Unfortunately, a substantial number of health plans have been unwilling to negotiate with providers during the open negotiation period, leading providers to use the IDR process at rates that are higher than anticipated. The agencies have discussed including the open negotiation process as part of the federal portal, which we expect will encourage more payers to be willing to engage with providers in discussions regarding reimbursement and hopefully avoid many IDR claims.

Recommendation: Monitor and incentivize payer participation in the open negotiation process.

Information Sharing between Health Plans and Providers

Providers are hampered in the negotiation process due to incomplete or inaccurate information shared by plans. Reimbursement remittances often do not include the QPA (or a number identified as the QPA), nor do they indicate whether the claim is subject to the NSA (something only the payers will know definitively as health plan eligibility cards do not often indicate the exact form of coverage for the patient). At a minimum, **payers should be required to use the agencies' NSA-specific Remittance Advice Remark Codes (RARCs) when communicating information about claims to providers and**

facilities. These RARCs are a series of alert codes specific to the NSA that can be used on payers' remittances to convey NSA-related information to providers. For example, the RARCs include alerts as to when the NSA applies to a claim; that the cost-sharing is calculated according to the NSA; whether the initial, final and denial of the payment amount are made in accordance with the NSA; and whether notice and consent were obtained for the provider to bill out-of-network and whether the notice and consent obtained were in accordance to the NSA. Consistent use of the RARCs could greatly improve the processing of NSA claims and helping to determine whether such claims fall within the IDR process.

In addition, and as mentioned earlier, for employer-sponsored coverage, the health plan eligibility card will not indicate the employer but rather only their TPA. Without accurate information, providers may inadvertently initiate disputes on claims that are ineligible or batch claims that cannot be batched under current rules. Payers are the only party to know the definitive type of health plan, and they should be required to share it with the providers and facilities.

Recommendations: Mandate that payers use the agencies' RARCs when communicating information about claims to providers and facilities and require payers to include information on the patient's plan type at the time of initial payment or payment denial.

Timeliness of Payment

Contrary to the statute, a substantial number of claims subject to the NSA are not being paid within 30 days. One of our hospital systems reports that insurance plans have not responded to 40% of their out-of-network claims — neither remitting a payment nor issuing a denial. In reviewing their out-of-network claims in a single hospital market from June 2022, of the 2,361 claims filed, only 1,229 were paid or denied within June or July 2022; 796 were paid or denied over the subsequent six months; and 336 (14%) have received no response either way. **This represents a gross violation of the law, and the payers must be held accountable.** In these instances, providers have no recourse but to initiate an IDR dispute and, as a result, the failure by plans to provide any response to a claim is contributing to the substantial volume of disputes.

In addition, our hospital members report they are not being paid in a timely manner — if ever — when IDR entities decide in their favor, and often they are making multiple contacts with the insurance plans to attempt to receive payments. A review of this aspect of the IDR process is essential to ensure it is operating in a manner that is fair to providers.

Recommendation: Ensure plans are making payments in a reasonable period.

CONCLUSION

Thank you for your leadership to end surprise medical billing and for working with stakeholders to protect patients while addressing this important issue. We appreciate your ongoing reviews of NSA implementation process and look forward to continuing to work with you.

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Ways & Means

Re: Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections

September 19, 2023

Division of Legislative Counsel

202-789-7426

Statement for the Record
of the
American Medical Association
to the
Committee on Ways & Means

Re: Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections

September 19, 2023

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on Ways & Means as part of the hearing entitled "Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections." The AMA has long supported the goal of protecting patients from unanticipated medical bills. As such, we applaud the leadership of this committee in addressing surprise medical billing through a balanced approach to reconciling differences between physician charges and plan payments, while at the same time protecting patients by removing them completely from the dispute. The No Suprises Act (NSA) Congress enacted in 2020 has the potential to protect patients in surprise billing situations while maintaining market forces that ensure physicians, especially those in independent practices, can meaningfully participate in contract negotiations with health plans. The way in which the Administration has been implementing the NSA has not realized that potential and, if not corrected, will stymie achievement of this important policy goal to the detriment of patients and physicians.

Very broadly, the AMA is disappointed that the Administration has chosen to capitalize on a targeted policy response to surprise medical billing and use it as an opportunity to myopically address health care costs by artificially deflating payment rates for physicians who are providing the direct medical care to patients. By taking the balanced Independent Dispute Resolution (IDR) process specified in the statute and attempting to strip it down to a process that is largely inaccessible and unaffordable to independent or smaller practices and to where the outcome is nearly always predetermined and prejudicial to physicians, the Administration has disregarded the result of Congressional negotiations and placed yet another thumb on the scale in favor of health insurers in already highly concentrated health insurance markets.[1] In fact, members of the Ways and Means Committee, including the then Chairman and Ranking Member, wrote numerous times to outline the extensive bipartisan Congressional negotiations and implore the Departments of Health and Human Services (HHS), Treasury, and Labor to avoid any ambiguity or misinterpretations of the statute and, in turn, to implement the NSA to the letter of the law[2].

Unfortunately, under the Administration's approach to implementation, the immensely dominant insurance companies in already concentrated markets continue to gain more market power and physician practices are being forced to make difficult choices in response—consolidate, join health care systems, sell to insurance companies, turn to private equity, or close their doors. The result is not increased value for patient premiums but decreased patient choice and access.

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[1] American Medical Association. Competition in Health Insurance: A Comprehensive Study of U.S. Markets. 2022 Update. Available at: https://www.ama-assn.org/system/files/competition-health-insurance-usmarkets.pdf.

[2] See, e.g., www.aans.org/-/media/Files/AANS/Advocacy/PDFS/surprise-billing-regs-Neal-Brady-letter.ashx; www.aha.org/system/files/media/file/2022/11/key-house-committee-express-serious-concerns-regarding-latest-efforts-to-implement-the-bipartisan-no-surprises-act-letter-11-21-22.pdf; https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FSuozzi-Wenstrup-SMB-Implementation-Letter-w-signa-6.17.21.pdf; and https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf.

The AMA and dozens of organizations representing health care providers have taken every opportunity to express our concerns to the Administration and suggest changes to rules and guidance that would protect patients and the market balances Congress sought. Small improvements have been made aligning with our recommendations and we continue to express our concerns to the Centers for Medicare & Medicaid Services (CMS). However, the Administration continues to deviate from the statutory language and exceed its administrative authority in its implementation of the dispute resolution process, specifically. We have thus engaged in and supported[3] lawsuits that challenge the implementing regulations. For the AMA, litigation efforts are an option of last resort. But unfortunately, that is where we find ourselves and are validated by the U.S. District Court decisions that continue to recognize the Administration's overstepping of its authority.[4]

To be clear, the AMA supports the concept of the IDR process in the NSA and believes this process has the potential to fairly resolve payment disputes between physicians and health plans. Our current concerns are not with the process as outlined in the statute, but with its implementation. We believe the Administration has made several *correctable* missteps in the implementation process and urge Congress to support quick action by the Administration to address these issues and ensure that the NSA functions as intended. Below we identify and discuss the current and most pressing implementation issues that must be addressed quickly to ensure that physicians are able to meaningfully negotiate with health plans and keep their practices up and running in order to provide needed care to patients.

Overreliance on the QPA in the IDR process

Perhaps no implementation flaw has had greater repercussions on patients, physicians and the health insurance market than the Administration's overreliance on the qualifying payment amount (QPA) in determining a fair out-of-network payment. As this Committee knows, the statute was *not* drafted in a way that suggests the median contracted rate paid to other physicians should systematically be valued over other factors by IDR entities (IDREs) when determining the appropriate out-of-network rates, but rather in a way that recognizes there are many relevant factors that the IDREs should consider when determining a fair payment amount.

Unfortunately, the Administration has twice directed IDREs to consider the QPA the dominant factor in determining an out-of-network rate and to essentially disregard statutorily allowable information supporting a party's offer, including those enumerated in the law which Congress determined were relevant to determining a fair payment.[5] The AMA was pleased to finally see guidance in March 2023 that better reflected the balance Congress sought by permitting IDREs the independence to consider all allowable evidence presented by a party. Subsequently, we were disheartened to learn that the Administration appealed the US District Court ruling that ultimately led to that improved March guidance, and the AMA recently filed an amicus brief with the American Hospital Association (AHA) in support of the appellees.[6]

Some stakeholders have suggested physicians' opposition to the QPA playing a central role in IDR decisions is akin to exploiting market failures and inflating costs. This is a false narrative offered by those that seek to drive policy changes to undercut the ability of all physician practices—large and small, urban, and rural—to negotiate fair network contracts. The push to essentially force arbiters to consider only a

[3] See AMA-AHA amicus brief in TMA II; AMA amicus brief in TMA III

[4] See *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:21-cv-425; *Texas Medical Association, et al. v. United States Department of Health and Human Service*s et al., Case No. 6:22-cv-372; *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:23-cv-59-JDK; *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:22-cv-450-JDK.

[5] 42 USC § 300gg-111(c)(5)(c)

[6] AMA-AHA amicus brief (5th Circuit).

single, insurer-calculated amount when determining payment to an out-of-network physician does not correct an imbalance in the system, it exploits it. Physicians are the backbone of the health care system and ensuring the financial health and sustainability of physician practices, specifically independent physician practices, should be a goal of all stakeholders who care about patient choice and access to medical care.

Market impact of overreliance on the QPA

Overreliance on the QPA during the payment resolution process will continue to have negative implications in the health insurance market and, therefore, patient access to care. With implementation of the NSA, the demands of patients and employers for in-network care for certain services has been lessened, which in turn has reduced the incentive for health plans to engage in meaningful contract negotiations with physicians. While we strongly support removing patients from the middle of payment disputes, we also appreciate that Congress recognized an additional check on health plans was necessary to reinforce this market force—a meaningful and balanced IDR process to allow providers the opportunity to make their case for a fair out-of-network payment.

Congress understood that this process could help influence a health plan to come to the contract negotiating table in the first place, offer a reasonable initial payment when a surprise bill happens, and settle most disputes in the open negotiations process. But when the IDR decision is essentially predetermined to be at or below the QPA, this important check on negotiating incentives established by Congress is significantly diminished.

We agree with analyses that insurers will likely pay many contracted physicians much less in the coming years as they negotiate contracts (and renegotiate current contracts) under the QPA's ceiling. We have already seen these scenarios playing out in states like North Carolina, where the largest commercial market insurer in the state sought contract amendments that slash long-standing fee schedules directly as a result of the Administration's first regulation establishing the IDR process in 2021. We have seen similar efforts by health plans across the country, as well as broader network reductions by health plans who are no longer concerned about patient access to in-network hospital-based care.[7] Whether such payment and network reductions will translate to reductions in health insurance premiums for patients is not yet known, though past experience suggests it is very unlikely. But they are certain to put an additional, if not fatal, financial strain on many independent physician practices and rural health care providers already struggling to make ends meet in their small businesses and in many areas where patient access is already under serious stress. The AMA continues to urge the Administration to codify in regulation that IDREs are not required to consider any allowable information over another when making a payment determination.

QPA calculation concerns

Problems associated with overweighting the QPA in the IDR process have been compounded by a QPA calculation methodology that permitted plans to offer QPAs below the median in-network rates, which the QPA is intended and required to represent. For example, the methodology laid out by the Administration in their July 2021 interim final rule (IFR) and subsequent guidance allowed plans to include rates for services that may never be provided and were never negotiated (e.g., ghost contract rates); permitted rates from other specialties to be included in QPA calculations; failed to include bonuses, penalties, and other risk-sharing adjustments that impact final rates; and allowed self-insured payers the discretion to choose whether they want to use rates solely from their individual product for QPA determination or incorporate

[7] See e.g. "Coming to a contract negotiation near you: the No Surprises Act," Modern Healthcare, 8/3/2022, available at https://www.modernhealthcare.com/insurance/no-surprises-act-influencing-insurers-rate-setting-plans.

all of the health plan's products' rates in the area. These allowances permitted plans and payers to manipulate the QPA in order to misrepresent the true median in-network rate to IDREs to their benefit.

The most recent NSA decision out of the US District Court for the Eastern District of Texas vacated many of these unlawful liberties taken by the Administration to deflate the QPA.[8] We are hopeful that the Administration will not appeal this decision but instead issue a new regulation and guidance that adhere to the District Court's decision and ensures that health plans are restricted in their ability to manipulate the QPA.

Additionally, we continue to press for more transparency requirements on health plans to demonstrate or explain how the QPA is calculated. The QPA remains an important component of the dispute resolution process, but when only one party understands how it was derived and the data used to generate it, the integrity of the process is compromised. The Administration should require health plans to provide physicians and IDREs with the data and methodology used to calculate the QPA.

Backlog in IDR process

Despite statutory timelines governing payment resolution in the NSA, there continues to be significant delays in the IDR process, separate and apart from pauses due to court decisions. According to the Departments' Initial Report on the Federal Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022,[9] there were over 90,000 claims submitted to IDREs between April 15 and September 30, 2022, but only 23,107 had been resolved by the end of the report period, and only 3,576, or 15 percent, resulted in an IDRE making a payment determination. A follow-up report[10] looking at the fourth quarter of 2022, found that while a greater percentage of closed disputes resulted in a payment determination (40 percent), still only 31,714 of the 110,034 initiated disputes had been closed. The AMA is very concerned about the financial impact, and the subsequent threat to practice sustainability, of the IDR backlog on the physicians waiting for resolution of their claims.

According to the reports, a cause of IDR claim delays has been the complexity of determining whether a claim is eligible for the federal process. Specific eligibility determination issues highlighted in the initial report include determining whether the federal IDR process or a state process applies, whether claims were batched correctly according to regulatory guidelines, and whether pre-IDR requirements, such as completion of the open negotiations period, have been satisfied.

Suggestions that the backlog is due to physicians and other health care providers submitting frivolous claims overlook the complexity associated with determining eligibility at the physician practice level, the regulatory requirements, or lack thereof, that fail to promote efficiencies, and the incentives for plans to challenge eligibility at every turn and disengage from the process all together. From the physician's perspective, significant financial resources go into pursuing the NSA's dispute resolution process, and allowing claims to pend for long periods of time in this process not only leaves physicians practices in difficult financial situations but threatens the legitimacy of the entire process that Congress carefully created to balance contracting incentives.

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[8] *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:22-cv-450-JDK

[9] U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor, "Initial Report on the Independent Dispute Resolution (IDR) Process April 15-September 30, 2022," (December 2022), available at https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf.

[10] U.S. Department of Health and Human Services, U.S. Department of the Treasury, U.S. Department of Labor, "Federal Independent Dispute Resolution Process – October 1 – December 31, 2022," (April 27, 2023), available at https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf.

Helping physicians determine the appropriate dispute resolution process

The AMA continues to hear from physicians who are struggling to determine whether an out-of-network claim is eligible for the federal process, or whether the specified state law applies in those states with existing surprise billing laws. While there are many nuances to determining the correct process beyond whether the health plan is state or federally regulated, including whether the federal law fills gaps in a specified state law, there are immediate policies that could aid physicians early in the process to reduce resource waste and consequential delays.

For example, the AMA believes that requiring plans to use Remittance Advice Remark Codes (RARCs), when providing the initial payment or notice of denial, would significantly reduce confusion. Specific RARCs were created with passage of the NSA and are available to identify if the NSA is applying to a claim or a specified state law, what process was used to determine an initial payment, how cost-sharing for an eligible claim under the NSA or a specified state law was calculated, and more. Ensuring the use of RARCs for all claims will provide physicians and IDREs with critical information about whether a particular claim is eligible for the federal IDR process and how to process claims if they are eligible.

Improving efficiencies through expanding batching of claims and bundling of services

Strict regulatory rules on batching of claims to take to the IDR process have resulted in inefficiencies and confusion, perpetuating the IDR claims backlog. Under the statute, batching is permitted whenever "items and services are related to the treatment of a similar condition," but the Administration's rules permitted batching only in much narrower circumstances—if the "items and services are the same or similar items and services," which are defined as an item or service that is "billed under the same service code, or a comparable code under a different procedural code system." This narrowing of the definition meant that far fewer claims could be batched together for IDR.

Again, a recent District Court decision vacated the Administration's inefficient batching rules,[11] and the AMA is hopeful that the Administration will now issue new rules and guidance compliant with the decision that expand the ability of physicians to batch claims for IDR purposes to reduce the backlog.

Similarly, the Administration should consider allowing greater flexibility in the bundling of services for a single claim. Although an October 2021 IFR described a bundled claim as one for which the health plans pays a single payment for multiple items or services furnished during an episode of care, August 2022 guidance clarified that a single payment for multiple items or services must be made at the service code level for the entire bundle in order to be considered a bundled arrangement and, therefore, be treated as a single determination under the IDR process. We think that greater efficiency, and reduced IDR backlog, could be achieved through a broader definition of bundled claims that includes services furnished during a single episode of care.

Addressing a lack of engagement in the open negotiations process

Congress required the 30-day open negotiations process as an important component of the dispute resolution process under the NSA and consistent and good faith use of this process should lead to fewer IDR claims. Unfortunately, we understand that health plans are frequently dismissing outreach from physicians to participate in the open negotiations process and refusing to respond with offers for payment. We also understand that payers may be using questions of eligibility regarding completion of the open negotiations period as a tactic to delay or deter the dispute resolution process from proceeding.

[11] *Texas Medical Association et al. v. United States Department of Health and Human Services et al.*, Case No. 6:23-cv-00059.

To address any disingenuous questions of eligibility, the AMA has encouraged the Administration to collect information from IDREs about parties that regularly question claim eligibility with a frequency and manner that suggests bad faith and urged the Administration to immediately address the actions of these parties through corrective action and penalties when necessary.

Additionally, to address a lack of engagement in the open negotiations process, we believe there are potential benefits to formalization of the open negotiations period and requiring the process to be conducted through the federal IDR portal. Such benefits include increased clarity on initiation and completion of the open negotiations period, which would reduce related eligibility issues. This transition could also reduce confusion about to whom or where initiating parties should send the open negotiation initiation form. Additionally, moving the open negotiations process to the portal provides an opportunity to make a preliminary eligibility determination regarding federal or state authority on a claim prior to IDR initiation.

As such, the AMA has asked the Administration to further explore the feasibility of this transition, with the caveat that there will be no additional administrative fee for use of the federal portal for the open negotiations period (i.e., the administration fee must not apply until the claim advances to the IDR phase). Good faith negotiations during this stage of the dispute resolution process must be encouraged and assessing a fee at this time would do just the opposite.

Financial barriers to accessing the IDR process

It is clear that Congress did not intend to create a dispute resolution process that purposely excluded those physicians who remain in independent practice, who serve rural or underserved populations, or who are facing financial instability, especially because these are the types of practices who may have little to no negotiating power with large health plans in the first place. However, policies established during the implementation process have essentially ensured that the process is only accessible for physicians in large enough or sophisticated enough practices, systems or financial arrangements to accept the financial risk that comes with pursing an IDR claim.

For example, in January, the Administration announced that the nonrefundable administrative fee, used to cover their costs associated with the IDR process, would increase 600 percent, from $50 to $350, in 2023. Notably, this decision was released in updated guidance on December 23, 2022, one week prior to taking effect, and reversing guidance released just two months prior stating that administrative fees would remain the same. This gave physician practices no time to anticipate or financially plan for this fee increase. Furthermore, the same guidance also simultaneously increased the IDRE fees by up to 40 percent for individual claims and up to 82 percent for batched claims.

Once again, a district court ruling invalidated this administrative fee increase due to the lack of notice and comment provided to stakeholders.[12] While the fee is now currently at $50, the AMA remains concerned about future increases that may be done through proper notice and comment.

In the immediate term, significant increases to the administrative fee create a threshold cost to participating in the IDR process, a policy which we note was considered but rejected by Congress during drafting of the NSA. For example, with a $350 administrative fee, if a physician is paid at or below $350 for a claim, which is the case for many claims currently being advanced to IDR, the process becomes cost prohibitive for that physician. While this is a barrier for all physicians, it is particularly harmful for smaller, less resourced practices, and for those practices that serve large Medicaid or uninsured populations whose ability to overcome this threshold through the use of batching and bundling

[12] *Id.*

commercial insurer claims is extremely limited. Moreover, it is unlikely that financially strained practices would be able to withstand an IDR loss and cover the increasing IDR fees in addition to the administrative fee, making pursuit of the dispute resolution process too financially risky.

Over the long term, higher fees and resulting inaccessibility of the IDR process means that the careful balance of the NSA's statutory scheme is thrown off once again. If physician practices have no resolution process available to them when they are consistently underpaid by health plans, the underpayment will persist. Moreover, there will be even less incentive by health plans to offer these physician practices a fair contract, or keep contracted physicians in their networks, because their ability to underpay these physicians while out-of-network is now even easier. These results have major implications for patients' access to care. For these reasons, it is imperative that the IDR process remains financially accessible to all physicians.

Failure of plans to make payments upon an IDR decision

It seems nothing could serve to delegitimize the IDR more than having decisions ignored by losing health plans. But it is the AMA's understanding that many physicians are not receiving payment from health plans within the statutory 30-day time period following an IDR decision in their favor, and in fact many physicians are reporting receiving no payment at all. A recent survey by the Emergency Department Practice Management Association (EDPMA)[13] reported that 87 percent of payers did not pay in accordance with the IDRE's decision. Surely Congress did not intend physicians to have to pursue health plans in court following an IDR decision in their favor.

To be clear, health plans are blatantly ignoring binding IDR decisions, continuing to collect interest on money owed to physicians, and threatening the financial stability of thousands of physician practices across the country. Moreover, their actions, or lack thereof, are rendering the IDR process meaningless and, as a result, the backstop that the process is supposed to serve as under the statute is not having the effect of encouraging fair contract negotiations. The current situation is unacceptable and immediate action must be taken because without a meaningful and enforced IDR process, the NSA's careful balance and consideration of competing market forces falls apart.

The AMA has asked that the Administration work closely with state regulators to ensure that once an IDRE makes a final determination, payment is made to the prevailing party within the 30-day statutorily required timeframe. Should a party not comply with a required timeframe, a financial penalty should be applied and compounded over the course of the delay. Another option that the Administration might consider, especially for repeat offenders, is a requirement that payment be made up front and held by the IDRE, along with the IDR fee, and refunded with the IDR fee if the party wins or paid to the winning party when appropriate. The AMA urges Congress to work with the Administration to ensure that health plans are not ignoring IDRE decisions and are paying physicians within the required timeframe.

Complaints, audits, and reports

Complaints

The AMA has heard from many physicians that overall enforcement of NSA dispute resolution requirements is lacking, including but not limited to plan failure to pay post-IDR decision, to pay

[13] Emergency Department Practice Management Association, "No Surprises Act Independent Dispute Resolution Effectiveness," available at https://edpma.org/wp-content/uploads/2023/04/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-FINAL.pdf.

administrative fees, provide the QPA with the initial payment, etc., and that when physicians encounter enforcement issues, there is not a reliable way to quickly have concerns resolved.

While we appreciate tools such as the NSA Help Desk set up by the Administration and email addresses for provider questions, we also understand that in many cases it takes several weeks for physicians to even receive confirmation that the request has been received or is being addressed. In addition to being frustrating and financially impactful for physician practices, such delayed responses undercut a system that was set up with clear timelines and requirements and perpetuate disregard by certain parties for the rules. Accordingly, the AMA has urged the Administration, working closely with state regulators, to establish a more functional and responsive process for physicians to report compliance issues and ask questions and receive a timely response.

Audits and reports

Congress wisely included minimum auditing of health plan requirements in the statute, recognizing the opportunities that exist for error in implementation of this major new law. The AMA understands that some statutorily required audits are being performed, however, little if any of this information has been made public to date. The NSA requires HHS to submit an annual report to Congress on the number of plan audits that were conducted during such year, starting in 2022. To our knowledge, such a report has not yet been submitted. The AMA has urged HHS to submit this report with all due expediency and to make the report available to the public. HHS is also expected to issue a report on downcoding and other such payer behaviors. We similarly ask that this report be made available to the public.

Conclusion

The AMA appreciates this Committee's focus on addressing the NSA implementation flaws that are, ultimately, a threat to patient's access to physician care. We reiterate that these flaws are largely correctable through improved regulation and guidance.

We continue to be committed to ensuring the NSA is implemented in manner consistent with the statutory text Congress so heavily debated and ultimate enacted. We stand ready to work with this Committee, Congress and the Administration to ensure patients are protected from surprise medical bills while physician practices of all sizes, in all areas of the country and serving all populations are able to remain financially stable in order to provide needed care to patients.

October 3, 2023

The Honorable Jason Smith
Chair
House Committee on Ways & Means
1139 Longworth HOB
Washington D.C. 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways & Means
1139 Longworth HOB
Washington D.C. 20515

Submitted via email to WMSubmission@mail.house.gov

RE: ***Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections***

Dear Chair Smith and Ranking Member Neal:

On behalf of America's ER Medical Centers, I am writing, first and foremost, to express our appreciation for the attention you are bringing to the failed implementation of the *No Surprises Act*. We applaud the statute's goal of removing patients from the middle of billing disputes between providers and health plans. However, the federal agencies implementing the law have repeatedly attempted to tip the scales in favor of health plans, deviating from the plain language of the statute passed by your Committee and the full Congress, a statute which struck a balance between ensuring that commercially-insured patients are shielded from unexpected medical bills while providing a fair opportunity to resolve payment disputes between providers and health plans after providers have furnished care to insured patients outside of the health plan's network.

Located in the State of Texas, America's ER Medical Centers is an independent, privately owned, non-hospital affiliated, small network of facilities comprised of a fully licensed emergency department classified with the highest state rating for capabilities, services, and staffing for non-traditional emergency departments, a 24-hour Urgent Care

Center, an independent diagnostic testing facility for both laboratory and advanced diagnostic imaging services, as well as a host of primary and preventative care services, all under one roof. For almost a decade, America's ER has become a trusted healthcare provider for unscheduled emergency and urgent care in the communities we serve because of our dedication to providing patients with high quality, appropriately directed medical services and ethical billing practices within a patient-centric environment focusing on patient satisfaction and continuity of care. During the COVID-19 pandemic, America's ER further expanded its commitment by offering large-scale COVID-19 testing services supplementing testing traditionally provided by local and state governments. As a result, America's ER became the third largest COVID-19 testing provider in the state and a valued contributor to minimizing the impact of COVID-19 in the greater Houston area. Unfortunately, and to the detriment of our patients, despite our commitment and valued contribution to the healthcare environment in which we operate, America's ER has been unsuccessful in its efforts to obtain in-network status with insurance providers. Their unwillingness to negotiate or offer reasonable in-network contracts, serving only to limit patient access to quality outpatient emergency and urgent care services provided at America's ER, we have been forced to remain out-of-network and thereby rely heavily on the independent dispute resolution process on both a state and federal level. As such, and in light of recent limitations imposed by the Departments of Health and Human Services, Labor, and Treasury ("the Departments") during this most recent and other previous closures of the dispute resolution process, in addition to the unbalanced, pro-insurance favorable rules promulgated by the Departments in the process as a whole, America's ER's ability to provide readily accessible access to quality emergent and urgent medical services in the communities we serve is at risk.

In addition to thanking you for holding the hearing to bring attention to these issues, below, I am providing information to be of assistance in your continued oversight efforts and for your consideration in conversations with the Departments and in the event you consider changes to the statute.

Federal Agencies Should Immediately Announce Accommodations for Extended IDR Portal Closure

While the Federal agencies administering the portal are grappling with re-opening the Federal IDR portal, we believe that it is essential for the Departments to issue immediate guidance outlining the accommodations that will be made for the disputes that have completed the Open Negotiation phase and are thus considered timely for initiation of Federal IDR but remain in limbo because the portal remains closed. There is no reason that the Departments cannot provide a small bit of stability during this closure by telling providers how the processes will proceed once the Departments are able to re-open the portal. We would also recommend that Members of the Committee encourage the Departments to incorporate the following policies into that guidance:

- ***During IDR portal closures, initiating parties should still be able to submit disputes to the portal***. While there may be reasons (e.g., statutory authority, transparency requirements, etc.) that the Departments might not yet be able to direct certified IDR entities to make actual payment determinations for disputes initiated after recent court rulings, the portal should remain open to the *initiation*

of disputes. The administrative burden that has been placed on providers under the new mechanisms created by the *No Surprises Act* are overwhelming. For those of us who have attempted to create processes to navigate these new requirements, the resources dedicated to these efforts have been tremendous. For the Departments to ignore the statute during implementation, be overruled by Federal courts, and then place the problem at the foot of the providers who the statute sought to provide a fair opportunity to seek adequate reimbursement for services rendered is unacceptable. If we were allowed to continue to initiate IDR under the timelines dictated by statute, the administrative burden would be reduced even if we understand that final payment determinations will be delayed as the Departments regroup in the wake of recent court rulings.

- ***After payment determinations are allowed to proceed, previously submitted materials should be provided an amendment window.*** If initiation of IDR is allowed to proceed, once the portal is re-opened (likely with changes in important policies), the Departments should have a mechanism to allow submissions to be amended within a specific timeframe. Again, this allows for current processes to proceed under statutory timelines as well as accommodate the coming changes in policy that will apply to individual disputes.
- ***The Departments Should Immediately Announce Deadline Accommodations for Disputes in the Queue Waiting for IDR Initiation.*** The Departments decision to close the portal to even the *initiation* of disputes has created a large queue of disputes seeking remedy from IDREs. In order to help providers develop a plan for addressing this backlog, the Departments should *immediately* tell providers what the deadline accommodations will be for these initiations so that providers can develop a work plan in advance for addressing the backlog.

The Departments Must Reduce Confusion Over Application of State vs. Federal Out-of-Network Billing Protections

The Departments continue to cite volumes of disputes for which Federal IDR has been initiated but that are "ineligible" due to coverage of those disputes by State law. While this might be true in some instances, it is no surprise since whether state or federal law applies to the dispute is often a mystery to initiating parties. In Texas, we have a Specified State Law that applies to out-of-network services for most commercial insurance plans *except for self-insured health plans*. While the Departments continue to heap blame on providers for initiating Federal IDR over these disputes, it is not the providers fault these disputes end up in Federal IDR. Providers do not have access to whether a health plan is self-insured. And the Departments know full well that absence of this information doesn't suspend the *No Surprises Act* timelines. Further, who has this information? The health plans. Yet the health plans refuse to develop mechanisms to share this information with providers, information that would clarify whether state or federal law governs the out-of-network dispute. Because of this, ***we request that Members of the Committee encourage the Departments to mandate plan identification of self-insured plans, standardize delivery of this information, and articulate a policy for instances in which insurance ID cards and Explanation of Benefit (EOB) documentation present conflicting information in this regard.***

Health Plans Lack of Engagement in Open Negotiation Leads to Increased Reliance on IDR

We believe that the statute incorporated the concept of Open Negotiation as an effort to avoid the number of instances in which payment disputes must proceed to Federal IDR. Members of the Committee should be aware that in instances where we have been underpaid for services by health plans, while we repeatedly engage in Open Negotiation efforts in the hopes of avoiding initiation of Federal IDR, health plans rarely engage or even acknowledge our initiation of Open Negotiation. While we understand that it is difficult to mandate participation in negotiations, it is important that Members of the Committee know that the health plans with which we have experiences have rendered the Open Negotiation process outlined by statute essentially meaningless. Because of the lack of any interaction with these health plans during this phase, Open Negotiation has become nothing more than a countdown clock for providers to decide whether to advance a dispute to Federal IDR. This bad faith on the part of the health plans should be a serious consideration for Members of the Committee.

The Departments Must Make Changes to Current Regulations in Order to Reduce the Pressures on Federal IDR

There are a number of changes to the current regulations and processes that we can provide as suggestions that will improve the efficiency of all the processes while simultaneously reducing either the need to initiate IDR or the level of effort needed for all parties (i.e., initiating party, non-initiating party, IDREs, and the Departments) in moving disputes through IDR. The main policy driving these recommendations: change the *No Surprises Act* implementing regulations so that "disputes" better reflect the patient encounter and revenue cycle management processes.

Enforce Compliance with No Surprises Act QPA Disclosure Requirements

As we approach the third year of the application of the *No Surprises Act*, health plans continue to fail to provide the Qualifying Payment Amount (QPA). Not only is this required by law, but it is essential to administering the patient cost-sharing protections required by statute and informing the ability for parties to engage in Open Negotiation and make decisions about how to proceed relative to IDR. Darkness and confusion regarding the QPA only leads to increased reliance on IDR in the hope that the certified IDR entity will offer the provider a fair assessment of the health plan underpayment for services provided to the health plan's insured patient. Because of this, ***we implore the Members of the Committee to demand enforcement of the already-existing health plan QPA disclosure obligation.***

In addition to enforcing the QPA disclosure requirement, ***it is imperative that the Departments develop a standardized delivery method for the disclosure of the QPA.*** If a health plan provides the QPA (although many still do not), where the QPA appears on the remittance advice varies, making it difficult to locate and nearly impossible to automate capture of. While the health plan obligation to provide the QPA is clear, how this is done is not, and standardization of the

delivery of the QPA would be of tremendous benefit to the entire system, including patients so they can better understand their cost-sharing protections.

Organization of Delivery of the QPA & "Disputes"

In understanding the cause of the volume of disputes that have advanced to IDR, the Members of the Committee need look no further than the Departments decision to define QPA delivery and "disputes" and "batches" as the "same service code." In the emergency department, a single patient encounter will include (a) a claim for the professional services rendered; and (b) a claim for the facility services.

- Professional Services: Professional services on a claim form, including those of an emergency physician, are described by CPT codes. A professional claim in the emergency department might have multiple CPT codes on it. Because the Departments have chosen to organize disputes by CPT codes, if a health plan underpays a provider, a single patient encounter that includes, for example, 5 CPT codes, has now been turned into 5 disputes. ***Members of the Committee should encourage the Departments to organize disputes by patient encounter***. This will reduce the number of "disputes" moving to IDR. It will also allow IDREs to take a more holistic approach to evaluating the adequacy of payment for the services delivered in a given patient encounter.
- Facility Fee: In the hospital outpatient setting, including emergency departments, the CPT codes billed by the physician are used as a trigger for the facility payment, typically a bundled payment for groups of services delivered. In Medicare this bundled payment is administered through assignment of CPT codes to an Ambulatory Payment Classification (APC). Some commercial health plans utilize APCs for their outpatient facility rates, while some offer bundled payments based on the standardized revenue codes associated with CPT codes. We have examples where health plans will provide the information for an emergency department claim (i.e., a hospital outpatient claim) by providing QPA information for a DRG. DRGs are uniquely inpatient- this makes no sense for a hospital emergency department claim. This has demonstrated that health plans are at their own discretion picking a QPA proxy based on something other than on what contracts for emergency department services are actually based (i.e., APCs or revenue codes). ***The Departments must standardize the service reference codes under which health plans provide the Qualifying Payment Amount (QPA), particularly for outpatient facility services.***

Because health plans seem to have unfettered discretion to pay for the claim using whatever groupings or bundles it sees fit, unless Congress or the Departments restrict the ability of health plans to do this, ***the Departments must allow a dispute to proceed to IDR organized as the health plan paid for it.*** That is, if payor issues bundled payment, then the dispute should be allowed bundled submission. However, under the current rules and IDRE

practices, our disputes are often restricted to a single line on the claim for (e.g. a single CPT code) even though a single payment was made for the *entire* claim. This policy has resulted in confusion and an exponential increase in the number of disputes in IDR because each line item could be litigated separately. To avoid this, and as mentioned above, ***Members of the Committee should encourage the Departments to organize "disputes" by patient encounter.*** Even in the absence of allowing the entire patient encounter to proceed as a single dispute, reduced reliance on IDR and better informed payment determinations could be made if a dispute was at least organized in the same configuration as the payment made by the health plan for the service. IDR should accommodate bundled payment, not just for disputes related to service codes meant to represent bundled services (e.g., DRGs and APCs), but should also incorporate all services lines on a facility claim and not just a single CPT code. We often see multiple lines on a facility code with a $0.00 payment, and it is not clear whether the claim for that service was denied or if the health plan is making a bundled payment on the line representing the ED visit (or other) CPT code. Further, in these instances, if health plans are providing QPAs at all, they are *not* providing a QPA for the line items that have been designated as $0, leaving providers without any information about what was reimbursed and what the QPA (i.e., median contracted rate) is for that service.

This practice alone has injected tremendous confusion and administrative cost into the system. Under the Departments' rules, if there are 10 lines on a facility emergency department claim (which is not unreasonable), and a hospital believed it was collectively underpaid for these services, each would have to proceed to IDR separately. First of all, this means the IDRE never gets a full picture of the services vs. the payment because each line would be litigated separately. Second, for that *SINGLE PATIENT ENCOUNTER*, if all lines were to be disputed, it would result in 10 disputes, and the payment of 10 administrative fees by the initiating party (or $1,500 under the Departments' proposed new administrative fee) and 10 administrative fees by the non-initiating party, for a total of $3,000 just in administrative fees for a single patient encounter. And whichever party loses the disputes would be subject to 10 certified IDRE fees- under the Departments proposed new certified IDRE fees, this could be $4,800 (i.e., 10 payments of $480). This is irrational and does not comport with how care is delivered to patients or the claims processing system. This confusion and burden created by the health plans must be cleaned up or the strain on the entire system will continue.

IDRE Practice Reforms

While we understand that IDREs are often overwhelmed due to many of the health plan behaviors described above, we also believe that there are several changes that could be made to improve the IDR process and the efficiency of IDREs.

- Require IDREs to Provide Fair Hearing to All Parties. In several instances to which we have been party, some IDREs have closed a dispute following receipt of unilateral (and false) information from the health plan, without any opportunity for the provider to weigh in. The most common example is of a health plan challenging the eligibility of a dispute by stating that it is governed by State law when it is, in fact, not. Once the dispute is "closed" by the IDRE, the provider is without recourse. Yet the dispute was indeed eligible for Federal IDR and the IDRE would have realized this had we had a chance to provide the IDRE with the accurate information. To make matters worse, the Departments should know this is happening but include these disputes in their calculations of those that were "ineligible" for Federal IDR.
- Require IDREs to Observe the Timelines in Statute and Regulation. Since the launch of the Federal IDR portal, IDREs have continually been breaking payment determination timelines with the blessing of the Departments. This routine deficiency is disruptive to provider and facility revenues, it is in defiance of law and regulation, and it deprives the only parties who have provided any value in these circumstances, the providers who delivered emergency medical care to patients experiencing a medical crisis, the opportunity for a timely review of their request for fair payment as established by federal statute. While during initial rollout this might have been understandable, but now, it is clear, without penalties for non-compliance, this behavior will continue. As such, ***we request that Members of the Committee consider provisions that would refund initiating parties' fees or provide some other method of ensuring that IDREs meet the timelines supposedly required of them***.
- Cap the Amount of Fees an IDRE is Allowed to Charge for a Single Dispute. The Departments have recently proposed new rules changing the methodology for establishing the non-refundable fee submitted by both parties to a dispute and the certified IDRE fee that is the responsibility of the non-prevailing party. The Departments are also setting the actual fee ranges that an IDRE can set for both of those fees. As part of these proposals, the Departments also establish a tiered fee range for batched disputes, which can be added based on the number of "lines" included in a dispute. This means that there is no total "cap" on the amount of fees that could be involved in a batched dispute. We believe that it is clear that Congress intended for (a) the IDR process to be accessible to parties in the event of unfair payment and (b) the dispute batching mechanism to create an economy of scale for quick resolution of multiple disputes. The methodology and fees issued by the Departments will continue to serve as an unfair barrier to accessing the Federal dispute resolution mechanism. Because of this, ***we request that Members of the Committee work with the Departments to establish an absolute cap on single and batched disputes to ensure access to the IDR mechanism and to prevent IDR fees from stacking up to unreasonable total amounts.***

Congress and the Departments Must Enforce Health Plan Obligations to Make Payments in Accordance with IDRE Payment Determinations and Statute

Quite simply, many health plans are ignoring IDRE payment determinations. This health plan practice of ignoring IDREs and federal statute has been ongoing for nearly 2 years at

this point. ***We urge the Members of the Committee to demand that the Departments enforce the timely payment of these payment determinations as dictated in statute.*** In addition, out of consideration for the length of time that health plans have ignored these IDRE payment determinations, ***we urge Congress to impose penalties and fees on health plans that do not make payments in line with IDRE payment determinations under the timelines already established in the No Surprises Act.***

The Departments Must Reform the *No Surprises Act* Complaints Process
Statute requires that the Secretary stand up a process to receive complaints process for violations of the *No Surprises Act.* According to the *No Surprises Act,* these complaints also serve an important purpose in that the Secretary is allowed to perform additional audits (outside of the annual general audits) based on the receipt of these complaints.

High performing organizations engage in continual process improvement, and the complaint function of the *No Surprises Act* is an opportunity for the federal government to be a good steward of the statute, patient protections, and patient access to care. However, the current complaint process leaves submitters frustrated without any indication that the complaints have been reviewed or addressed. To remedy this and ensure the complaint process goals of the statute are met, ***we urge Members of the Committee to require the Departments provide information to the public on the resolution of complaints, improvements instituted as a result of submitted complaints, the number of health plan audits conducted in response to submitted complaints, and overall submission statistics.***

We also believe the Departments are failing on basic tenets of customer service. While we understand that implementation of the *No Surprises Act* is a significant undertaking, there is no reason that an organization with as many resources as the federal government should not be able to make the customer service functions of the complaint process a priority and assure taxpayers that the government is performing the most basic functions required of it under statute. It is as though the Departments are content to let the stereotypes of large government bureaucracies permeate their implementation. As such, ***we urge the Members of the Committee to encourage the Departments provide the basic functions of acknowledging receipt of a complaint, providing a response as to whether action was taken in response to the complaint (and the resolution action taken), and offering users a streamlined, efficient process for filing the complaints that are sanctioned by federal statute***. The Departments themselves will become overwhelmed if this type of feedback is not offered to submitters. For instance, if a submitter is under the impression that health plans are in violation but are in fact not, under the current practices of the Departments, the submitter will never know to halt complaint submissions on that practice. This helps no one.

Thank you for the opportunity to provide this input. We remain extremely concerned that because the federal agencies tasked with implementing the *No Surprises Act* did not engage in notice-and-comment rulemaking prior to establishing the process for IDR, the opportunity to incorporate this type of input was unnecessarily missed. And, therefore,

we again thank you for your attention to these issues and ask that you continue your outreach to the Departments.

Sincerely,

Mark A. Feanny, MD
Chairman & CEO

BlueCross BlueShield Association
1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

Statement for the Record
Submitted to U.S. House Committee on Ways and Means
"Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections"
Tuesday, September 19, 2023
By: David Merritt, Senior Vice President of Policy and Advocacy

The mission of Blue Cross and Blue Shield (BCBS) companies is simple: We want everyone to have access to high-quality, affordable and equitable health care. This is especially critical when someone has a health care emergency, which is why we supported the bipartisan federal solution to ensure that no one would experience the financial burden and stress of costly, unexpected and unfair surprise medical bills. The No Surprises Act has already protected millions of Americans from receiving costly surprise medical bills from providers – a huge win for patients. The Blue Cross Blue Shield Association (BCBSA) commends Chairman Smith, Ranking Member Neal, and members of the House Ways and Means Committee for holding this important oversight hearing to examine the implementation of the law to ensure it continues to protect consumers from the threat and harm of surprise medical bills while driving health care cost reductions across the system.

BCBSA is a national federation of 34 independent, community-based and locally operated BCBS companies that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS companies contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, purchase coverage on their own or obtain coverage through an employer. We are committed to providing coverage that delivers affordable access to high-quality care for every American.

Preventing 20 Million Surprise Bills

Since its implementation on Jan. 1, 2022, the No Surprises Act has protected Americans from 20 million surprise medical bills – about 1 million surprise medical bills a month. The law removes patients from the middle of payment disputes, allowing them to focus on their top priority – their own health – rather than the stress of a costly surprise bill they did not expect to receive.

Improving the Effectiveness of the Independent Dispute Resolution Process

The No Surprises Act gives patients the peace of mind that comes from knowing they will not face crippling medical debt after a health care emergency. We support ongoing efforts by the Departments of Health and Human Services, Labor and Treasury/IRS (Departments) to thoughtfully navigate implementation of the No Surprises Act in a balanced and transparent manner, and we are eager to continue working with the Administration as further regulations and guidance are developed.

A key area of focus for the Administration is the independent dispute resolution (IDR) process. Earlier this year, the Departments released a report showing a much higher-than-expected number of submissions to IDR from providers. The high volume of IDR cases has been challenging for everyone involved in the implementation and is driving up the cost for all involved – including patients who may face higher costs through premiums, deductibles and increased provider rates.

Another key concern of policymakers is whether claims are being paid per the statutory timelines after the IDR entity decisions are made. We acknowledge that health plans have struggled to comply with the timelines in some instances. However, these delays are driven primarily by incomplete information from IDR entities. When IDR entities are clear about which specific claims in a batch should be paid at what specific amount, payments occur promptly. Yet, health plans often do not receive all relevant determination information from IDR entities, resulting in delays in processing the decisions. For example, health plans and providers often struggle to identify the case, specific items and services, or line item for batched cases associated with a particular refund. The refund is provided as a lump sum and does not specify what cases or line items are accounted for in the amount. Clearer detail on the claims to be paid is necessary to expedite final payments to providers.

Earlier this year, BCBSA offered a robust set of recommendations (attached) to address this and other concerns surrounding the IDR process. We urged CMS to require IDR entities to use the standardized template released from CMS for determination decisions, including completing the chart detailing the additional factors considered and providing information on associated payments. Mandating the use of the standardized template, along with cross-walking to associated payments using claim numbers associated with each line item, should help ensure all information is included and aligned to individual cases and specific items or services to address this issue. In addition, ensuring confidence in the qualified payment amount and preventing ineligible claims from getting through the IDR process on the front end will help improve the system for both payers and providers.

Conclusion

The good news is these implementation issues can be addressed by the Administration. The Administration has worked diligently to date to implement these new patient protections, savings millions of Americans from surprise medical bills. The No Surprises Act is working for patients, and we thank the House Ways and Means for their leadership in holding today's oversight hearing. We look forward to continuing to work with the committee and other lawmakers in Congress to support and strengthen the No Surprises Act to ensure a robust, transparent and predictable IDR process.

Sincerely,

David Merritt
Senior Vice President, Policy and Advocacy
Blue Cross Blue Shield Association

COLLEGE of AMERICAN PATHOLOGISTS

September 29, 2023

The Honorable Jason Smith
Chairman
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal:

The College of American Pathologists (CAP) strongly supports protections that keep patients out of the middle of billing disputes. We have continually called for safeguarding patients from surprise bills while balancing disputes between our members and insurers. However, we have serious concerns about the implementation of the No Surprises Act and its impact on access to care for patients. As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

As you know, the CAP worked closely with Congress and other stakeholders in the development of the No Surprises Act. After its passage, the CAP provided recommendations on the implementation of the No Surprises Act in June 2021[1] and submitted comments on the Part I interim final rule (IFR) in September 2021[2] and on the Part II IFR in December 2021[3]. We have also engaged with Centers for Medicare & Medicaid Services (CMS) staff on issues related to the No Surprises Act's good faith estimate requirements, which remain a major concern and source of confusion for our members.

Finally, we communicated many of the below concerns to the CMS in April 2023[4], yet we have seen no recent improvement or action to address these issues. In fact, since we last wrote the CMS, the agency suspended the federal independent dispute resolution (IDR) process and directed certified IDR entities to pause all IDR-related activities[5], which will undoubtably exacerbate the current backlog and other problems that make the IDR essentially inaccessible for many physicians. Continued litigation, while necessary, has led to additional confusion and uncertainty. Further, as recently as July 2023, we have heard from members who have, despite the many hurdles, successfully taken their case through the federal IDR process, received a payment determination in their favor, and are still awaiting payment for their services with no recourse to hold insurers accountable.

The CAP appreciates the September 19 hearing examining the flawed implementation of the No Surprises Act. We understand the work that has been done thus far and as expressed above, we share an interest in the important goal of these efforts. Throughout the COVID-19 pandemic and beyond, what has remained the same for health care providers is our unwavering commitment to care for our patients and communities.

[1] https://documents.cap.org/documents/CAP-Recommendations-No-Surprises-Act-Regulations.pdf
[2] https://documents.cap.org/documents/september-2021-surprise-bill-comments.pdf
[3] https://documents.cap.org/documents/cap-comments-on-surprise-billing-part-ii.pdf
[4] https://documents.cap.org/documents/cap-letter-IDR-april-2023-2.pdf
[5] As of September 20, 2023, the Departments have directed certified IDR entities only to perform limited federal IDR process functions.

College of American Pathologists
1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100

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Pandemic or not, pathologists are guiding hospitals and health systems to make decisions that ensure testing and diagnostic accuracy, improve patient care for better patient outcomes, mitigate risks, and ensure quality. Thus, we urge you to consider the below so that pathologists can continue to focus on the essential task of testing and ensuring proper treatment for their patients.

Narrowing Networks and Low Initial Payment

As is called for in the No Surprises Act, insurers are required to send the provider an initial payment or a notice of denial of payment within 30 days of a bill for applicable out-of-network services. If this initial payment represented appropriate reimbursement for services rendered, there would be no need for the IDR process. Yet, as the Departments stated in their December fee guidance amendment[6], between April 15, 2022, and December 5, 2022, disputing parties initiated over 164,000 disputes through the federal IDR portal, which is "nearly ten times greater than the Departments initially estimated it would be over the course of a full calendar year[7]." From the experience of our members, the great number of cases are a direct result of inappropriately and unfeasibly low initial payments received from out-of-network insurers. This is evidenced by the fact that the majority of IDR cases are decided in favor of providers[8].

We share the widespread concern over the volume of cases, as the delay in receiving a payment determination puts physicians and practices in financial limbo as they wait for reimbursement for their services. Additionally, as was expressed by Seth Bleier, MD, FACEP during the September 19 hearing, this "increased focus on our collections and the rates being paid by insurers takes up valuable provider and staff time as well as resources that we would rather devote to patient care." **To minimize insurer manipulation/underpayment and reduce utilization of the IDR process, an insurer's initial payment rate should also be the insurer's offer in IDR, in instances where the dispute is not resolved during the open negotiation period.**

Importantly, we continue to stress that inadequate insurer networks are the root cause of out-of-network payments that then need to be resolved by the federal IDR process. Simply put, if there are more in-network providers, there will be fewer out-of-network bills to arbitrate. Unfortunately, the No Surprises Act is exacerbating this problem, instead of fixing it. For example, recent data from a CAP-conducted survey show that in 2023, 19% of pathology practice leaders reported that their practice had been denied continued participation in a commercial health plan or insurer network in which it was previously a participating provider, up from 9% in 2021[9]. Seventeen percent reported their practice attempted to join a commercial health plan or insurer network but was denied participating provider status or were unable to reach agreement, up from 12% in 2021. As we expressed to the Committee last year[10], insurers continue to slash reimbursements across the board – or cease reimbursement for critical services altogether, without consideration for an individual physician/practice, leaving many pathologists in serious financial jeopardy across the nation. **We urge Congress to require adequate networks**

[6] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf
[7] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf
[8] [8] https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf
[9] CAP 2023 Practice Leader Survey (forthcoming)
[10] https://documents.cap.org/documents/final-wm-letter-on-private-sector-issues-071322.pdf

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1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100

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in the future, especially as we are now better able to evaluate the implementation of the No Surprises Act.

Misuse of the Open Negotiation Process

As you are aware, before either party may initiate the federal IDR process, the disputing parties must exhaust the 30-business-day open negotiation period. Ideally, the open negotiation period provides an opportunity for the disputing parties to reach an agreement and avoid the federal IDR process. However, it is the experience of our members that instead of using it as an opportunity to engage in good faith negotiations, insurers are making the open negotiations period difficult to initiate and ineffective to navigate. Further, insurers are erecting hurdles and delaying engagement with physicians seeking to receive appropriate payment for their services. **While the CMS has provided some clarity on the inability of insurers to require the use of their own online portals to initiate open negotiation, for example, further formalizing and/or centralizing the open negotiation period would be helpful in ensuring notice is properly/easily provided and the timeline requirements are successfully met.**

Additionally, we echo the American Medical Association's (AMA's) January request[11] that the Departments collect information about parties that "regularly question claim eligibility with a frequency and manner that suggests bad faith and urge the Departments to immediately address the actions of these parties through corrective action and penalties when necessary." A successful open negotiation period benefits all disputing parties and will increase efficiencies later in the IDR process.

Limited Batching and Increased Fees

The ability for physicians and other providers to batch together claims (allowing "multiple qualified IDR dispute items and services" to be "considered jointly as part of a single determination by an entity") was an important provision included in the No Surprises Act. Batching ensures an equitable and accessible IDR system, while also encouraging efficiency and minimizing costs. Especially for pathology services, which often have lower reimbursement rates, flexibility that facilitates broader batching of qualified IDR items and services will ease access to the IDR process and further the statute's goals of encouraging "procedural efficiency," while minimizing administrative costs.

Thankfully, a recent court decision vacated regulatory text governing the batching of claims that had made batching more difficult. The regulatory text went beyond the requirement of the No Surprises Act that batched items and services be "related to the treatment of a similar condition," and instead required that the items and services be "the same or similar items or services." Permitting batching only when the items and services are billed under the same service code (such as Current Procedural Terminology (CPT) codes with modifiers), or a comparable code under a different procedural code system, is unduly restrictive and understandably resulted in incorrect batching submissions and, unfortunately, the closing of payment determination as "ineligible for the federal IDR process." As the Departments noted in a 2022 report[12], incorrectly batched disputes result in delays in processing and require additional actions by the parties. Even if promulgated appropriately through notice and comment rulemaking, restrictive requirements around batching will single out and hurt those specialties/practices with

[11] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfr.zip%

[12] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

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lower reimbursement rates, such as pathology, while increasing the IDR process' administrative costs and procedural inefficiencies.

Instead, as stated in our 2021 comment letter, **the CAP believes that providers should be able to batch claims at the CPT code *or* CPT *family level* (ie, allowing the same *category* of service codes to be batched together).** Unlike the specificity needed for the Qualifying Payment Amount (QPA) calculation, using the CPT family level for batching purposes would allow a broad, but still cohesive, set of claims to be brought together for consideration. We also urged the Departments to increase flexibility by allowing all claims related to the same patient encounter to be batched together. **Further, as the AMA argues, the Departments could allow claims to be batched together "when they are paid through the same third-party administrator, regardless of whether it is the same employer or payer[13]." Finally, the batching timeframe could be extended to allow more claims to be batched together**[14]. Each of these measures would support efficiency – reduction in the high volume of IDR cases – and better ensure the IDR process is available to pathologists and other providers, as well as small/rural providers/practices.

Regarding costs of the federal IDR process and payment, the Departments' regulations specify that each party must pay to the certified IDR entity (1) the administrative fee due to the Departments and (2) the entire certified IDR entity fee. On December 23, 2022, the Departments increased both fees, including raising the administrative fee from $50 to $350 per party[15]. This drastic increase in the administrative fee, which is not refunded to either party regardless of the outcome of the IDR determination, has been vacated by the same recent court decision. This change would have been extremely harmful for pathologists because most claims will likely be under $350, making the $350 threshold cost prohibitive. This is even more true without any of the flexibility in batching outlined above. On September 20, 2023, the Departments issued notice and comment rulemaking on the administrative fee and the certified IDR entity fee ranges. **While the procedural issues have been fixed, the CAP still has concerns that these increased fees represent a significant barrier for small/rural providers/practices, and for most of pathology, in accessing the IDR process at all**.

Unfair Weighting of IDR Factors

As you are aware, regulatory requirements around what IDR entities must consider when making the payment determination have been the subject of multiple lawsuits. The CAP has supported this litigation, including with an amicus brief[16], as we strongly believe the regulations contravene both the terms of the statute and congressional intent, and would result in inadequate reimbursement for health care providers, which in turn would harm patients as they lose access to pathologists and other physicians. It is our understanding that Congress rejected approaches that would have tied health care provider reimbursement to the QPA, opting instead for a balanced process in which an independent, expert arbitrator would consider all the relevant facts and circumstances in a particular case. The courts agreed; and at this time, arbitrators are directed to apply the

[13] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfr.zip%2F2023-1-23-Letter-to-Becerra-Walsh-Yellen-re-No-Surprises-Act-v2.pdf

[14] An alternative period of time may be determined by the Secretary, for use in limited situations.

[15] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/Amended-CY2023-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf

[16] https://documents.cap.org/documents/Amicus_Curiae_Brief_by_COLLEGE_OF_AMERICAN_PATHOLOGISTS.pdf

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1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100

plain language of the statute and make a payment determination without giving any statutory factor special weight.

If this current direction were to change again, **we strongly urge Congress to intervene and clarify through statute, if necessary, that IDR entities must consider the full range of statutory factors that Congress directed them to consider in determining health care provider reimbursement, without an administratively manufactured thumb on the scales in favor of the QPA.** Not only will any presumption/weighting in favor of the QPA cause substantial harm, but the continued need for litigation heightens uncertainty around the availability of IDR, increases the backlog and volume of IDR cases, and emboldens insurers' bad behavior. The ultimate losers will be patients, who will have less access to care and suffer worse health outcomes, contrary to Congress's intent.

Lack of Enforcement

Perhaps most critically, we urge Congress to ensure robust oversight and strengthen enforcement of the No Surprises Act's dispute resolution requirements. **Specifically, either through statute or direction to the Departments, Congress must impose strong financial penalties for those insurers that do not comply with the 30-day statutorily required timeframe post-payment determination**. As noted above, the CAP heard from our members who were named the prevailing party by a certified IDR entity that they have not received payment from insurers within the required timeframe. Despite sharing this information with the CMS, there has been no action to require payment from insurers, and our members are left with no recourse to recoup the full payment for services rendered, as determined by the IDR entity and required by statute. Strong regulations/penalties are needed to stop health plan manipulation and gaming that harms patients.

At the same time, Congress and the Departments must ensure an accessible and transparent audit/complaint process. We understand that the Center for Consumer Information and Insurance Oversight (CCIIO) may be investigating complaints against insurers but the results of any audit or other investigation have not been made public. At the very least, we urge Congress to increase transparency around enforcement and call on CCIIO to publicly share any information related to the number of complaints received as well as the status of any audits and investigations conducted.

At the same time, the CAP has urged the CMS to increase the ease of submitting a formal complaint against an insurer. Currently, there is an email address that provides little support and, in many cases, "takes several weeks for physicians to even receive confirmation that the request has been received or is being addressed[17]." More problematic is the fact that our members have faced confusion/contradictions in the complaint submission process around various requirements for – and at the same time, prohibitions on – the provision of protected health information (PHI). An evaluation by Congress or the Departments of the complaint submission process, improvement around submission and PHI, and enforcement of non-compliance issues would help ensure the equitable system Congress intended.

[17] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfr.zip%2F2023-1-23-Letter-to-Becerra-Walsh-Yellen-re-No-Surprises-Act-v2.pdf

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Summary

As we have previously argued, insurers, not small/rural providers/practices, benefit from the added costs or complexity around the implementation of the No Surprises Act. As such, it is vital that Congress ensure an even and fair playing field for all IDR parties. Additionally, network inadequacy is a growing problem that will only get worse, as "there will be even less incentive by health plans to offer physician practices a fair contract, or keep contracted physicians in their network, because their ability to underpay these physicians while out-of-network is now even easier."

Again, the CAP appreciates the hard work put forward on the No Surprises Act, but we strongly believe that its implementation must support an accessible and equitable system for resolving payment disputes, to ensure fair reimbursement for out-of-network services. **In summary, we urge Congress to consider the concerns and recommendations outlined by:**

1. **Strengthening enforcement and addressing non-compliance issues,**
2. **Clarifying consideration of IDR factors,**
3. **Ensuring broader batching and appropriate fees,**
4. **Further formalizing and/or centralizing the open negotiations period, and**
5. **Bringing down the need for IDR disputes through appropriate reimbursement and network adequacy.**

Congress can help ensure a more equitable, accessible, and efficient system to fairly resolve payment disputes between providers and health plans.

Please contact Michael Hurlbut, CAP Assistant Director, Legislation and Political Action as mhurlbu@cap.org if you have any questions on these comments.

Sincerely,

Emily E. Volk, MD, MBA, FCAP
President

College of American Pathologists
1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100

September 19, 2023

Chairman Jason T. Smith (R-MO)
Committee on Ways and Means
1011 Longworth House Office Building
Washington, DC 20515

Ranking Member Richard E. Neal (D-MA)
Committee on Ways and Means
372 Cannon House Office Building
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal:

On behalf of millions of members, supporters, and activists across America, the undersigned organizations collectively write to share our concerns about the implementation of the No Surprises Act (NSA). The NSA went into effect on January 1, 2022. The law established a national framework for resolving out-of-network billing disputes between insurers and providers that ensures patients are not forced to pay out-of-pocket costs beyond their in-network responsibility. In short, the NSA was passed to protect patients from surprise medical bills.

Unfortunately, the Biden Administration has to date ignored the intent of the NSA and significantly mismanaged the implementation of the law, and patients are paying the price. Specifically, the independent dispute resolution (IDR) process established under the NSA is being manipulated by insurers at the expense of the patients it seeks to protect.

Stories of violations of the NSA from payers have been documented across the industry. The pervasiveness and scale of these violations not only threaten patient access to care, but present direct harm to patients' financial and physical health. Complaints of NSA violations have included:

- Payers informing providers that arbitration awards from the IDR process are "unenforceable."
- Misreporting of the patient cost-share on EOBs and claim documents, despite NSA protections. In other words, payers are informing patients and their doctors that their cost responsibility is greater than what the provider is allowed to bill.
- Reports that after a bill is sent to the Independent Dispute Resolution (IDR) process, some payers are converting the IDR award amount to become the patient's responsibility. The result is a potential surprise out-of-pocket expense to patients in clear violation of NSA prohibitions.

Since the enactment of the NSA, these violations have been increasing at an alarming rate.

In a recent testimony before the Senate Finance Committee, Secretary Xavier Becerra made clear that the Department of Health and Human Services (HHS) is failing to address systemic problems in NSA compliance. The agency is currently overwhelmed as more than "10 times the number of claims" that were expected have been submitted for arbitration. Sec. Becerra considers many of these claims to be "frivolous," and yet has still requested Congress provide additional funding to support the agency's ability to carry out the arbitration process.

However, adding more regulators to the HHS is not the solution to this problem. According to HHS's own data, providers have prevailed in more than 70% of NSA disputes. This raises questions as to whether HHS is effectively monitoring implementation of and compliance with

the NSA. The reality is the agency's failure to properly implement the law is encouraging abuses and undermining the goal of protecting patients from surprise medical bills.

We strongly urge Congress to hold the HHS accountable for its actions and ensure the agency follows the letter of the law as it pertains to the NSA.

Sincerely,

60 Plus Association, Saulius "Saul" Anuzis, President

American Commitment, Phil Kerpen, President

Center for American Principles, Anthony (Tony) Zagotta, President

Center for Individual Freedom, Tim H. Lee, Senior Vice President of Legal and Public Affairs

Center for Innovation & Free Enterprise, Dee Stewart, President

Center for a Free Economy, Ryan Ellis, President

Consumer Action for a Strong Economy, Gerard Scimeca, Chairman

Institute for Liberty, Andrew Langer, President

FreedomWorks, Adam Brandon, President

Taxpayers Protection Alliance, David Williams, President

Trade Alliance to Promote Prosperity, Kent Kaiser, Ph.D., Executive Director

Less Government, Seton Motley, President

Cc: House Ways and Means Committee Members

Via Electronic Mail
United States House of Representatives
House Committee on Ways and Means
Attn.: Chairman Jason Smith
WMSubmission@mail.house.gov

Re: Failure to Implement Protections Contained in the No Surprises Act

September 20, 2023

Dear Chairman Smith and the House Committee on Ways and Means:

Thank you for holding hearings yesterday examining the impact of shortcomings of the implementation of No Surprises Act provisions. Dane Street is a medical review company. Our comments concern the administration of the Independent Dispute Resolution (IDR) program, pursuant to the No Surprises Act (NSA).

The Departments of Health and Human Services, Labor, and Treasury (the Departments) launched the IDR portal in April 2022. The purpose was to determine appropriate out-of-network payment rates subject to the billing protections contained in the NSA. The engine of the IDR program is the use of IDR Entities (IDREs) to facilitate the foregoing payment rate determinations.

Dane Street has a current application to become a certified IDRE. Our company has the resources, infrastructure, and professional expertise to deliver IDR services effectively. However, we have been unable to elicit any feedback from the Departments since submitting our application in June. We were told to expect a response within three weeks at the time of submission. Notwithstanding multiple attempted emails and phone calls, other than being told that our application will be reviewed, we are unable to receive any communication concerning our application.

Periodic communications to the public from the Departments indicate that there have been a high volume of disputes and there is a significant backlog of unresolved disputes. Resolution of billing disputes is a key component of the NSA as a whole. However, the inaction in reviewing applications for new IDREs and bringing new IDREs on board is contributing to the backlog of unresolved billing disputes.

Dane Street is committed to assist the Departments in getting rid of the backlog and resolving these billing disputes. To do so, action on our application, including communication with us, is necessary to advance our certification process as an IDRE. This will enable Dane Street to be ready to resolve the outstanding disputes as soon as the IDR process, which is currently suspended, resumes.

Thank you for taking time out of your busy schedules to review these comments. Please write me at 7111 Fairway Drive, Suite 201, Palm Beach Gardens, Florida 33418, if I can answer any additional questions or provide further information.

Sincerely,

Eric Hatfield

Eric Hatfield, Esq.
Director of Legal, Compliance, and Regulatory Affairs
Dane Street, LLC

September 14, 2023

The Honorable Xavier Becerra
Secretary, Department of Health
and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Julie A. Su
Acting Secretary
Department of Labor
200 Constitution Ave NW
Washington, DC 20210

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

Dear Secretaries Becerra, Su, and Yellen:

The Emergency Department Practice Management Association (EDPMA) writes to you today because we believe that with improved regulations and enforcement, the *No Surprises Act* (NSA) will meet Congress's goals of protecting patients, sustaining provider networks, and ensuring access to emergency care. A functional law will significantly benefit patients, employers, and clinicians, and reduce the need to access Independent Dispute Resolution (IDR). We further believe that the Departments of Health and Human Services, Labor, and Treasury ("the Departments") have the tools and ability to make the NSA fair and balanced and to rebuild provider networks, which will benefit patients, clinicians, and health plans alike, all per the intent of Congress in passing the *No Surprises Act* in 2020.

EDPMA is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. Together, EDPMA members see or support 60% of all annual emergency department visits in the country.

EDPMA and its members are active stakeholders and firm supporters of the *No Surprises Act*. However, we believe that the Departments have, in many instances, written implementing regulations inconsistent with the law as passed by Congress. EDPMA has been actively engaged with the Departments and have communicated our concerns in over a dozen letters.

It is important to further note that emergency medicine practices strive to be in-network with health plans and make meaningful attempts to contract with health plans. Often, however, we find we do not have a willing payer partner in these negotiations. Many payers now find it 'easier' to merely terminate long-standing in-network agreements with emergency physicians and instead, default to the NSA's currently flawed implementation. As a result, given the dramatically lower payments for out-of-network services health plans are imposing, by using the currently skewed Qualifying Payment Amount (QPA), together with the inability to secure or maintain in-network contracts, emergency physicians' only option is to use the Open Negotiation and Independent Dispute Resolutions (IDR) process to attempt to achieve fair reimbursement. This too provides little recourse because the IDR processes are broken and often inaccessible, and health plans have little incentive to utilize IDR payment determinations as meaningful reference points for in-network agreements.

Commercial health plans are using the *No Surprises Act's* implementing regulations to disrupt payment to clinicians by paying inadequately or not paying at all. Further, the current incentives have resulted in a universe in which plans simply fail to engage in the IDR process. EDPMA members report that 52% of the time, payers do not acknowledge an IDR dispute has been filed. And of the payers who actually respond, 75% do not make an actionable offer.

Consequently, physician groups' cash-flow is interrupted and clinical resources are reduced, affecting timely access and quality care for patients. The stability of clinical practices is at significant risk.

Given the significant issues around the implementation of and processes embedded in the *No Surprises Act*, EDPMA offers the following additional recommendations and solutions to continue our efforts as productive stakeholders.

EDPMA addresses five primary areas of concern below:

1. Overview and Perspective: Unique aspects of emergency care
2. Qualifying Payment Amount ("QPA"):
- QPA Methodology
- QPA transparent disclosure
- QPA Audits

3. Eligibility: Recommendations for eligibility allowing the efficient and effective use of the Open Negotiation period and the Independent Dispute Resolution (IDR) process.
- Use of RARCs
- Clarity on responsible financial party

4. Independent Dispute Resolution: Recommendations for clarity throughout the Independent Dispute Resolution process and suggested solutions to reduce dependency on the process and ease the burden on certified IDR entities (IDREs).
- Open Negotiation Recommendations

5. Enforcement: Recommendations on current enforcement opportunities and suggestions to solve IDR non-compliance.

1. Overview and Perspective: Unique aspects of emergency care
Before providing our recommendations, EDPMA offers an overarching perspective on the unique aspects of emergency care that frame our comments and suggested solutions.

We understand that the process of rule-writing rightfully seeks uniformity and efficiency for all patient care settings and specialties. We support uniform approaches and broad provisions wherever achievable.

However, fundamental realities and ubiquitous differences in emergency care require a more focused approach. In the United States, all patients are guaranteed access to emergency medical care in a perceived emergency. Longstanding federal law, especially the Emergency Medical Treatment and Labor Act (EMTALA)[i] and the Prudent Layperson standard,[ii] guarantee access to emergency care. As emergency physicians, we strongly support both of these federal laws and welcome the additional patient protections offered in the *No Surprises Act,* provided that the EMTALA and Prudent Layperson Standard patient protections are accommodated in the implementation of the *No Surprises Act.*

Emergency physicians are subject to EMTALA, which requires that we provide patients with emergency medical care regardless of their insurance status, immigration status or ability to pay.[iii] EDPMA strongly supports the patient protections embedded within the EMTALA requirements. This includes that a hospital may not place any signs in the emergency department about the payment of fees, co-pays, and deductibles.

Additionally, hospitals and physicians may "not delay examination and/or treatment in order to inquire about the individual's insurance or payment status." In effect, EMTALA provides for a universal network of emergency care, irrespective of the existence of an in-network agreement between emergency care clinicians and health plans. However, this federal requirement provides no funding, no standard of payment, and no specific ability to collect amounts owed by patients or health plans after health care has been provided. These provisions are unique to emergency care in the entire United States, and are significantly different from other specialties, especially scheduled care settings.

These foundational principles of EMTALA's patient protections were enacted almost four decades ago. If emergency medicine physicians attempted to collect patient cost-sharing payments prior to their assessment and stabilization, it could cause the patient's condition to deteriorate due to the delay in critical care, and it would that be a significant EMTALA violation.

Due to the unscheduled nature of emergency care and EMTALA's unique requirements, providing emergency care includes logistics and requirements that are substantially different than other health care settings. Emergency physicians cannot seek pre-authorization, verify insurance, or collect certain billing information prior to delivering emergency care. Additionally, emergency physicians are not able to collect patient cost sharing amounts at the time of service, especially for out-of-network claims.

The Prudent Layperson standard was first made part of federal law in the Balanced Budget Act of 1997 and subsequently adopted in both the ACA and other statutes/regulations. Since then, the federal Prudent Layperson Standard also protects both clinicians and patients from having to obtain prior authorization for patients who present to an emergency department.

EMTALA and Prudent Layperson Standards not only protect patients in need of timely care and ensure communities have 24/7 to access to emergency care (including during disasters and mass casualty events) but also create high standards and obligations for emergency physicians that must be acknowledged by and integrated throughout the *No Surprises Act*. To the extent that the NSA's provisions do not accommodate the requirements of EMTALA and the Prudent Layperson standard, the resulting dramatic reductions in payments for emergency care will cause the entire economic ecosystem of emergency care to fail. This would be a severely detrimental, unintended consequence of the No Surprises Act – one that affects our nation's unique healthcare safety net.

EDPMA believes there are efficient solutions that accommodate these realities, and we offer these below.

EMERGENCY MEDICINE: UNIQUE FROM A CLINICAL AND REIMBURSEMENT PERSPECTIVE

As stated, emergency care involves the unscheduled acute diagnosis, treatment, and stabilization of diverse and undifferentiated clinical conditions.

For example, two of the most common patient presentations to the emergency department are "chest pain" and "abdominal pain." These initial presenting complaints have a broad range of final diagnoses and may require a variety of patient-specific lab tests, radiology exams, and other interventions to ensure that the emergency medical condition has been identified and stabilized as required by EMTALA.

Evaluating, stabilizing, and treating patients based on their presenting systems is very different from assessing and treating a patient in a scheduled, office-based setting with a previously determined diagnosis. In fact, if a patient in an office-based setting requires urgent evaluation and/or stabilizing care, they are usually immediately referred to the emergency department.

- A Rand study reports that emergency departments are increasingly used by primary care clinicians to perform accelerated diagnostic workups of patients with potentially serious problems.[iv] Conversely, expedited evaluation often avoids a hospitalization by safely determining that a hospitalization is not necessary.
- The Rand report further referred to a Berenson & Rich study, "The time pressure on primary care physicians has grown so great, many regard any unscheduled visit, even one involving a relatively minor problem, as a disruption to their workday."[v]
- The American Academy of Family Physicians reports that many primary care physicians' offices are not prepared for an emergency presenting in their office.[vi] And it is common that most office-based physician offices and health insurance companies' direct callers to hang up and call 911 if they are experiencing a medical emergency.
- As the Rand report summarizes: "Most patients who visit an ED for a non-emergent health problem do so because they were sent by a health care clinician, believed they had a serious condition, or perceived that they lacked a viable alternative."[vii] The people directed by their office-based physician then present in the emergency department as undifferentiated patients to the ED. Because all patients require and deserve a prompt medical screening exam and stabilizing treatment in the emergency department in accordance with the Prudent Layperson standard and EMTALA, the complicated and unpredictable nature of emergency care makes it impossible to estimate ahead of time what services are going to be delivered during an individual patient encounter.

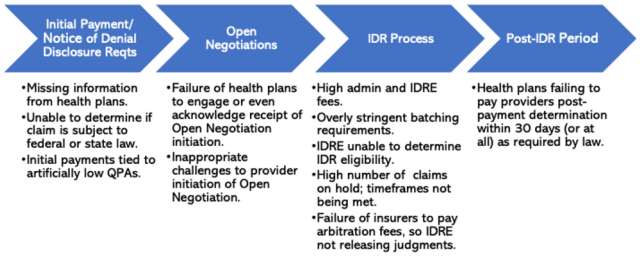
The EMTALA patient protection requirements not only influence how emergency medicine clinicians interact with patients — but they also impact how and when health plans determine the appropriate cost-sharing amount for the timely services already rendered.

Patients often do not have insurance information with them nor the ability to pay their cost-sharing portion at the time of the emergency department visit. As directed by the EMTALA statute, a medical screening examination and stabilizing care must be completed *before* seeking insurance information and/or payment.

In fact, physician groups often do not know the patient's definitive insurance information for several days or weeks after their emergency care encounter. And, unlike scheduled care when the cost-sharing amount is known and collected up-front, physician groups do not bill, nor do they attempt to collect cost-sharing payments from patients for emergency care until *after* the health plan determines what the total allowable amount for the services will be — which is long after the patient has been discharged from our care and the emergency department. So, it is both legally and logistically impossible for emergency physicians to collect cost share from patients before or immediately after the service is provided.

These realities have created confusion about when the *No Surprises Act* applies and what the appropriate venues for resolution are. EDPMA believes that the Departments should take every possible action to address these system vulnerabilities that might result in confusion about whether state or federal rules apply to out-of-network services. The Department can achieve significant improvement in the related processes and ensure that only eligible disputes end up in Federal IDR by (1) requiring health plans to include the plan type on patient insurance identification cards; and (2) by mandating the use of Remittance Advice Remark Codes (RARCs) (which we discuss in further detail below).

Refer to the visual representation of emergency medicine billing, the Independent Dispute Resolution process, and challenges with the *No Surprises Act* below:



2. QUALIFIED PAYMENT AMOUNT (QPA)

Since March 2021, EDPMA and others, have sent 15 letters[viii] to the Departments, the Center for Medicare & Medicaid Services (CMS), and the White House Office of Management and Budget (OMB) offering solutions-based recommendations to fix the implementation of the *No Surprises Act.*

EDPMA and its members, who represent 60% of annual US emergency department visits, view fixing the QPA as the most important concept in future NSA rulemaking. As we have written several times and as acknowledged in federal court, the regulations related to calculation of the QPA are flawed. This is further compounded by the fact that many health plans fail to properly adjust their 2019 QPAs for inflation as required by law and regulation. These two factors are a large driving force in the demand to file IDR disputes. While not required by law, most plans base their initial payments on the QPA – when the QPA is artificially low, often without the legally required inflation adjustment, the only recourse for providers is to file Open Negotiation requests and subsequently file claims for Independent Dispute Resolution when the dispute has not been resolved in Open Negotiation. This is a frequent

event because of health plan behavior: EDPMA members report that 46% of the time, health plans did not reply during the 30-day Open Negotiation period.[ix]

The Departments reported nearly 14 times as many federal IDR disputes as originally anticipated.[x] Although we are unconvinced that the original estimates had a solid foundation, the current number of IDR disputes is almost entirely in direct response to the unreasonably low initial payment based on an unreasonably low QPA or a payment made without identifying the required QPA.

For example, in 2022, the average initial payment and/or QPA for a local Third-Party Administrator (TPA) in downstate New York was less than 90% of Medicare rates for that locality. Such payments are almost 3 times less than payments received in years prior to NSA implementation. Additionally, EDPMA members report that 60% of payers are not updating the QPA amounts with the statutorily required inflationary update.[xi]

When a clinician is paid an unreasonably low initial payment or does not receive the required information on the QPA to understand the basis for the payment, their only recourse for fair payment is to initiate Open Negotiation. Most Open Negotiation requests are simply ignored by the health plan. This strains the entire process and is the primary reason the Departments report that there were nearly 14 times as many federal IDR disputes as anticipated.[xii]

By fixing the initial payment and QPA, our health system will benefit from a process where both parties participate in good faith, clinicians are fairly reimbursed in a timely manner for already-delivered emergency care, especially those services delivered under the federal EMTALA law, and the *No Surprises Act* is implemented as enacted.

EDPMA suggests the following solutions:

MODIFY THE METHODOLOGY TO ENSURE THE QPA REFLECTS MARKET RATES
EDPMA and the American College of Emergency Physicians (ACEP) have requested numerous modifications to the QPA methodology in previous comments.

> **EDPMA requests that the Departments base the QPA rate on the total number of actual payments issued to individually contracted physicians. By basing the QPA on claims rather than contracts, the QPA would more accurately reflect the actual negotiated rates between payers and clinicians.**

TRANSPARENT DISCLOSURE of the QPA
Only the health insurance plan can calculate the QPA. Often, physician groups do not receive information about the QPA, how it was calculated, the plan type, nor if it was adjusted for inflation. If this information was provided at the time of the claim adjudication, many IDR claims would be avoided.

> **EDPMA recommends that the Departments enforce the requirements for plans to disclose the QPA concurrently with the initial payment in compliance with current regulation and to do so in an easily identifiable, user-friendly format. Further, EDPMA recommends the Departments require that plans disclose the market the QPA is based upon (i.e., individual, small, large group market, a self-insured market) or if it is based on an all payers database (APD) or an all payers market analysis (APMA), if so, which APD/APMA and disclose what inflation adjustments (by year) have been made to comply with 45 CFR 149.140(c)8.**

AUDIT QPA CALCUATIONS
We reiterate and request the Departments audit QPA calculations in accordance with the Act. Additionally, we request the Departments publicize which health plans will be audited, and whether or not the health plan's QPA(s) were in compliance with the Act.

3. ELIGIBILITY
EDPMA offers these eligibility recommendations to allow the efficient and effective use of the Open Negotiation period and the Independent Dispute Resolution process.

As you know, the *No Surprises Act* created many new administrative processes and EDPMA requests that the Departments consider ways to limit the administrative burden on all parties. Since January 2022, clinicians have often

found it challenging to appropriately identify whether state or federal rules and processes apply to an out-of-network claim. In fact, the Departments issued a status update on April 27, 2023, in which they acknowledge the "primary cause of delays in the processing of disputes is the complexity of determining whether disputes are eligible for the federal IDR process."[xiii]

USE OF REMITTANCE ADVICE REMARK CODES (RARCs)
A report issued by the Departments states that it "is difficult to determine because the health plan type is unknown upon dispute initiation in approximately one third of disputes in Texas and Florida and over half of disputes in Georgia," all of which have specified State Laws. The departments had to hire consultants to help determine eligibility. The high volume of ineligible claims directly results from health plans not disclosing the plan type covering the patient at the time of the initial claim remittance."[xiv]

When health plans and issuers adjudicate claims and communicate information to the health care clinician, they do so in a standardized format called an ANSI 835 (835) remittance. The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set (TCS) standards already require that health plans and users use ANSI Claims Adjustment Reason Code (CARC) and RARC for their 835 electronic healthcare transactions.

Appropriate RARCs already exist and are common for both health plans and clinicians, so mandating their use will not require changes to the templates that health plans and issuers typically use to relay information about a claim to a clinician. Said another way, there are enough fields on the standard 835 remittance to accommodate the *No Surprises Act*-related RARCs.

EDPMA recommends that the Departments request a modification to the standard 835 remittance form so that all the information, including the QPA, is disclosed uniformly. Again, there are open fields and appropriate RARCs are in place that will resolve many issues with *No Surprises Act* implementation, but the open fields will need to be designated to be used for the required NSA information.

Requiring plans to use RARCs when providing the initial payment or denial notice will clarify state or federal eligibility for out-of-network dispute resolution and reduce confusion and unnecessary administrative transactions and delays. It will reduce "ineligible" claims being submitted for IDR, which reduces administrative burdens and backlogs for all parties.

Specifically, group health plans or health insurance issuers should be *required* to use exactly one of two mutually exclusive RARC codes with the initial payment or notice of denial to clearly identify whether state or federal rules apply:

> **N871 Alert:** This initial payment was calculated based on a state specified law, in accordance with the *No Surprises Act.*
>
> ***OR***
>
> **N859 Alert:** The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es).
>
> Use of both N871 and N859 together on a claim renders their use moot and should be prohibited.

EDPMA recommends these processes and remedies for failure to use appropriate RARCs on the initial payment or notice of denial.

- Should the clinician not receive a RARC code delineating whether state or federal rules reply to a claim for an item or service furnished out-of-network with the initial payment or denial and the provider has reason to believe the federal rules apply, the clinician may make a notation on the Open Negotiation notice indicating each item or service that did not receive a RARC. The Departments should also make and enforce a provision that a clinician may add a statement to the Open Negotiation notice requesting the health plan to provide the RARC for each claim within ten (10) business days of receipt of the Open Negotiation notice.

- If a "State Specified Law" applies to a claim and the health plan did not return the appropriate RARC at the time of the initial payment or notice of denial, the clinician has the option of following the federal or state process. In either case, fees are paid solely by the non-compliant party.

- If the claim is appropriately subject to the federal IDR process and the payor returned a RARC indicating the claim was subject to a "Specified State Law," then the clinician has the option of following the federal IDR process OR following the "State Specified Law," procedure if the State allows the claim to enter the state's process.

  In either case, any federal nonrefundable filing fees and IDRE fees are paid solely by the health plan. Additionally, any deadlines for federal IDRE open negotiation letter submission are extended to 30 days after the payor notifies the clinician with the correct RARC code that the claim is subject to federal IDRE.

  In summary, If the health plan did not provide the correct appropriate RARC code on the first remittance, the health plan should be estopped from benefiting by forcing the clinician to the federal IDRE or "Specified State Law."

CLARITY ON RESPONSIBLE FINANCIAL PARTY

Current NSA Rules state that items and services "may be considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet" certain requirements, including "by the same plan or issuer". The Act does not define "group health plan" or "health insurance issuer", however, those terms are defined in pre-existing portions of ERISA and the Public Health Service Act. It follows that the existing definitions of "group health plan" and "health insurance issuer" confirm that parties must batch by the *same employer-funded plan* and not the third-party administrator.

Accordingly, EDPMA recommends that the employer-funded plan is named with the initial payment or denial. Clinicians require clarity and specificity regarding employer-funded plans to ensure they can batch correctly and efficiently.

Specificity and clarity on the employer-funded plan may be conveyed as follows:

> The ANSI 835 remittance accompanying the initial payment or denial notice must include the employer-funded plan with whom the clinician may initiate the Open Negotiation and/or IDR process. The Departments should enforce meaningful penalties for non-compliance. The required information shall include the employer-funded plan and a US mailing address and/or functional e-mail address.

EDPMA recommends remedies for failure to correctly disclose the responsible party:

> Failure to include the correct information will result in an automatic adjudication in the amount initially requested by the clinician during Open Negotiation.
>
> All filing or administrative fees paid to an IDRE and/or the Departments shall be refunded to the compliant party and simultaneously paid by the non-compliant party. Additionally, the non-compliant party shall pay the compliant party a $50 penalty.

4. EDPMA RECOMMENDATIONS TO REDUCE DEPENDENCE ON THE INDEPENDENT DISPUTE RESOLUTION (IDR) PROCESS

Expanding the Scope of the Federal IDR portal

A robust and comprehensive federal IDR portal would formalize the Open Negotiations process and provide a more structured way for health insurers and clinicians to have certainty of when the 30-day Open Negotiations process begins, to share information, and use best efforts to resolve disputes before the IDR process (including assisting with eligibility determinations). The Departments should expand the scope of the IDR portal to span the entire out-of-network process, beginning with the initiation of Open Negotiation and continuing all the way through remittance of accurate payment after an IDR payment determination has been rendered.

An improved portal would increase efficiency for *all* parties by:

- ensuring each party is appropriately notified the IDR process has commenced.
- ensuring each party receives accurate and complete information regarding each claim;

- providing a clear and accurate timeline of all communications exchanged throughout the process;
- ensuring compliance with the law and determinations of IDREs.

EDPMA recommends the following functionalities for a comprehensive IDR portal:

Administrative Log-Ins. All parties should be given administrative logins for the portal. Each administrative username will let the party review all pending or closed actions and/or disputes. Also, each party with a username can select a primary e-mail address that will be automatically notified of communications or documents uploaded to the portal.

Proper Forum. If either party believes in good faith the dispute should be properly adjudicated via the comprehensive portal, the portal will accept the claim. This serves to memorialize the dates of filing and preserve the rights of the initiating party to file in the appropriate forum.

Use of the portal begins with the Open Negotiation notice. Federal requirements already establish that a party that wishes to access the federal IDR process to determine the out-of-network rate for an item or service, such party must send the other party an initiation of Open Negotiation notice. All parties will be aided if the party initiating Open Negotiation is required to utilize the portal to submit the Open Negotiation party to the non-initiating party.

Submission of Offers and Payment of Certified IDRE fee.

- Parties shall submit their offers through the portal and attest to payment. This function is already implemented.
- Any follow-up request by an IDRE will be done only through the portal. And subsequent documentation requested will be uploaded to the portal.
- All documentation uploaded to the portal will be readily available upon request by the other party within 24 hours of IDRE determination.

Other processes of IDR that will take place solely in the portal.

- Any communication, inclusive of settlement offers and acceptance, occurring during Open Negotiation will take place in the portal.
- Initiation of the IDR process by submitting a Notice of IDR Initiation through the portal.
- Selection of the Certified IDRE will occur within the portal.
- Communication with IDREs.

Other recommended features of the portal that will contribute to efficiency and efficacy of IDR process.

- Assign an identification number to specific items or services under dispute to better track them through the process.
- Implement timestamps for each step of the process.
- Clearly include the contact information, including the email addresses, for all contacts involved in the dispute.

OPEN NEGOTIATION RECOMMENDATIONS

As per statutory requirements,[xv] a party must send an initiation of Open Negotiation notice to the other party that includes information sufficient to identify the items and services (including the date(s) the item(s) or service(s) were furnished, the service code, and initial payment amount, if applicable), an offer of an out-of-network rate, and contact information for the party sending the Open Negotiation notice in writing within 30 business days beginning on the day the clinician, facility, or provider of air ambulance services receives an initial payment or a notice of denial of payment from the plan or issuer regarding the item or service.

EDPMA members report that 46% of the time, health plans did not reply during the 30-day Open Negotiation period.[xvi] Additionally, based on experience and data, the 30-business day Open Negotiation period, in most cases, has become a delay, rather than an opportunity, to resolve payment disputes. The lack of meaningful engagement by health plans in the critical Open Negotiation process forces clinicians to submit claims through the IDR process.

Accordingly, EDPMA recommends mandating participation by clinicians and health plans in Open Negotiation as follows:

- Health plans must respond to an Open Negotiation notice via the portal within 10 business days of receipt of the notice.

- Declining to negotiate the initial payment or notice of denial will accelerate the time frame by which the clinician may initiate IDR. Upon receipt of communication declining to negotiate, clinician may initiate IDR beginning on the 11th day of Open Negotiation.
- Failure to respond to an Open Negotiation Notice within 10-business days will result in a forfeiture of IDR eligibility for the plan and the clinician shall automatically be awarded (via the portal) the requested amount in the open negotiation request.

5. ENFORCEMENT

EDPMA is alarmed by the growing trend of health insurers' failing to pay what they owe to the clinician after a certified IDRE makes a payment determination that results in a balance owed to the clinician.

EDPMA members report that 87% of payers did not pay in accordance with the IDRE payment determination[xvii] *despite numerous attempts by clinicians to collect the payment. Some health plans are indicating that they are refusing to pay amounts owed after an IDRE's payment determination because they later disagree with the federal IDR eligibility determination*.

Most alarmingly, some health plans have written that they are refusing to pay amounts owed after an IDRE's payment determination because they do not agree with the decision or believe it is enforceable.

These assertions are occurring despite the health plan's refusal to provide RARC codes at the front end or other information during the IDR process that would clearly and proactively identify whether claims are or are not subject to the federal IDR process, as has been repeatedly requested by the clinician community. **These instances of blatant disregard for the requirements under the law, which essentially neuter both the intent and the practical purpose of IDR process, point to a significant need for enforcement and consequences for noncompliance.**

To empower enforcement and compliance, the Departments should require that the comprehensive portal described in previous sections should include timestamped submission by either party of proof of payment made for any amounts owed following an IDR payment determination. This will allow for easier auditing and verification that these statutorily mandated payments are being made and allow for more actionable enforcement when they are not.

Health insurers who are not paying what they owe the clinician after the IDR process is completed must be penalized and forced to compensate the clinician the total amount owed, plus **interest and penalties**. Insurers continue to record profits quarter after quarter,[xviii] and any delay or lack of payment of the amounts they owe to clinicians under the *No Surprises Act* allows them to continue to accrue substantial one-sided benefits including additional interest on the amounts owed. This common practice cash-starves clinicians who provide timely access to emergency care and medical care to their members.

EDPMA recommends penalties shall be assessed to a non-compliant party as follows:

Interest. Once an IDR determination is made, the non-prevailing party must make up the difference with the prevailing party within 30 days, as per the statute. If such a payment is not made by the end of the 30-day period, interest should immediately apply. The Departments could consider setting the interest rate at the rate which HHS currently applies to overdue and delinquent debts, pursuant to 45 CFR Part 30—which is determined and fixed by the Secretary of the Treasury.

Penalties. Failure to pay certain fees associated with the IDR process and the IDRE should result in penalties as follows:

- Should the party owed funds not receive payment within the applicable timeframe, the party owed funds will attest to same. The Departments, via the portal, will automatically assess a penalty of $100 per item or service within each dispute. Additionally, the IDRE's payment determination will be increased by 25%.
- Should the prevailing party use small claims court/arbitration/etc. to procure payment on the IDRE payment determination, any fees associated with filing, including attorneys' fees, shall be reimbursed by the non-prevailing party. The court may, in its discretion, assess a penalty to the non-compliant party by increasing the IDRE payment determination by 50%.

EDPMA applauds your commitment and focus on the noble purpose of the *No Surprises Act to* protect patients from unexpected healthcare costs. You are a champion of the patient and the clinicians who care for them. We request that you consider our positions and requests and continue to work with the Departments to ensure the *No Surprises Act* is implemented as intended and to protect our country's healthcare safety net.

Sincerely,

Andrea Brault

Andrea Brault, MD, MMM, FACEP
Chair, Emergency Department Practice Management Association

cc: Senator Bernie Sanders, Chair, Senate HELP Committee
Senator Bill Cassidy, MD, Ranking Member, Senate HELP Committee
Rep. Jason Smith, Chair, House of Representatives Committee on Ways & Means
Rep. Richard Neal, Ranking Member, House of Representatives Committee on Ways & Means
Rep. Cathy McMorris-Rodgers, Chair, House of Representatives Energy & Commerce Committee
Rep. Frank Pallone, Jr. Ranking Member, House of Representatives Energy & Commerce Committee

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[i] 42 U.S.C. § 1395dd
[ii] 45 CFR § 147.138
[iii] CMS State Operations Manual – Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Care
[iv] Rand Study: The Evolving Rule of Emergency Departments In the United States, page 66
[v] Rand Study: The Evolving Role of Emergency Departments In the United States, page 66
[vi] American Family Physician: Medical Emergency Preparedness in Office Practice
[vii] The Rand Report: The Evolving Role of Emergency Departments In The United States: Page 70
[viii] EDPMA No Surprises Act Advocacy
[ix] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[x] Federal Independent Dispute Resolution Process – Status Update: April 27, 2023
[xi] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[xii] Federal Independent Dispute Resolution Process – Status Update: April 27, 2023
[xiii] Federal Independent Dispute Resolution Process – Status Update: April 27, 2023
[xiv] CMS Partial Report on the Independent Dispute Resolution (IDR) Process. October 1 – December 31, 2022
[xv] (45 CFR § 149.510(b)(1))
[xvi] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[xvii] EDPMA Data Analysis: Independent Dispute Resolution in the No Surprises Act – Deficiencies and Compliance Failures
[xviii] National Association of Insurance Commissioners: U.S. Health Insurance Industry Analysis Report - 2021

FAMILIESUSA ACTION

Statement for the Record

House Committee on Ways and Means

Hearing entitled "*Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections*"

Prepared by *Families USA Action*
September 19, 2023

1225 New York Avenue NW, Suite 800 Washington, DC 20005
p: 202-628-3030
f: 202-347-2417
info@familiesusa.org

Chairman Smith and Ranking Member Neal, on behalf of Families USA Action, we thank you for your work to pass the No Surprises Act, a landmark consumer protection law, and for hosting this conversation today. Families USA Action is proud to have worked with the Ways and Means Committee and the other committees of jurisdiction to help craft and advocate for the No Surprises Act. That statute, and the Biden administration's implementation of the law to date, have undoubtedly helped millions of families who are already struggling to pay for groceries, gas, and rent, from facing the added stress of being saddled with out-of-network surprise medical bills when they seek care at an emergency facility or hospital. Despite this progress, we are concerned about the relentless pushback from corporate health care interests who are seeking to weaken the No Surprises Act's protections from rising health care costs.

No one should go bankrupt from seeking health care. Prior to the No Surprises Act, a single surprise bill could prove devastating and leave families on the hook for hundreds to thousands of dollars for bills they had no way to avoid and were often unable to pay. In the years before passage of the law, one in five insured adults had received a surprise medical bill[i], which could reach or exceed median amounts of $482 for a balance bill due to an emergency visit[ii]. There is also strong evidence that the abusive practice of balance billing contributed to higher premiums and health care costs for everyone with commercial insurance,[iii] and it is well-documented that private equity owned provider groups and facilities have used surprised billing as a business model to keep costs high.[iv]

Now, because of the No Surprises Act, consumers have critical protections from this particularly egregious brand of corporate price gouging. The No Surprises Act was passed by Congress with the dual purposes of protecting consumers from surprise out-of-network balance bills and from rising health care costs and inflated premiums that were caused by industry exploitation.[v] Since its passage, the No Surprises Act has seen tremendous initial success, preventing more than 9 million potential surprise bills between Q1 and Q3 of 2022[vi] and an estimated total of nearly 17 million by May 2023[vii]. The law also holds the potential to help reduce rising premiums that were driven by market failure of out-of-network balance billing[viii]. It is also an immensely popular law: recent polling has indicated that an overwhelming majority – 92% – of voters are supportive of the No Surprises Act[ix].

Despite these successes, implementation of the No Surprises Act has been impeded by an unrelenting barrage of provider-led litigation and overuse and abuse of the independent dispute resolution (IDR) process by a small number of corporate entities. These attacks risk eroding the strong consumer protections enacted by the law and could yield way to the return of categorically unreasonable out-of-network prices for healthcare services.

Since the No Surprises Act went into effect, provider organizations like the Texas Medical Association (TMA) and their allies have filed over 20 lawsuits attempting to undermine the law and important regulatory guardrails that are supposed to limit consumer exposure to rising health care costs. The litigation and resulting court decisions have already forced changes to rulemaking that offer weaker protections from rising health care costs than the administration originally put forward. Most recently, a ruling in favor of TMA struck down a critical piece of the rules – calculation of the qualifying payment amount (QPA) – which could have massive implications for patient cost-sharing protections and directly raise costs for families protected under the No Surprises Act. For example, if the QPA for an anesthesiologist's service increased from $6,000 to $8,000, a 30 percent coinsurance charge for anesthesiology could leave a patient responsible for an additional $600.[x] The erosion of other guardrails could likewise cause payer-provider IDR decisions to trend higher and higher, leading to increased costs for consumers in the form of premiums. And most concerning, some of the plaintiffs[xi] in these cases

want to overturn the entire law and go back to the days before the No Surprises Act, when they were able to purposefully stay out-of-network and take advantage of everyday Americans who have done their due diligence to ensure the care they seek is covered by their insurance plan.

In addition to the legal challenges, corporate provider interests have flooded the No Surprises Act's IDR system with claims, all the while maintaining that it is failing to result in fair payment and advocating for it to be altered through additional rulemaking. The administration's own reporting on usage of the IDR process points to overuse and potentially abuse by a small number of staffing companies, financial management firms, and private-equity backed provider practices that are aggressively submitting claims to IDR and stressing the system.[xii] Analysis of available IDR usage data further shows that the flux of IDR cases is not happening nationwide, but is concentrated in just four states: Texas, Florida, Tennessee and Georgia.[xiii] Reporting also shows that initiating parties were the prevailing party in approximately 71% of the disputes[xiv], which points to the provider interests getting their preferred payment amount the vast majority of the time. Claims that the administration's design of the IDR process are not resulting in fair payments to providers are therefore overblown.

These efforts to undermine the No Surprises Act come as America's health care affordability crisis is growing. More than 100 million Americans are in medical debt,[xv] two-thirds of which are forced to cut back on spending for food, clothing, and other necessities. Nearly half of Americans report having to forgo medical care due to the cost.[xvi] At the same time, people's premiums keep rising, employers are spending increasingly more to keep their workers covered, and many workers' wages are suppressed. It should come as no surprise then that the American people are deeply concerned about the attacks on the No Surprises Act eroding their protections and making their situation even worse. A November 2022 poll found a bipartisan majority of voters with employer health insurance –73% – are concerned lawsuits could overturn or delay patient protections in the No Surprises Act and increase health care costs for patients.[xvii]

Families USA Action appreciates the leadership of the Committee on Ways and Means in your work to pass a strong consumer protection law that has already helped millions of families who won't receive a financially devastating surprise medical bill. We urge this committee and your colleagues in Congress to remain steadfast in protecting consumers from surprise bills and rising health care costs, and to work with the administration to stand up to corporate health care interests seeking to weaken to law. Please contact Jane Sheehan, Director of Federal Relations at Families USA, JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

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[iii] Congressional Budget Office (January 2021). Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260 https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

[iv] https://www.arnoldventures.org/stories/part-1-in-pursuit-of-profit-private-equity-expanded-into-health-care-the-results-raise-concerns-about-cost-and-quality

[v] Congressional Budget Office (January 2021). Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260 https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf; Chairman Bobby Scott and Ranking Member Virginia Foxx, Letter to the Secretaries of Labor, Health and Human Services, and Department of the Treasury, November 19, 2021 https://edworkforce.house.gov/uploadedfiles/11.18.21_surprise_billing_letter.pdf; Chair Murray and Chair

Pallone, Letter to Secretary Becerra, Department of Health and Human Services, January 7, 2022 https://www.help.senate.gov/imo/media/doc/01072022_HHS%20Surprise%20Billing%20Letter_signed_FINAL.pdf

[vi] America's Health Insurance Plans, No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022 https://ahiporg-production.s3.amazonaws.com/documents/202211_1P_Surprise_Billing.pdf

[vii] Coalition Against Surprise Medical Billing, New Polling Shows Voters are Concerned about Threats to the No Surprises Act https://stopsurprisebillingnow.com/new-polling-shows-voters-are-concerned-about-threats-to-the-no-surprises-act/#:~:text=%E2%80%9CWith%20over%201%20million%20bills,that%20works%20to%20protect%20patients.%E2%80%9D

[viii] Congressional Budget Office, H.R. 5826, Consumer Protections Against Surprise Medical Bills Act of 2020, as Introduced on February 10, 2020 Estimated Budgetary Effects. February 11, 2020 https://www.cbo.gov/publication/56122

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[x] Zachary Baron, "Latest Twists and Turns in No Surprises Act Litigation: What it Means for Consumers and Ongoing Implementation," https://oneill.law.georgetown.edu/latest-twists-and-turns-in-no-surprises-act-litigation-what-it-means-for-consumers-and-ongoing-implementation/

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[xiii] DHHS, DOL, and Dept of Treasury, Partial Report on the Independent Dispute Resolution Process, October 1-December 31, 2022, https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf, and "Surprise Billing: Volume Of Cases Using Independent Dispute Resolution Continues Higher Than Anticipated", Health Affairs Forefront, July 27, 2023. DOI: 10.1377/forefront.20230727.458390.

[xiv] https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf

[xv] Naomi N. Levey, 100 Million People in America are Saddled with Health Care Debt, Kaiser Health News, June 16, 2022, https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/

[xvi] NORC at the University of Chicago and West Health, Americans' Views on Healthcare Costs, Coverage and Policy, March 2018 https://www.norc.org/NewsEventsPublications/PressReleases/Pages/survey-finds-large-number-of-people-skipping-necessarymedical-carebecause-cost.aspx

[xvii] CASMB and Morning Consult, No Surprises Act, November 2022 https://drive.google.com/file/d/1DvLXqD37TBeN7TtFZxoLvOqxXYJujZQn/view

Written Comment for the Record

Global Medical Response

Hearing on "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

October 3, 2023

On behalf of Global Medical Response, we appreciate the opportunity to provide written comments on the House Ways and Means Committee's hearing on Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections. Global Medical Response (GMR) is the country's largest air and ground ambulance provider with nearly 37,000 employees including over 600 employees in Missouri. In 2022, we had 15.3 million patient encounters. As the nation's largest provider of emergency medical services and medical transportation, we are on the frontlines both in the communities we serve as well as in the areas that need additional aid to supplement fellow emergency service providers.

As the largest air and ground ambulance provider in the United States, GMR services 1 in 6 medical transports each year. Our 66 communications centers take millions of 911 and non-emergency calls per year, operating 24/7, 365 days a year, including holidays. GMR also serves the Federal Emergency Management Agency (FEMA) as their prime medical responder for natural disasters, acts of terrorism, and public health emergencies.

Following the effective date of the No Surprises Act (NSA) (January 1, 2022), Global Medical Response has experienced a change in behavior by certain large national payors who appear to be violating the requirements of the NSA. These violations are undermining the goals of the NSA and are resulting in financial harm to emergency air ambulance providers which may compromise our ability to provide life-saving patient care, specifically in rural and underserved areas of the country.

We support the goals of the NSA, but implementation has led to several challenges. Specifically, we are concerned that the law has been implemented in a way that undermines Congress' intent to take the patient out of the middle. Our two biggest concerns are medical necessity denials for emergency services and delayed payments from the country's largest insurers, even when independent dispute resolution entities have determined the amount providers should be paid for their services.

Medical Necessity Denials for Emergency Services

We continue to face challenges on medical necessity denials, a practice that insurers have engaged in with drastic increases in frequency since Congress passed the NSA. Recently, an individual with a stroke was taken to the nearest hospital in Tennessee, and when it was determined that the hospital could not provide the care he needed, he was transported to a medical center that could provide the appropriate level of care. Air Evac, a GMR company, transported him, however, BlueCross BlueShield (BCBS) of Tennessee denied the claim.[i] This is not an aberration, or an isolated incident; BCBS of Tennessee sharply increased medical necessity denials since passage of the NSA. BCBS of Tennessee denied claims for medical necessity 66 times in 2019 (6.9% of trips), 96 times in 2020 (9.9% of trips), 370 times in 2021 (32.4% of trips), and 442 times in 2022 (47.3% of trips). From March 2022 to February 2023, we saw 622 instances where the insurer did not pay for the service. While BCBS of Tennessee has been the most

egregious, we have seen this behavior from UnitedHealth Care, Cigna, Aetna (CVS Health) and other BCBS plans.

This practice by insurers has again placed patients in the middle because the insurer has refused to pay for the services. In fact, patients are even at a greater disadvantage because, in the case of a medical necessity denial, the insurer pays $0 towards the cost of emergent care. While medical necessity may have a place for elective procedures, it has absolutely no place in emergent situations where the patient needs immediate help and an independent, qualified third party determines the most appropriate action to care for the patient. Congress must address the medical necessity loophole that once again places patients in the middle of payment disputes and threatens the viability of providers who must be reimbursed for the care they provide. Congress should include medical necessity denials in the independent dispute resolution (IDR) process.

Payment Delays for Claims after IDR Process

We continue to see insurers delay payments even after an independent dispute resolution entity has determined the payment amount. This creates cash flow issues, additional administrative costs, and legal costs when we must file litigation to seek payments for what we are owed. In fact, we have been forced to file lawsuits against Cigna, Aetna, and Health Care Service Corporation for claims that went through the independent dispute resolution process. It should not have to come to this. While insurers are required to pay, there is little incentive to do so as there is no adequate enforcement mechanism to penalize insurers who withhold payments. It should also be noted that the companies engaging in the practice include Fortune 10 companies. CVS Health (Aetna), UnitedHealth Group, and Cigna have a collective market cap of $642 billion.[ii] Meanwhile for GMR, nearly 30% of our owed payments as determined by an independent dispute resolution entity are delinquent past 60 days. This results in tens of millions in unpaid claims.

Congress has the opportunity to address delays in unpaid claims and we were pleased that this issue was raised during the House Ways and Means Committee hearing held on September 19, 2023. We strongly urge Congress to create a meaningful enforcement mechanism, including financial penalties, for insurers that delay payments to providers that went through the independent dispute resolution process. Congress should consider charging insurers interest on an unpaid clean claim within 30 days.

Thank you for the opportunity to provide written comments and we look forward to working with the Committee on improving implementation of the No Surprises Act.

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[i] https://www.newschannel5.com/news/newschannel-5-investigates/patients-who-suffered-emergencies-say-bcbstn-wont-pay-for-their-air-ambulance-flights-to-the-hospital

[ii] Market data obtained on September 29, 2023.

Kansas Emergency Physicians, LLC

Members of the Committee,

Thank you for your investigation into the implementation of the No Surprises Act (NSA). We appreciate the intent of the legislation, but the implementation has had a significant impact that could be catastrophic for private ED groups.

My name is Dr. Timothy Chilcote. I am a board-certified Emergency Physician and have been practicing in the greater metropolitan area of Kansas City for the last 18 years. I am a partner and the current vice president of Kansas Emergency Physicians, a physician-owned independent group consisting of 35 physicians and 12 advanced care practitioners. We currently provide staffing for 6 different units, 5 emergency departments and one clinical decision unit.

I graduated with my Doctorate from the University of Illinois-Chicago in 2006. I subsequently matched in Emergency Medicine at the University of Missouri-Kansas City, the second oldest emergency program in the country. My family and I have lived in Kansas City ever since.

Kansas Emergency Physicians and its subsidiaries (Emergency Room Physicians South and Emergency Physician Specialists) was founded 50 years ago by Dr. Charlie Jones. Since our founding, we have been focused on providing quality emergency care to the residents of greater Kansas City. We have long believed that physicians should control their own business and while physicians receive no formal business training, our group has been blessed with leaders who are business savvy and determined to preserve our independence.

Our group sees approximately 85,000-95,000 patients annually across a varied patient population. We cover a large tertiary hospital and observation unit, smaller regional suburban hospital, a critical access facility and two free standing emergency departments. We are engaged in our community as well, sponsoring initiatives such as the currently under construction AdventHealth Cancer Institute, the Lee Ann Britain Infant Development Center as well as supporting mission trips to underserved areas with members of our staff. We are proud members of all of the communities we serve and strive to provide our fellow residents with access to the best possible care in their moments of crisis. We believe there is immense value in local, independent practices like ours, and we are loathe to sell out to a big corporate entity or private equity backed group that views us as a profit center not a community.

Covid-19 and the resultant pandemic was the most challenging time in our group's history. While everyone had a unique experience, I can tell you that I would shower at work with a go-bag of clothing daily and wouldn't be allowed into my house until anything I had brought home was in a hot wash cycle. Some members stayed in hotels or in basements to protect family. Multiple members got sick and as a group it was a constant struggle to maintain available physicians. I personally worked over 100 hours the first major week of the pandemic as we had multiple providers out symptomatic at a time when testing took 5-7 days. I had multiple end-of life discussions via Zoom and phone with families who couldn't be present as their loved one suffered. Every day was filled with despair. Stories of successful recoveries were few and far between. Through it all we maintained our core values as a group and continued to provide emergency care to all comers. I saw some of the most tragic cases during that time as people who needed us avoided the emergency room when they shouldn't have, leading to horrific long-term outcomes.

We survived the nightmare that was the pandemic, but without changes to the NSA, we're not sure how long we can survive as an independent group. Simply put, private commercial carriers are squeezing us in a way that is unsustainable. Unlike other providers, we have no say over who we see or who we get paid from. EMTALA, rightfully, requires we treat everyone who walks through our door without regard to their ability to pay.

We have a longstanding practice of being in-network with all major local carriers, and we have never balance billed. Surprisingly, after the NSA was implemented, our commercial carriers began demanding significantly lower reimbursement rates, even lower than Medicare (70% of Medicare in one example). When we've tried to negotiate,

we've seen carriers unwilling to budge—cutting off negotiations, forcing us to be out of network, and further lowering reimbursements.

The IDR process proven administratively burdensome and cost prohibitive. For example, the amount in dispute is often far less than $350 IDR fee, and it's not uncommon for it to be less than $150 fee recently proposed by the regulators. We cannot justify a $350 fee for the chance of winning $180 dollars in increased revenue. That's further exacerbated when the rules require us to fight an across the board reduction billing code by billing code.

The drastic changes by the carriers can be seen in the attached explanations of benefits (EOBs). These are examples from two different commercial carriers, first in 2021 followed by 2023. They are the same billing code, 99285, as seen in the middle of the left side of the EOBs. The amount our practice billed is the same on all 4 claims, $2,058.00. In other words, we did not increase our fees. In addition, there are no late filing charges or other procedural deductions. Yet both commercial carriers are paying drastically less after the implementation of the NSA. The Aetna claim is about a 20% reduction, while the Cigna claim is a whopping 58% reduction.

About 30% of the visits are patients with commercial insurance, 30% are covered by Medicare, 20% are covered by Medicaid, and 20% are uninsured. There is no way to offset the lower reimbursements we are forced to take from commercial carriers, which is making our business unsustainable.

Something must change, and we believe that starts with recognizing the unique struggles of EDs. EDs are particularly burdened by the NSA because EMTALA requires us to see every patient that walks in the door regardless of insurance coverage. We are at the mercy of the payers at this point because the care has already been provided. We do not have the ability to control our patient and payer mix, and therefore have a much higher percentage of uninsured and Medicaid claims, which reimburse significantly lower than the cost of providing the care—if anything at all. Further, the economics of EDs means what seems like a modest IDR fee for others is not financially viable for us. There must be more incentives to drive carriers to the negotiating table and penalties for those that do not negotiate in good faith if we are going to stabilize the economics of EDs.

Emergency medicine specialists are typically cited as having the highest burnout rates in any medical profession. My group is required to sacrifice sleep, holidays, and weekend family time to be available to our community 24/7. All we ask is the ability to maintain our autonomy and to have the ability to negotiate our life-saving services in a reasonable way. At some point in life, everyone will need our services. If we want to continue having high-quality care in our moments of crisis, we have to provide a sustainable model of compensation to the physicians providing it.

Thank you for your time and consideration.

Sincerely,

Timothy J. Chilcote MD
Vice-President, Kansas Emergency Physicians

October 3, 2023

The Honorable Jason Smith
Chairman
House Committee on Ways & Means
1100 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways & Means
1100 Longworth House Office Building
Washington, D.C. 20515

Re: MGMA Testimony – "Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections" Hearing

Dear Chairman Smith and Ranking Member Neal,

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Committee for holding this important hearing on "Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections" and appreciate the opportunity to provide feedback on this critical topic.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following feedback.

The *No Surprises Act* (NSA) was passed by Congress as part of the *Consolidated Appropriations Act, 2021* and created certain patient protections from surprise medical bills. MGMA and our members applaud Congress for protecting patients' access to necessary care while creating a pathway to ensure physicians and practices receive appropriate payment for out-of-network services. However, since its flawed implementation, certain NSA requirements have increased administrative and financial burden for providers, threatening the financial viability of group practices and access to care.

General Concerns

Since its inception, the independent dispute resolution (IDR) process has placed substantial burdens on medical groups. MGMA continues to hear how high administrative fees, overreliance on the qualifying payment amount (QPA), lack of insurer engagement during the open negotiation process, and the ongoing backlog in IDR cases has created an imbalance in power between the provider and insurer parties. Further, these ongoing challenges have made it nearly impossible for medical groups with fewer resources to even utilize the IDR process, thereby forcing them to accept lower reimbursements. MGMA urges Congress to work with the Administration to rectify these issues and align current implementation rules with congressional intent, which was to create a balanced system that did not largely favor one party over the other.

IDR Backlog

MGMA is aware that there are statutory timelines associated with the IDR process. However, there continues to be a significant backlog in cases, made worse by the fact that the Administration has still not fully reopened the IDR portal for filings of new IDRs, following the recent court decision. The backlog continues to worsen. These delays directly impact a medical group's ability to get reimbursed an appropriate amount for services that, in some cases, happened many months ago. The lack of payment for services rendered, coupled with inflation and ongoing administrative challenges, is simply unsustainable for medical groups and must be addressed immediately.

Communication and Implementation Guidance

From the onset of the NSA, medical groups have struggled to understand and stay abreast of the ever-changing requirements. While MGMA is relieved that recent NSA court decisions have sided in favor of providers, the reality is that the court decisions have largely required the publication of new guidance. Subsequently, medical groups are not given long to decipher this guidance and additional education from the Administration is lacking. MGMA urges Congress to encourage the Administration to engage with medical practices, health plans, and Independent Dispute Resolution Entities (IDRE) to provide education opportunities and resources.

Enforcement of Payments Due

MGMA members report they are not receiving timely payment following IDR process dispute settlements, with most payments being withheld beyond the 30-day reimbursement requirement. Moreover, we continue to hear that insurers who lose an IDR case are shamelessly not paying in accordance with the IDRE's decision. In these situations, does the Administration expect the medical group to take the insurer to court over nonpayment? MGMA urges Congress to shine a light on this predatory behavior — it delegitimizes the entire IDR process and puts medical groups' viability at risk.

Financial Barriers – High Administrative Fees

The current IDRE administrative fees are cost-prohibitive for providers, especially smaller practices with limited resources. Consequently, providers weigh incurring the financial burden of entering the IDR process or losing leverage in the market. Following a recent court case, the Administration recently proposed a new administrative fee, of $150 for 2024. A fee of $150 is still a 3x markup from the 2022 fee of $50. These excessive fees also do not take into consideration the number of claims involved and depending on the service, can act as an additional barrier to accessing the IDR process.

IDR Portal

MGMA urges Congress to work with CMS to continue developing a more robust IDR Portal. Providers are struggling with redundancy and administrative burdens in the IDR dispute submission process. The existing process is equally as administratively challenging for larger practices that may have higher volumes of claims under the federal IDR process and smaller practices that do not have the staff and resources available to invest in manually tracking claims through the IDR process. These updates would be especially impactful for smaller and rural practices that struggle with financial viability.

Conclusion

MGMA thanks the Committee for its leadership on this critical issue. We look forward to working with you and your colleagues to address the ongoing issues associated with NSA implementation. If you have

any questions, please contact Claire Ernst, Director of Government Affairs, at cernst@mgma.org or 202-293-3450.

Regards,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

NAFEC Comments on Ways & Means Committee Hearing on "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

October 3, 2023

Chairman Smith and Ranking Member Neal,

The National Association of Freestanding Emergency Centers (NAFEC) is appreciative that the Ways and Means Committee is providing much needed oversight into the disastrous implementation of the bipartisan No Surprises Act. As you know, the Committee played a critical role in fashioning a balanced approach that protects patients from "surprise medical bills" and also treats health care providers and health plans equitably through carefully crafted criteria for resolving disputes for payment to out-of-network providers.

NAFEC and the entire provider community has been shocked at how insurance companies are using the enactment of the No Surprises Act (NSA) as a pretext to slash provider reimbursement to pennies on the dollar, unreasonably delay payments, and flood the independent review process with easily resolved claims due to terribly inadequate payment. These actions threaten patient access to critical emergency care, causing some facilities to go out of business and putting many more on the brink of economic insolvency. While recent litigation has illuminated the flawed and biased implementation of the statute, it has also created disruptions in payments as the portal for independent dispute resolution has been frozen and FECs and other providers have an indefinite waiting time even if we ultimately prevail in those decisions.

NAFEC welcomed enactment of the NSA and explicitly requested that freestanding emergency centers, licensed by states to provide emergency medical care, be included in the patient protections and recognized for the first time in federal statute. Freestanding emergency centers (FECs) are emergency departments that are fully staffed 24/7 with emergency-trained ER physicians and nurses and have all the capabilities of a hospital-owned ER, including advanced imaging, lab, and pharmacy. FECs are also fully compliant with EMTALA laws. The only difference between FECs and hospital-owned ERs is ownership, not capability. FECs are able to treat patients within minutes and quickly stabilize them, avoiding unnecessary and costly inpatient admissions.

NAFEC's testimony specifically addresses:

- Payers' abuse of the independent dispute resolution (IDR) process to underpay emergency providers by offering preposterously low initial payments and qualifying payment amounts (QPAs).

- The lack of enforcement around payment timelines for payers processing and paying out reward amounts to providers after an IDR entity (IDRE) determination is made. Similarly, there is also no enforcement around IDRE fee refund timelines for the prevailing party.
- The egregious violation of a key patient protection provision in the NSA by reprocessing bills to include the IDR award amount for the provider after losing the IDR process, thus increasing the out-of-pocket (OOP) amount the *patient* owes.
- The inability of providers to effectively and efficiently batch claims due to strict requirements, thus contributing to the backlog of the IDR process.
- The urgent need for CMS to issue new rulemaking to fix the problems identified in the TMA lawsuits as well as the suggestions and issues made and identified in the Ways & Means hearing.
- The immediate need for the IDR portal to be reopened so that claims can continue to be adjudicated so that providers can continue to seek adequate payment.

Low Initial Payment Offers and Inaccurate Qualifying Payment Amounts (QPAs)

A fundamental problem with the implementation of the NSA is the flagrant abuse of the independent dispute resolution (IDR) process by payers, who are significantly undercutting freestanding emergency centers by offering absurdly low initial payments and QPAs, which do not reflect historical payments or our costs. These low initial payments from payers for the life-saving emergency care force providers to enter the long, drawn-out IDR process in order to attempt to recoup more adequate payment for critical care that has already been rendered to patients. These initial payments, as well as the QPAs that are also offered during the IDR process, are not representative of historical and customary payments made for services provided to insurers' enrollees, and are often well below the Medicare rate, which was explicitly abandoned by Congress in the development of the law for being too low and unreflective of commercial market rates. Additionally, CMS defied Congressional intent by prioritizing the QPA offered by payers as the main factor in IDR determination, rather than considered all of the factors that Congress had listed out in the law for equal consideration. CMS appears to have intentionally stacked the deck in favor of insurers, a point that has been validated by the courts in the various Texas Medical Association lawsuits on the implementation of the NSA[1,2,3,4].

During the rulemaking process, CMS implied that the administrative costs associated with an open negotiation period and the IDR process would deter plans from offering low rates that providers are unlikely to accept. Unfortunately, this assumption is far from reality as providers were forced to initiate 334,828 disputes through the IDR process between April 15, 2022 and

[1] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:21-cv-00425 (E.D. Tex. October 28, 2021) – TMA I
[2] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:21-cv-00425 (E.D. Tex. September 21, 2022) – TMA II
[3] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:22-cv-00450-JDK (E.D. Tex. November 30, 2022) – TMA III
[4] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:23-cv-00059-JDK (E.D. Tex. January 30, 2023) – TMA IV

March 31, 2023.[5] Yet, rather than address the root cause of these appeals to arbitration – inadequate payment, CMS massively (and illegally) hiked the administrative fees by 700 percent in order to deter providers from appealing thousands of lower dollar claims. It is evident that plans are not incentivized to offer adequate and appropriate initial payment amounts and are abusing the IDR process to delay fair and full payment to providers, which forces them into a financially untenable position and threatens their ability to provide vital emergency care.

Congress should compel CMS to revise the IDR process so that IDREs are considering all of the factors delineated in the statute, and not simply picking the offer that is closest to the QPA, which is typically not an accurate calculation to begin with. The courts ruled in the TMA II that preferring one of the six criteria is a clear violation of the statute and congressional intent.[6] Though CMS has since revised its rules around consideration of the QPA following its loss, the language still heavily favor the QPA factor and need further revising. CMS should require payers to offer the QPA as a **minimum** for the initial payment, then the IDREs can adjust final determinations based on other factors and information presented during the IDR process. However, to use the QPA as a starting point in provider reimbursement, CMS must ensure that the QPAs being used are accurate and that the data going into the calculation of the QPAs are applicable to the service and specific provider type being considered.

Payers have been artificially deflating QPA rates by forcing in-network providers to accept rate cuts in order to stay in-network and incorporating non-negotiated contracted rates (or "ghost rates") into QPA calculations. CMS must conduct transparent audits of payers' QPA calculations to ensure that they are appropriate to be used for reimbursing emergency care and penalties should be applied if payers continue to underpay providers.

We have recently learned that payers are arbitrarily downcoding certain E/M codes, apparently by using artificial intelligence (AI) claim analyzers. Typically, FECs determine coding and acuity levels through CPT guidelines for the professional side and the hospital guidelines for the facility side. However, these AI analyzers utilized by plans are downcoding thousands of claims, and in many cases several levels below the appropriate level. This is another example of payers changing the rules as they go and finding new ways to effectively underpay providers, which forces many more claims through the IDR process.

Payment and Fee Refund Delays and Lack of Enforcement

Not only have payers capitalized on the lack of enforcement around QPAs and initial payment offers, but they also fail to abide by the 30-day timeline for final payments following the IDRE determinations. When an IDRE rules in favor of a provider, the payer has 30 calendar days to promptly pay the provider the amount owed. However, more than two years since NSA was

[5] Centers for Medicare and Medicaid Services. "Federal Independent Dispute Resolution Process – Status Update," April 27, 202. https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf
[6] [6] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:21-cv-00425 (E.D. Tex. September 21, 2022) – TMA II

enacted, CMS has yet to release regulations spelling out compliance and enforcement. As such, payers face no financial consequences for delaying (in some cases indefinitely) owed payments to providers. Providers carry the burden of initiating the IDR disputes on claims paid unfairly by payers and must provide detailed evidence supporting their case. In order for these claims to be considered for the IDR process, providers must file an open negotiation within 30 days of the EOB, file a dispute within 4 days of the expiration date, pay the invoice dispute, and submit an offer by the 10-day expiration date, with no extensions being granted unless there is an extenuating circumstance. If providers do not strictly follow all of these deadlines and requirements, then their case is rejected as ineligible for the process with no ability to appeal the decision. Meanwhile, payers have no financial pressure or incentive whatsoever to promptly pay claims owed to providers after the IDRE determination, as required by law and as instructed by the IDREs. Payers utilize the lack of enforcement around payment deadlines to delay payments in an attempt to further defund providers who refuse to accept their low reimbursement rates.

There must be an enforced standardization around IDRE determination payouts or the viability of many providers across the country – and the patients that depend on them for their emergency care -- will be further put at risk, which certainly appears to be the intention of payers who delay these required payouts. NAFEC recommends that CMS and the Departments use Texas' Prompt Payment law as a model for establishing payment deadlines and penalties to ensure prompt payment claims to providers throughout the IDR process. Under this law, health plans are required to pay, deny, or audit claims within 30-45 days (based on if it is an electric or paper claim) and cannot delay a claim without payment in this timeframe. For claims that are not correctly paid on time, a penalty is issued based on how late the claim is paid and the difference between the amount that the provider bills and the amount that is agreed upon by provider and payer for the service.[7,8] It is worth noting that nearly every state has laws in place around timelines and penalties for health claim payments, so it is puzzling why the Federal government has yet to implement a similar enforcement mechanism.[9] It is vital that CMS implement enforcement policies that ensure providers remain economically viable as they win IDR disputes and ensuring payment deadlines are adhered to by insurance companies is critical. Congress can compel such enforcement by withholding funding from the Department of Health and Human Services and Department of Labor for failure to enforce statutory deadlines prescribed by Congress in the NSA.

Similarly, there are major delays in IDRE fee refunds for the prevailing party in an IDRE determination, despite the 30-business day timeline laid out in regulation. CMS' March 2023 Federal IDR Process Guidance for Disputing Parties states that "*[t]he certified IDR entity fee that was paid by the prevailing party will be returned to the prevailing party by the certified IDR*

[7] Texas Department of Insurance. Prompt Pay FAQ
[8] Texas Medical Association. Summary of SB 418 Prompt Pay Legislation
[9] Anesthesia Business Consults. A Survey of State Prompt Pay Laws, Part I. Fall 2012

entity within 30 business days of the certified IDR entity's determination."[10] However, this has not been the case as members have reported major delays in getting these fees refunded.

While we understand that the IDREs have been overwhelmed by the number of cases, it is important that these fees are refunded during the appropriate timeframe, as they are often a lifeline for providers who continue to be underpaid by insurers for their services. While the major payers, who have million to billion dollar margins to operate under, are able to withstand these cashflow delays, providers face increasing personnel and overhead costs and are in a less stable financial position. We implore CMS to address these delays and ensure that IDREs are issuing timely and accurate fee refunds to the prevailing parties.

Patient Protection Violations

Payers have been egregiously violating patient protections that were explicitly built into the NSA and subsequent regulations, resulting in illegal and excessive patient out-of-pocket liability. Major payers have been improperly reprocessing claims after the IDRE determination to apply a higher patient OOP copayment by incorporating the reward amount that is owed to the provider by the payer. This occurs after the patient has already received their OOP bill and explanation of benefits for the original bill. Payers are carrying out this practice of intentionally harming patients fully knowing that they are in violation of the law, as explained in CMS' March 2023 IDR guidance for Disputing Parties where it is noted that "*[t]his determination of the OON rate does not change the participant's, beneficiary's, or enrollee's cost sharing, which is based on the recognized amount, or, in the case of air ambulance services, the lower of the QPA or billed charges."*[11]

This practice by payers is not only harmful to patients, who are once again being put into the middle of patient/provider surprise billing disputes (the entire reason for the NSA law in the first place) but is also a thinly veiled attempt to further drag out the IDR process by further delaying payments owed to providers. When payers attempt to reprocess claims to include the reward amounts in patient OOP expenses, providers are forced to file an appeal to reverse the insurance processing error, which is time consuming and further delays the claim from being paid out properly. This new payer tactic is simply another malicious tool in their toolbelt they can use to further encumber providers and the IDR process, as we once again point out that there is no enforcement of payment, or any penalties for payers after a final payment determination is made and the claim is not processed correctly.

To protect patients from further harm and increased OOP expenses, Congress must ensure that CMS take action to ensure that payers are not passing IDRE determination payments for providers onto patients. We recommend CMS issue a warning to payers and if the practice

[10] Centers for Medicare and Medicaid Services. Federal Independent Dispute Resolution Process Guidance for Disputing Parties. March 2023. Page 28
[11] Centers for Medicare and Medicaid Services. Federal Independent Dispute Resolution Process Guidance for Disputing Parties. March 2023. Page 27

continues, CMS must issue penalties or some type of enforcement mechanism to ensure providers are not solely responsible for correcting these intentional billing inaccuracies.

Inability to Effectively Batch Claims

Lastly, we want to draw attention to the challenges around batching claims, which puts a huge burden on providers and makes the IDR process incredibly tedious and more overrun with claims. We highlighted the restrictive timelines that providers are expected to comply with if they want to submit a claim to the IDR process, and that timeline is even more challenging when having to go through thousands of claims to figure out which ones could be batched together. Batched claims require a strict criterion which forces providers to comb through the thousands of underpaid claims they receive from payers and figure out which ones are from the same insurer, have the same codes, and are within three days of each other. Once again, the burden is placed on the provider to do all this work while also meeting the tight deadlines allowed to meet IDR eligibility.

The restrictive batching rules were also part of the TMA IV lawsuit, and after losing the case CMS has been forced to vacate the batching rules until they can go through the required rulemaking process.[12] As CMS goes through this rule process, it would be prudent to modify the batching criteria so that it more closely aligns with how providers and insurers perform their billing, such as codes typically associated with specific episodes of care. If there was a more efficient way to effectively batch claims, then the IDREs could efficiently review more claims at one time. This would also reduce the number of administrative and IDRE fees that providers have to pay, which has been a barrier to entering the IDR process, particularly for smaller providers.

New NSA Rulemaking Needed Immediately

It is imperative for the health care system that CMS issue new rulemaking addressing the problems identified related to the IDR process. Providers and their practices are not able to subsist on the grossly undervalued reimbursement they are offered by payers for their services, and therefore patient access to care continues to be put in jeopardy. The TMA lawsuits and the Ways & Means hearing have identified the many flaws in CMS' implementation of the NSA, and pressure should be placed on the Administration to revise and rectify these rules as quickly as possible so they work as intended.

Reopen and Keep Open the IDR Portal After Litigation

We object to CMS's frequent shutdowns of the IDR process that follow successful litigation from the Texas Medical Association (TMA). As you know, this litigation takes months to go through the legal process before reaching a ruling, leaving plenty of time for CMS and the Departments

[12] Tex. Med. Ass'n, v. U. S. Dep't of Health and Human Servs., Case No. 6:23-cv-00059-JDK (E.D. Tex. January 30, 2023) – TMA IV

to plan and prepare for their outcome. Yet, CMS has repeatedly shut down the IDR portal for long intervals, paralyzing the dispute resolution process for weeks or even months. It is inexcusable that CMS is closing the portal for IDR claims, which means providers are being punished by not being allowed to submit claims that they have been flagrantly underpaid. FECs and other providers who must continue to provide care to patients and pay their staff and vendors are put in an impossible situation.

Additionally, since the portal has been shut down for months, providers will have to pay hundreds of thousands of dollars in upfront fees for IDRE review for the claims held from the time of the freeze, which is especially burdensome on small providers who are already suffering cash flow issues due to the underpayments from insurers. The expense may be so significant as being prohibitive for many small providers. As an example, one FEC estimates that it will have to pay nearly a million dollars in up from administrative and IDRE fees when the portal begins accepting new claims again. That will be followed by months-long process to recoup these fees. It is evident that only the insurance industry benefits when the CMS portal is suspended. CMS should reopen the IDR portal without further delay and increase staffing of the entire IDR process so that these claims can be properly and promptly processed. CMS should also extend the timeline for IDR claims that are submitted from the time of the freeze to give providers ample amount of time and resources to file. This will also allow providers to spread the amount of upfront fees over time, possibly waiting until some of their claims are processed so they have cashflow coming in and out over an adequate amount of time.

Conclusion

NAFEC would like to once again thank the Committee for its attention on this important issue. CMS' handling of NSA implementation has been frustrating and devastating for providers and continues to threaten patient access to care. Providers are being driven out of business due to bureaucratic incompetence and malicious practices by payers. As concern over health care consolidation continues to grow, particularly in the provider space, we implore Congress and CMS to ensure policies are implemented to support small, independent providers and work to reverse these consolidation trends. We look forward to working with the Committee and the rest of Congress to implement meaningful change to ensure the NSA is being properly executed in a way that helps patients, rather than harms them.

Statement for the Record by the American Heart Association

Submitted to: Committee on Ways and Means, United States House of Representatives

RE: "Reduced Care for Patients: Fallout from Flawed Implementation of the Surprise Medical Billing Protections"

On behalf of the American Heart Association (AHA) and its more than 40 million volunteers and supporters, we thank you for the opportunity to submit comments on the implementation of the No Surprises Act (NSA).

The No Surprises Act of 2020 marked a major step forward in protecting patients from medical debt by curbing surprise medical billing, a practice in our health care system that imposed unnecessary, excessive costs on patients. The law passed with bipartisan support and represented the strongest protections for patients since the Affordable Care Act. The AHA led years of national advocacy to pass the NSA and continues to urge the White House and Congress to ensure meaningful enforcement of the law.

Prior to the implementation of the NSA, it was estimated that 1 in 5 emergency claims and 1 in 6 in-network hospitalizations included unexpected medical charges from out-of-network providers.[1] Cardiovascular patients were particularly susceptible to these bills because of the unexpected and urgent nature of the event and the care. Cardiovascular patients rely on emergency transportation, including air ambulances, to ensure they receive the care they need as fast as possible. Without the NSA, patients were routinely billed as much as $30,000 per air ambulance ride, an unaffordable cost especially when patients don't have a choice over how they're transported in emergency situations.[2]

Surprise medical bills ultimately drove up premiums for millions of people by adding more than $40 billion in additional spending each year for those with employer-sponsored insurance.[3] [4] Surprise medical bills can also cause patients to take on significant medical debt, joining the estimated 100 million people in the United States in debt due to medical and dental bills.[5] Medical debt can be overwhelming, causing patients and their families to make impossible decisions to balance paying for basic household needs while managing debt and continuing health care. It can also affect a patient's ability to obtain medical care.[6] The NSA has protected patients across the country from most surprise medical bills and

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[1] *Surprise Medical Bills: New Protections for Consumers Take Effect in 2022.* KFF, 4 Feb. 2021, www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/.

[2] *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk.* Government Accountability Office, March 2019. khttps://www.gao.gov/assets/gao-19-292.pdf

[3] *In Pursuit of Profit, Private Equity Expanded into Health Care. The Results Raise Concerns about Cost and Quality.* Arnold Ventures, 7 Sept. 2020, www.arnoldventures.org/stories/part-1-in-pursuit-of-profit-private-equity-expanded-into-health-care-the-results-raise-concerns-about-cost-and-quality.

[4] Cooper, Zack, et al. *Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians.* Health Affairs, 16 Dec. 2019, https://doi.org/10.1377/hlthaff.2019.00507.

[5] Levey, Noam N. *100 Million People in America Are Saddled with Health Care Debt.* KFF Health News, 16 June 2022, www.kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/.

[6] Lopes, Lunna, et al. *Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills.* KFF, 16 June 2022, www.kff.org/report-section/kff-health-care-debt-survey-main-findings/.

their consequences. In the first nine months of 2022, the law prevented an estimated 9 million surprise bills.[7]

The No Surprises Act is an important law that protects patients from the harmful practice of surprise medical billing. When patients are faced with a medical emergency, their only focus should be on the immediate care they need – not the network status of their specialist or the laboratory running medically necessary tests. The American Heart Association looks forward to continuing to work with Congress and the implementing agencies to preserve and strengthen the No Suprises Act and ensure patients continue to be protected from surprise medical bills. If you have any additional questions, please do not hesitate to contact Emily Holubowich, National Senior Vice President of Federal Affairs, at emily.holubowich@heart.org or at (202) 785-7912.

[7] *No Surprises Act Prevents More than 9 Million Surprise Bills Since January 2022.* AHIP and the Blue Cross Blue Shield Association, November 2022. https://www.ahip.org/resources/no-surprises-act-prevents-more-than-9-million-surprise-bills-since-january-2022

October 2, 2023

The Honorable Jason Smith
Chairman
House Committee on Ways & Means
Subcommittee on Health
1139 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways & Means
Subcommittee on Health
1139 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Neal:

On behalf of our physicians, other clinical providers, patients, and the communities that we serve, Pediatrix Medical Group ("Pediatrix") thanks you for holding the hearing entitled: *"Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"* on September 19, 2023. Pediatrix, like most healthcare providers, has struggled with the Administration's implementation of this well-intentioned law, and we share many of the concerns raised by the witnesses at the hearing. We specifically wish to highlight one of our major concerns related to the implementation of the *No Surprises Act* (the "Act") and present solutions to help address this issue.

Pediatrix is a national, physician-led health care organization that partners with hospitals, health systems and health care facilities to offer clinical services spanning the women's and children's continuum of care. Our affiliated physicians and advanced practitioners are reshaping the delivery of care within their specialties and subspecialties, using evidence-based tools, continuous quality initiatives, clinical research, and telehealth programs to enhance patient outcomes and provide high-quality, cost-effective care. Pediatrix, through its affiliated professional entities, provides services through a network of more than 5,000 affiliated physicians and other clinicians in 37 states and territories. Pediatrix-affiliated neonatologists provide professional medical services in neonatal intensive care units ("NICU") across the country and collaborate with affiliated maternal-fetal medicine, pediatric cardiology, pediatric critical care, and other pediatric subspecialists. Pediatrix is also the nation's largest provider of newborn hearing screens.

We have been and remain strongly supportive of the underlying tenets of the Act and its overall goal of protecting patients from surprise billing and keeping patients out of billing disputes. Additionally, our goal is to be in network with all health insurers and we continuously work towards this preferred outcome. However, the implementation of the Act has resulted in many unintended consequences, including contract terminations and payment rates that are a fraction of historical market rates, that challenge the ability of our physicians and our other clinical providers to care for our patients.

One of our major concerns is with the methodology that is currently used to calculate the qualifying payment amount (the "QPA"). The current methodology utilized by payors has directly led to unreliable QPAs that do not reflect market rates, which is contrary to what was intended by Congress. For example, although mandated by law, payors are not required to calculate the median

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contracted rate for each specialty that provides a service. Instead, payors have unreasonably broad discretion to define specialties for purposes of calculating QPAs, which has enabled payors to include "ghost rates" in the QPA calculations. Under this practice, payors include rates for certain specialty services in the contracts of other unrelated specialists who rarely or never bill for the service. Providers have little incentive to negotiate a rate for services that they do not provide. For instance, an office-based pediatrician providing primary care has little incentive to negotiate fair, market-based rates in a fee schedule for the codes utilized by neonatologists if they do not (and cannot) provide those services. Yet, a pediatrician's health plan contract will often include non-negotiated neonatology codes as part of the template agreement. Pediatricians may accept much lower rates – even zero – for codes that they do not use in exchange for higher rates for codes that they use frequently. Such ghost rates are lower (or even zero) than they would be if providers had an incentive to meaningfully negotiate them. Including such ghost rates in the QPA calculation is designed to and actually does lower neonatology rates. Using ghost rates allows payors to take advantage of and manipulate the QPAs to their financial advantage, and arbitrarily lower rates to a fraction of historical market rates.

Fortunately, the US District Court for the Eastern District of Texas opined in the Texas Medical Association (TMA) III Court decision that the inclusion of ghost rates in the QPA conflicted with the Act and explicitly prohibited this practice. However, even though the ghost rate policy has been rescinded, we nevertheless believe that additional clarification and guidance is needed to ensure that QPAs are fairly calculated. Specifically, the requirement to calculate QPAs for a service delivered by a provider in the *same or similar specialty* must be modified to be based upon the **highest degree of specialization.**

In the specific example of neonatology, QPAs for neonatology should be calculated separately and distinctly from all other specialties, including pediatrics. Neonatologists have skills that general pediatricians do not; they perform advanced procedures and furnish services to severely premature and/or critically ill neonates that general pediatricians are not sufficiently skilled to provide. Certain billing codes are also exclusively used by neonatologists. As described above, neonatologists are being combined together with general pediatricians under a single specialty of pediatrics for payment purposes. This practice distorts the QPA paid to neonatologists when it is coupled with contract rates for neonatology services that are never actually negotiated or received by general pediatricians.

Therefore, we strongly urge the Departments of Health and Human Services, Labor, and Treasury (the Departments) to instruct payors to differentiate among specialties, like neonatology, where the vast majority of services furnished for this patient population are rendered nearly exclusively by practicing members of that specialty, specifically, neonatologists. Further, to ensure that the QPAs are being calculated accurately, the Departments should consider granting certified IDR entities the authority to collect data needed to verify that the QPA is based on the most appropriate specialty. While we believe these policy changes can be made through rulemaking, we also ask you to consider enacting legislation that would require QPAs to be calculated in this manner.

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We must adopt policies that will address the problematic QPA methodology. Payors have been able to leverage the low QPAs as a way to drive down rates for existing in-network contracts or force providers out-of-network altogether. In practice, payors have threatened to, or actually terminated contracts in order to exert significant pressure on providers to accept lower rates. Providers are left with little recourse – accept significantly lower rates or go out-of-network.

This practice of terminating longstanding contracts and slashing reimbursement rates threatens access to care, particularly for patients in rural and underserved areas. In an out-of-network situation, patients are often forced to seek care outside of their immediate vicinity and to travel significant distances to find an in-network provider. As a result, there is a discrepancy in maternal health outcomes in rural versus urban areas. This has been well-documented, and this will only exacerbate this troubling trend[1]. Forcing neonatologists out-of-network not only impacts hospital-based patients like NICU babies, but also office-based patients because many managed care contracts include both hospital-based care and office-based care. For maternal fetal medicine, obstetrics and many other office-based specialties, a change in network status of a provider is extremely disruptive for patients and their families. This can have devastating consequences for pregnant women and potentially jeopardize health outcomes, as well as exacerbate provider shortages, placing unnecessary burdens on an already challenged system. Additionally, the loss of these ambulatory specialists can also affect network adequacy.

In all, the ability for health plans to exploit the Act as a means to arbitrarily drive down payment rates and drive providers out-of-network impacts patients across the health care continuum. Future rulemaking, guidance, and perhaps legislation should incentivize payors and providers to be in-network. It is the right thing for everyone, especially patients. Further, ensuring that QPAs are reflective of market rates for each specialty, using the highest degree of specialization, will help encourage in-network agreements and protect access to care for patients.

****

We thank you for the opportunity to share our comments. If you have any questions or would like to discuss any of these comments further, please do not hesitate to contact Barclay Gang, Vice President Government Affairs, Pediatrix Medical Group.

Sincerely,

James D. Swift, M.D.
Chief Executive Officer
Pediatrix Medical Group

[1] Rural-Urban Differences in Severe Maternal Morbidity And Mortality In The US, 2007–15. Katy Backes Kozhimannil, Julia D. Interrante, Carrie Henning-Smith, and Lindsay K. Admon. Health Affairs 2019 38:12, 2077-2085.

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October 3, 2023

Chairman Jason Smith
House Ways & Means Committee
1139 Longworth HOB
Washington D.C. 20515

Re: Hearing on Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections

Dear Chairman Smith,

Thank you for allowing us to offer our thoughts on this critical issue.

Pipeline Health, known as "Pipeline," owns and operates four safety net hospitals in the Los Angeles area and one in Dallas which provided care for 118,773 emergency department visits in 2022. Pipeline's patient population in Los Angeles is 60% Medicaid, 30% Medicare, and just 10% commercial/charity care. As a result, any fluctuations in Medicare or Medicaid funding have a dramatic impact on Pipeline's patients and our hospitals' ability to serve them. Additionally, Pipeline's lack of elective surgeries, which are critical to other hospitals, provides the system with narrow margins.

Those in at-risk populations residing in the low-income communities Pipeline serves often have limited access to care. Without Pipeline, many would have no access at all to acute healthcare. This makes Pipeline essential to the provision of medical care in its service areas. Its failure is not an option.

Despite its critical role, Pipeline was forced to file for Chapter 11 bankruptcy in 2022 due to the significant, industry-wide financial challenges facing hospitals, including skyrocketing labor and supply costs, decreased ability to generate revenue, and delayed payments from various insurance plans for critical patient care services already delivered. Though Pipeline emerged from bankruptcy earlier this year, payors' increasingly low payments and onerous claims processing requirements, some of which are the unintended consequences of the NSA, WILL continue to threaten Pipeline's survival and ability to care for its patients.

Unintended Consequences of *No Surprises Act* Implementation

For the hospital-based physician groups in our communities, we're seeing a pattern unfold:

A. The group revenue is declining sharply without remedy.
B. The group issues notice of term to hospital with a demand of hospital to cover the shortfall.
C. The hospital must pay the higher dollar amount for same level of service.
D. If the hospital cannot pay the higher dollars amount, then service to patients declines thru reductions in staffing.

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E. When service to patients declines in our catchment area, care ceases to occur, as there is simply no other place for care to be provided.

Pipeline is in support of the spirit of the *No Surprises Act* but urges Congress to ensure that CMS expeditiously oversees and reviews the out of network payment methodologies and polices payor practices. Though Pipeline does not balance bill, the *No Surprises Act*'s unintended consequences have hurt Pipeline's ability to provide care. Pipeline hospitals have seen the impact of the NSA through millions more in subsidies to hospital based physician groups and specialists. In the year and a half since the *No Surprises Act* was implemented, we have seen a dreadful trend of hospital based physician groups declaring bankruptcy, citing the NSA as a significant cause. Envision is one, and American Physician Partners is another (see Bloomberg report from July 18). It is believed that other groups will follow. Bankruptcies such as these put tremendous strain on the entire acute care system and will lead to less accessible care for inner city and rural families as well as higher costs as hospitals cover the shortfalls of failing provider groups.

We have also seen increased emergency department wait times, increased difficulty getting specialists to come to our hospitals to provide care to patients, and worst of all, physicians moving from our hospitals to those that pay providers more. In other words, physicians are leaving our lower socioeconomic communities and going "uptown" where the payor mix is better and reimbursement higher. Additionally, Gamesmanship by payors is rampant and is likely a factor in the enormous and record profits managed care payors received in 2023 as noted by many healthcare journals.

The NSA hasn't reduced the cost of care, enhanced quality of care, or improved access to care. In our inner city/urban Pipeline hospitals, it has done the exact opposite. And we are representative of 30% of all hospitals in the United States.

We hope to amend the legislation to accommodate providers when needed. Our goal is either for the QPA to be based on the historic median out-of-network payment rates or that like the California law (AB 72), Congress will carve out emergency room doctors from the No Surprises Act. Below we propose certain steps Congress could take to monitor and respond to ways in which the NSA and certain related payor practices are negatively impacting Pipeline and other providers.

Recommended Changes

#1 Base the Qualifying Payment Amount on the Historic Median Out-of-Network Payment Rates
We remain concerned that the NSA places a thumb on the scale of paying out-of-network providers at the QPA generally, and that IDR entities may place outsized weight on the QPA to the exclusion of other important factors.

The QPA generally approximates the median in-network payment rate, and its use as a "default" out-of-network payment rate may be devastating to providers over time. The median in-network rate makes little sense as the primary benchmark for out-of-network care. Using in-network rates as the basis for out-of-network reimbursement cuts against both industry expectations and the economics underpinning

network contract negotiations. We encourage Congress to amend the *No Surprises Act* so that the qualifying payment amount is changed to the median out-of-network historical rates.

#2 Carve Out for Emergency Room Doctors

An alternative to the above solution is, as California rightly did with its surprise billing legislation, AB 72, and as Congress did with front line ground ambulance services, is to carve out emergency physician providers from the NSA. Already, the law requires that insurers cover emergency services at the same price regardless of the hospital being in-network or out-of-network. Emergency physician providers should be carved out from no balance billing and the National NSA.

#3 Monitor and Address Potentially Abusive Claims Practices

In Pipeline's experience, the length of time payors take to process and pay claims, and the number of claims payors initially deny has increased significantly since implementation of the NSA, despite the fact that Pipeline's claims submission practices have remained largely unchanged. Under the NSA, payors generally have 30 calendar days from transmittal of a bill to send an initial payment or notice of denial to a non-participating provider. However, the 30-day clock does not start until the payor "receives the information necessary" to decide the claim. Pipeline has noticed a significant increase in the number of claims for which payors argue they lack necessary information. These delays significantly drive up the administrative costs associated with each and every claim submitted. Particularly with respect to emergency room claims, which may result in relatively low reimbursement, Pipeline's administrative costs in chasing payment may actually exceed the payment itself. Pipeline has experienced similar problems with payors unilaterally downcoding claims. Congress should request additional information from the health care provider community regarding the extent to which other hospitals and providers have faced similar claims practices that inappropriately delay or deny payment.

#4 Improve Upon the Existing IDR Process and Clarify Interaction with ERISA and State Law

We urge Congress to amend the NSA to:

A. Permit providers to attest, through a series of questions added to the portal's submission process, as to whether the health plan or issuer has complied with its obligations under the NSA to provide information (upon initial payment or denial and/or upon the provider's request);
B. Enable the IDR entity to establish a rebuttable presumption in favor of the provider in the dispute or, in appropriate circumstances, a default determination where the health plan or issuer has failed to provide this information as required by the NSA;
C. Ensure that CMS issues guidance to clarify that the exhaustion of administrative remedies under ERISA is not a prerequisite for providers that seek to initiate the federal IDR process;
D. Ensure that CMS issues guidance to clarify that the NSA is not the exclusive remedy between a provider/facility and plan/coverage in those states with established case law under which out-of-network payment disputes may be resolved, provided such remedies are available under existing law (i.e., case law) and the patient responsibility remains limited to the cost sharing amount permitted by the NSA; and

E. Require specialty-specific calculations in determining the QPA.

We remain available to provide any additional information that may be of help as Congress engages in further conversations in its attempts to rectify implementation of the *No Surprises Act*.

Once again, we very much appreciate your consideration and look forward to discussing with you further. Please do not hesitate to contact us with any questions.

Very truly yours,

[redacted]

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www.pipelinehealth.us

October 2, 2023

The Honorable Jason Smith, Chairman
The Honorable Richard E. Neal, Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith, Ranking Member Neal and Members of the Committee on Ways and Means,

On behalf of Radiology Partners (RP), we are pleased to offer these comments to the Committee on Ways and Means on its *Hearing on Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections*, regarding the implementation of the federal *No Surprises Act* (NSA).

RP, through its owned and affiliated practices, is a preeminent radiology practice in the U.S., serving hospitals and other healthcare facilities across the nation. We are a recognized clinical leader with distinguished artificial intelligence capabilities and broad telerad platform that empowers our Practice to transform radiology by delivering differentiated clinical care, including to the most rural parts of the country.

Our Practice strongly supports the patient protections established in the NSA. Protecting patients from surprise medical bills is patient-centric and patient-protective. Our Practice is committed to these values. As the Committee is aware, in addition to ending surprise medical billing (SMB), laws addressing SMB can disrupt good-faith contract negotiations that take place between medical providers (practices and hospitals) and insurance companies. The NSA was painstakingly and thoughtfully crafted to protect patients from surprise bills while preserving good-faith contract negotiations. As opposed to a rate-setting, benchmark approach, which Congress rejected, the arbitration-based approach in the NSA, supported by the Committee, was designed to protect patients' access to care by preserving good-faith contract negotiations between insurers and providers.

RP, and in our experience most other practices, have a strong preference to be in network with insurers. When in network, practices are paid quicker, more reliably, and in a less costly fashion. When practices cannot be in network, it is preferable to negotiate a reasonable payment with insurers prior to the NSA's Independent Dispute Resolution (IDR) process. Even at its most efficient, IDR is a costly and delayed process. Our requests for IDR reflect a failure of insurers to engage in meaningful efforts to have an in-network contract and resolve payment disputes.

Although the NSA was thoughtfully designed, implementation of the law, through rulemaking, has led to a dysfunctional arbitration process, an increased fraction of out-of-network care, and unacceptable delays in payment, all of which impact patients' access to high-quality medical care.

The fundamental problem is a dysfunctional dispute resolution process that provides a financial incentive for insurance companies to cancel in-network providers' contracts and take advantage of a broken system. As we detail later, delays in the IDR process benefit insurance companies, since insurers have the capital from patients' premiums, and have already invested it and earning interest. As opposed to reimbursing

providers fully and in a timely manner, insurers benefit from pushing practices out of network and underpaying them.

Submitting an underpayment to providers, lower than the market rate, as the initial payment benefits insurers. Here's why:

1. Some providers will not recognize the underpayment promptly and miss the required timeline to file for IDR. In such cases, insurers benefit from underpaying providers, along with the interest they earned from its investment (the delta from the previous in-network rate).
2. For other providers, the economics and timeline of IDR, given the numerous fees and protracted delays, outweigh the benefits and are forced to accept the payors' low initial payment. Thus, when insurers claim, as they did at the Ways and Means hearing, that most of their initial offers are not contested, it does not imply that payors made reasonable payments or that the IDR system is working. Rather, as we can personally attest, for many underpayments it is not feasible to request IDR. In fact, only 20% of our Practice's NSA-eligible charges are able to go through IDR – meaning the other 80% of underpaid charges we are forced to accept.
3. Finally, even when providers file for IDR, insurers can drag out the process. The longer the delay, the greater the benefit to the insurer. The net result is a system that incentivizes insurers to push practices out of network and underpay them.

As a result, the law has increased the volume of out-of-network situations, thereby decreasing access and worsening a problem the law was meant to address. As an example, prior to the NSA, RP was in network with 97% of commercial payors; today we are only 85% in network due to payor cancellations and their unilateral rate decreases forcing contract terminations. In a national survey of provider organizations, 100% of respondents indicated that they had been threatened with contract termination (16 times, on average) and 81% of respondents had at least one contract terminated by an insurer since the implementation of the NSA.[1]

To be clear, it is patients who ultimately face the repercussions of reduced resources that sustain the availability of care – underpayments and delayed payments result in fewer providers being available, longer wait times, and reduced access to critical care services.

In this letter, we outline several ongoing problems with the NSA's implementation, highlighting the direct impacts to patient care. At the conclusion, we also provide detailed suggestions for improvement, including:

- Widen batching criteria: Use of the American Medical Association's CPT code divisions for purposes of batching and improving efficiency of IDR
- Mandate use of RARCs and CARCs: Improve efficiency by making it easy to identify which disputes are eligible for the federal vs state IDR processes
- Create QPA integrity: Mandate reporting of the QPA with the initial payment, along with QPA audits and reporting
- Restart the IDR process and require reasonable initial payment: For example, use of the previously contracted rate for determining initial payment
- Enforce Payment: Mandate enforcement of the payment timelines after a winning determination and adherence to IDR determinations, with penalties for noncompliance

Increasing Out-of-Network Care

While the law was intended to promote in-network contracting, as noted above, we have seen a reduction in in-network care since the NSA took effect. The reduction is a result of actions taken by insurers, which directly impacts patients, who have less access to in network, high-quality medical imaging services. The inaugural Assistant Secretary for Planning and Evaluation (ASPE) report on the NSA, documenting the years prior to NSA implementation, noted that "there was a downward trend in OON [out of network] claims prior to NSA implementation – the prevalence of professional claims that were OON decreased from 6.0 percent to 4.7 percent from 2012 to 2020. In addition, the share of total payments that were OON declined over this period from 9.2 percent in 2012 to 6.8 percent in 2020."[2] Future ASPE reports will likely note that the trend has reversed, with an increased amount of out-of-network providers as a result of the NSA.

As an example, we are aware of a national insurance company, which had an 18-year-long contract with a medical practice, demanding a unilateral rate reduction to a 100% of Medicare reimbursement rate to provide care for their commercial insurance beneficiaries. The provider group's alternative is to go out of network, which many practices are forced to accept.

United Healthcare

10 Cadillac Drive, Ste 200
Brentwood, TN 37027

July 26, 2023

[redacted] TN [redacted]

Re: Participation Agreement for UnitedHealthcare Commercial and Medicare Advantage Benefit Plans

To whom it may concern:

[redacted] is currently contracted under a Medical Group Participation Agreement effective [redacted]. United requires the contract to be updated to compliant paper to remain contracted as a participating clinic. The Commercial Fee Schedule is [redacted] 100% CMS and the Medicare Advantage is [redacted] 100% CMS. Please review and sign the attached agreement.

If you have any questions, feel free to contact myself, Erin Domzalski, at 630-324-9749 and/or email me at erin_domzalski@uhc.com.

Thank you.

Erin Domzalski

Erin Domzalski
Senior Network Contract Manager I East & Middle TN

Access to Independent Dispute Resolution

A core element of the NSA is balanced and fair arbitration via IDR. The NSA was designed to incentivize in-network contracting, and when there is out-of-network care, settle disputes on reimbursement prior to IDR. A key to this approach is access to IDR. Without access to recourse through IDR, insurers are free to underpay providers without fear of consequence.

Radiology as a specialty has had difficulties accessing IDR. The fourth Texas Medical Association (TMA) lawsuit, which the Texas Radiological Society joined, dealt with restricted access to IDR. For radiology, pre-NSA, most charges were paid at less than $50. This means that when the non-refundable IDR administrative fee was $350, batching numerous charges was necessary to make IDR a realistic option for radiology providers. However, the rule limiting batches to a single CPT code meant that our average batch size was slightly under 2 charges. Even a fee of $150 per dispute submission, which was recently proposed in rulemaking, would essentially block Radiology practices from IDR, absent new and meaningful batching opportunities. Insurance companies, aware of this limitation, are incentivized to push practices out of network and underpay providers with low initial payments, knowing there is little chance of radiology practices accessing IDR. We have seen these actions nationally. Since January 1, 2022, approximately 20% of our Practices' charges with NSA remark codes are paid *below* Medicare rates.

Balanced and Fair Independent Dispute Resolution

Congress went to great lengths to establish a balanced and fair arbitration process. The Administration's implementation has been inconsistent with Congressional intent by establishing a Qualifying Payment Amount (QPA) calculation methodology that results in a calculation that does not reflect a true and believable measure of median in-network contracted rates, and then initially prioritizing that QPA above the other factors listed in the NSA for the IDR process. As a result, the TMA filed (and won) a series of lawsuits regarding calculation methodology and integrity (TMA 3) and weighting (TMA 1 and 2) of the QPA.

As noted previously, we regularly receive initial payments, presumably reflecting the QPA, far below commercial market rates, and often at or below Medicare rates. This is not what Congress intended and is inconsistent with CMS's stated understanding of the QPA. CMS previously stated, "the QPA generally will reflect standard market rates arrived at through typical contract negotiations (through arms-length negotiations…"[3] We have made the Administration aware of this ongoing problem.

Further, some certified IDR Entities accept the QPA by default, even when no supporting information is presented by the non-initiating party (insurance company) and the initiating party (provider group) submits complete documentation. By example:

IDR dispute status: Payment Determination Made
IDR reference number: DISP-[redacted]

Medical Evaluators of Texas has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-**[redacted] and has determined that Cigna Healthcare is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Medical Evaluators of Texas has determined that the out-of-network payment amount of **$89.59** offered by Cigna Healthcare is the appropriate out-of-network rate for the item or service 72148 on claim number [redacted] under this dispute.

Medical Evaluators of Texas based this determination on a review of the following:

[redacted] submitted an offer of $349.56

Cigna Healthcare submitted an offer of $89.59

For each of the following determination factors, an "x" in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act)	X	
2	The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided	X	
3	The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual	X	
4	The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service		
5	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
6	[redacted]		

Final Determination Rationale

The initiating party did not provide credible information that would demonstrate a higher out of network rate than what the initiating party has already been paid.

Therefore, the total out-of-network payment amount offered by the non-initiating party under this dispute has been selected as the appropriate out-of-network (OON) rate.

We hope that the new rules issued by the Administration in the wake of the TMA 3 and 4 verdicts are consistent with both the words and spirit of the law passed by Congress.

We also hope that the Administration does not proceed with its appeal of TMA 2 and accepts Congressional intent with respect to the IDR criteria. In their October 4, 2021, letter to Secretaries Becerra, Walsh and Yellen, Committee on Ways and Means Chairman Neal and Ranking Member Brady wrote that "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- that is the express result of substantial negotiation and deliberation among those Committees of jurisdiction, and reflects Congress's intent to design an IDR process that does not become a de facto benchmark."[4]

Timely Payment

Many medical practices are small business, and sufficient cash flow is necessary to remain solvent. While insurers delay reimbursing providers for items and services already provided to their beneficiaries, practices must continue to pay rent, equipment costs, and salaries for their care teams. Insurers are leveraging delays in the IDR process to extract rate reductions from practices. Practices are forced to weigh the lesser of two evils: accept an unsustainable rate reduction or be forced out of network and not receive full payment for services rendered in a reasonable time period.

Before the NSA, for our Practice, it took 45-60 days to appeal and receive payment from payors for out-of-network services. Even before the August 2023 pause in IDR, it was taking over eight months to receive an IDR ruling. Then, after waiting over eight months for a ruling, many insurance companies are not making their required payments correctly and/or within the required timeframe. Our average delay is approximately three months after the IDR determination, instead of the required 30 calendar days. This tracks with a national survey which demonstrated that 52% of the time payors were not making any payment after an IDR determination, and when they were, it was frequently both late and in an incorrect amount.[5] Our expectation is that the new rules issued by the Administration will clearly address late and incorrect payments after IDR determinations.

Service Level Impacts

As a preeminent radiology practice, we frequently receive calls from hospitals and health systems requesting imaging assistance. Specifically, local radiology practices are reducing service levels and/or terminating contracts with hospitals as a result of reimbursement challenges from insurers. Many of these practices go to the hospital after receiving a rate reduction notice from an insurer. If the hospital is unable to make up the difference necessary for the radiology practice to continue operating in the market, the hospital may lose services. As the Committee knows, there is a physician shortage, including for medical specialists.[6] This means that less well-resourced facilities, including those in rural and underserved communities, are more likely to be impacted since the hospital is less able to make up for insurers' reductions in reimbursement.

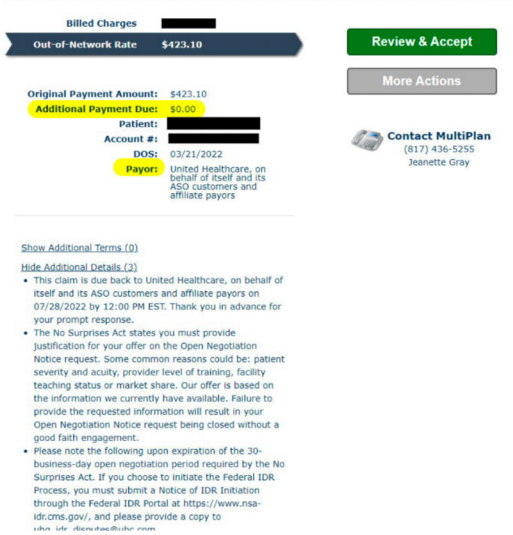
This impacts patients. As an example, we are aware of a medical group in Georgia that is evaluating reducing services or terminating contracts at 10 facilities, mostly rural. We spoke with a hospital administrator in rural Arizona who is concerned about their patients since the nearest hospital is 1.5 hours

away. He explained that insurance companies are shifting their expenses on to his rural hospital. We are also aware of a hospital emergency department in Texas with imaging turnaround times of over 24 hours. This means that physicians treating patients in their emergency department must make care decisions without the benefit of medical imaging.

Delays related to suspension of IDR

Following the August 3, 2023, decision by the U.S. District Court for the Eastern District of Texas in the lawsuit brought by the Texas Medical Association, IDR for any new disputes has been "temporarily suspended." This delay in new submissions, which is now over 50-plus days, is exacerbating an already unsustainable situation. Prior to the delay, for ruled batches, it took over 10 months to get through the IDR process, and even longer to receive payment. And this does not include the fact that nearly two-thirds of our submitted disputes have yet to receive a ruling; they are caught in the ever-growing backlog. Every day the IDR process is closed adds to this delay in providers receiving often essential payment for continued operations.

It is worth emphasizing that delays in the IDR process benefit the insurers, at the expense of patients, their communities, and the providers serving them. Insurance companies continue to collect and invest the premiums from beneficiaries. The longer the delay, the more these companies benefit from the profits of those investments. This time-based benefit also explains insurers' motives in pushing providers out of their networks and dragging their feet in IDR. For example, insurers frequently do not meaningfully engage in the mandated Open Negotiation prior to IDR, thus extending the process. When they do engage, they frequently offer insignificant or no additional reimbursement. Even when they offer $0 additional, they can check the box that they "engaged" (see below example). This benefit from delaying also helps to explain why insurers frequently do not pay in a timely fashion after an IDR determination.



Suggested Solutions

Medical providers, when they cannot be in network, would like an IDR process that is fair, efficient, timely, and enforced. We believe that the suggestions below would greatly improve the NSA's functionality and align with those values.

Part I: Rulemaking

The majority of the challenges providers are facing with the NSA are a result of actions taken through rulemaking and can be addressed through the regulatory process. To address the problems outlined above, we suggest the Administration could take the following actions.

Improved Batching: We hope that in future rulemaking the Administration will appropriately broaden batching. The NSA itself encourages batching to improve efficiency and lower costs. We suggest that for charges to be included within the same IDR batch, charges must relate to:

1. Same provider Tax Identification Number (TIN); (no change from status quo)
2. Same Employer Group Health Plan where self-funded; (no change from status quo)
3. Dates of service within same 30-business-day period; (no change from status quo), and
4. **Same Category I Current Procedural Terminology (CPT) division**, as defined by the American Medical Association (AMA). The AMA Category I Codes are used by providers to report services and procedures, and are divided into six (6) divisions and accepted as industry standard, specifically:[7]
    1. Anesthesia: 00100-01999
    2. Surgery: 10021-69990
    3. Radiology Procedures: 70010-79999
    4. Pathology and Laboratory Procedures: 80047-89398
    5. Medicine Services and Procedures: 90281-99607
    6. Evaluation and Management Services: 99202-99499

For example, a diagnostic radiologist is trained to interpret "similar conditions" which are in the AMA Category I Radiology Procedures codes (70010-79999). We recommend these "similar conditions" be eligible for submission together in the same IDR batch. This approach would greatly improve the efficiency of the IDR process. We believe that this approach is consistent with the statutory language ("items and services are related to the treatment of a similar condition") since all Radiology codes relate to conditions with pathologies which may be identifiable by medical imaging (i.e., they are all "radiologic diagnoses"). Further, batching like codes is consistent with how appeals between payors and providers often function in both in-network and out-of-network situations.

Here is a case study:

> Two co-workers, a 37-year-old female and 28-year-old male, are in a motor vehicle accident and brought by ambulance to the nearest hospital, which is out-of-network with their commercial medical insurance. At the hospital, each receives radiographs of their chest, cervical spine, and pelvis (a "trauma panel"). She then receives CTs of her head, cervical spine, and chest. He receives head and cervical spine CTs. Their commercial insurance plan, which is the same, reimburses the hospital-based radiology practice at 100% of Medicare, which is below the standard market rate. The insurer does not engage in the IDR Open Negotiation period, prompting the radiology practice to request IDR. All exams were interpreted on the same day by the same radiology practice for patients with the same medical insurance plan and

for the same indication, however since they are different CPT codes, six separate IDR disputes would need to be filed under the prior rule. Under our batching suggestion, the charges could be bundled in a single IDR dispute submission.

Mandated use of CARCs and RARCs: The Departments previously noted that, "The primary cause of delays in processing disputes has been the complexity of determining whether disputes are eligible for the Federal IDR process" and that "certified IDR entities can determine eligibility more efficiently when information about the health plan type is made available to the provider by the plan…However, the health plan type was unknown upon dispute initiation in more than half of disputes … causing certified IDR entities to conduct additional outreach, and further delaying the eligibility review process."[8]

While insurers could address this problem by providing the appropriate Claim Adjustment Reason Codes (CARCs) and Remittance Advice Reason Codes (RARCs), they are not required to do so, and frequently do not. To date, CMS has "strongly recommended" but not mandated the use of CARCs or RARCs. Such a requirement would allow for the prompt identification of Federal IDR eligible claims, limiting delays and reducing the backlog of cases.

Three of the top five states where disputes are being filed have "state specified laws," (Texas, Florida, and Georgia), with separate state and federal laws for out-of-network billing. Providers filing federal IDR disputes in these states cannot reliably determine federal versus state eligibility, creating additional burdens for IDR Entities and resulting in delays. These delays hurt medical practices and their patients (while benefiting the insurers, who profit from investments and use of the underpayment funds for an extended period of time). It is worth noting that reducing these delays would help ensure a timelier payment of administrative fees to the government for program management.

QPA Integrity: The Departments should require and enforce transparency and integrity of the QPAs. We suggest three actions that the Administration should take:

1. Require statement of the QPA with the initial payment.
2. Random and by request audits of QPAs to ensure that the calculation methodology was correct, and data was accurate.
3. Regularly publish a report with the findings of the audits and their enforcement.

Re-Start the IDR Process and Require Reasonable Initial Payments: The IDR process should be re-started as soon as feasible. In the TMA 3 verdict, Judge Kernodle wrote that the "Departments fail to explain why [IDR proceedings] cannot continue in the absence of properly calculated QPAs."[9]

Note that if insurers would make reasonable, fair-market initial payments, there would be no need for IDR. We suggest initial payments based on previously contracted, where one existed. This would reduce the incentive for insurers to push providers out of network and support network contracting. And if insurers feel that the previously contracted rate was inappropriate, they have the opportunity to request IDR. This would be done without altering the patient's cost-sharing payment.

Part II: Legislative

While the NSA was thoughtfully crafted, a minor adjustment should be considered by Congress. Specifically, if the Administration lacks the tools to enforce the statute, Congress should mandate enforcement, including of the payment timelines and adherence to IDR determinations, with penalties for noncompliance. Insurers should not be allowed to continue to flagrantly ignore IDR determinations and required timelines. As an example, after an IDR determination, parties that are delinquent in payment

beyond the 30 calendar days specified in the NSA should be penalized, including with interest applied per day.

Conclusion

Radiology Partners thanks the Committee for its work and appreciates the opportunity to submit these comments. We applaud the Committee's ongoing support for patient protections and its attention to the challenges of medical providers due to the implementation of the NSA. Please do not hesitate to reach out with any questions.

Respectfully submitted,

Anthony Gabriel, MD
President and co-founder, Radiology Partners

Krishna Nallamshetty, MD
Chief Medical Officer, Radiology Partners

Richard Heller, MD
Associate Chief Medical Officer, Health Policy and Communications, Radiology Partners

[1] https://www.americansforfairhealthcare.org/_files/ugd/11639b_a39a37a219aa40ee8d68a219ec2e84ed.pdf
[2] https://aspe.hhs.gov/sites/default/files/documents/48b874b63796dc6a68a783cf079ba42a/aspe-no-surprises-act-rtc.pdf
[3] Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities
[4] https://www.cmadocs.org/Portals/CMA/files/public/Surprise%20Billing%20Neal%20Brady%20Letter.pdf
[5] https://www.americansforfairhealthcare.org/_files/ugd/11639b_a39a37a219aa40ee8d68a219ec2e84ed.pdf
[6] https://www.npr.org/2023/07/03/1185740774/the-ama-predicts-a-shortage-of-medical-specialists-by-the-next-decade
[7] https://www.aapc.com/resources/what-is-cpt
[8] https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf
[9] The United States District Court for the Eastern District of Texas Tyler Division Case No. 6:22-cv-450-JDK

action
FOR HEALTH

Submitted electronically via WMSubmission@mail.house.gov

October 3, 2023

The Hon. Jason T. Smith
Chairman
House Committee on Ways and Means
1011 Longworth House Office Building
Washington, DC 20515

The Hon. Richard E. Neal
Ranking Member
House Committee on Ways and Means
372 Cannon House Office Building
Washington, DC 20515

Re: Statement for the Record: Full Committee Hearing, "Reduced Care for Patients: Fallout from Flawed Implementation of Surprise Medical Billing Protections"

Dear Chairman Smith and Ranking Member Neal:

Thank you for this opportunity to submit these comments regarding the House Committee on Ways and Means' hearing[1] on the Biden administration's failed regulatory implementation of the No Surprises Act. We are grateful for your leadership on this issue.

Introduction

Action for Health[2] is a national, non-profit advocacy organization. In all our work, we attempt to educate policymakers like yourself, the media, and concerned citizens about critical healthcare issues. Since our founding in February 2020, we have been a leading voice nationwide on the issue of surprise medical bills. From early legislative proceedings in Washington and the enactment of the No Surprises Act, to regulatory implementation and legal challenges across the country, we have worked tirelessly to ensure fair outcomes for patients and their physicians.

Unfortunately, in the 34 months since the No Surprises Act was signed into law,[3] the rules, guidance, and other outcomes from the Departments of Health and Human Services, Labor, and Treasury ("Tri-Departments") have been anything but fair. This regulatory malpractice

[1] House Committee on Ways and Means, Hearing on Reduced Care for Patients: Fallout From Flawed Implementation of Surprise Medical Billing Protections, September 19, 2023, accessed: https://waysandmeans.house.gov/event/hearing-on-reduced-care-for-patients-fallout-from-flawed-implementation-of-surprise-medical-billing-protections.
[2] Action for Health, www.action4health.org.
[3] H.R. 133, Consolidated Appropriations Act, 2021, (P.L. 116-260), December 27, 2020, accessed: https://www.congress.gov/bill/116th-congress/house-bill/133/text.

is in direct defiance of the bi-cameral, bi-partisan efforts in Congress to successfully pass the No Surprises Act.

This law was carefully designed to treat all relevant parties fairly. Your Committee played an exceedingly important role in not only ensuring the law was unbiased, but also providing federal regulators clear directives to implement the law. Additionally, the statue's language is unambiguous as to how disputes between medical providers and health insurance companies that enter the federal independent dispute resolution (IDR) process should be decided.

"Weaponization" of the Law

Given how, to date, the Tri-Departments have illegally implemented the No Surprises Act in favor of health insurance companies, these corporations have used this opportunity to threaten cancelation of long-standing contracts with medical providers,[4] narrow their coverage networks,[5] and ultimately jeopardize patients' access to the care they need.[6]

Specifically related to the law's IDR process, health insurance companies have used the administration's failed regulatory implementation to game the system. According to a recent survey[7] from the Emergency Department Practice Management Association (EDPMA), "95.6% of outstanding claims are 5+ months old from 127 health plans." Even worse, of the 200,000 claims surveyed, "87% of payers did not pay in accordance with the IDR entity decision." EDPMA continued:

> "Payers' blatant disregard of the No Surprises Act's intent and CMS issued guidance undermines the law and guts fair emergency physician reimbursement that underpins emergency care in America. Of the survey respondents, 60% quantified the percentage of payments won in IDR but not paid within the prescribed 30 days. Of these, 1/3

[4] BlueCross BlueShield of North Carolina, "Necessity to amend rate agreement", November 5, 2021, accessed: https://www.acr.org/-/media/ACR/Files/Advocacy/20211105-BCBSNC-rate-reduction-notice_Redacted.pdf.
[5] BlueCross BlueShield of Tennessee, "A Message from Robin Young", Letter to Employers, August 17, 2022, accessed: https://www.acr.org/-/media/ACR/Files/Advocacy/BCBS-of-TN-Letter-to-Employers.pdf.
[6] American Medical Association, "Surprise billing rule provision jeopardizes patient access to care", December 9, 2021, accessed: https://www.ama-assn.org/delivering-care/patient-support-advocacy/surprise-billing-rule-provision-jeopardizes-patient-access.
[7] Emergency Department Practice Management Association, Survey, "No Surprises Act Independent Dispute Resolution Effectiveness", March 9, 2023, accessed: https://edpma.org/wp-content/uploads/2023/03/EDPMA-Data-Analysis-No-Surprises-Act-Independent-Dispute-Resolution-Effectiveness-1.pdf.

> reported 100% noncompliance by health plans; 1/3 reported noncompliance from 89% to 98% of the time; and 1/3 reported noncompliance averaging 37% of the time."[8]

We, therefore, urge your Committee to use every lever of power at its disposal to ensure health insurance companies follow the law, comply with all timelines and deadlines set forth in the statue, and make their required payments on-time.

In no uncertain terms, the lawlessness of the Biden administration's regulators, coupled with health insurance companies' greed, has put our nation's healthcare delivery system on the brink of collapse. Already, 600 rural hospitals are at the risk of closing[9] due to the Tri-Departments' actions. Independent medical practices across the country are also being forced to close their doors or sell to large health systems, where costs are higher and the care delivered is of lesser quality.

Current State of Affairs

After their unprecedented fourth-straight loss[10] in federal court to the Texas Medical Association, federal regulators unilaterally – and in contradiction to court order – shut down the IDR process, yet again. With this misguided decision, the Tri-Departments are choking off the last remaining path for small hospitals and independent medical practices to remain viable. Last month, one of our statements urged the Department of Health and Human Services to quickly re-open the federal IDR process. I stated:

> "During the pandemic, the administration talked constantly about our medical providers being 'healthcare heroes'. How long will it take its regulators to walk this walk? Our heroes will soon be forced to retire their capes if the IDR process isn't up, running, and fully functional without bias toward either disputing party."

While our nation's medical providers are being starved of the resources they need to continue their operations, health insurance companies continue to post record earnings and profits. The Biden administration allowing these companies to manipulate the No Surprises Act

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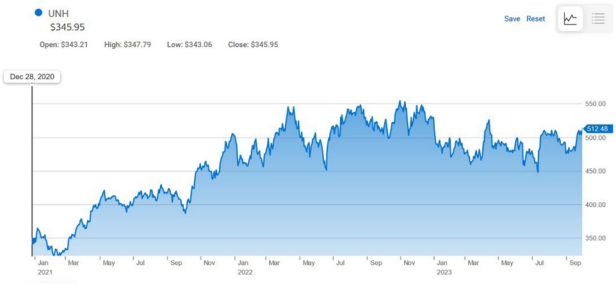
[8] Ibid.
[9] MedPage Today, Shannon Firth, "Flawed Rules in No Surprises Act Hurt Doctors and Patients, Experts Say", September 21, 2023, accessed: https://www.medpagetoday.com/publichealthpolicy/healthpolicy/106440.
[10] Texas Medical Association, Amy Lynn Sorrel, "TMA Wins Fourth Lawsuit Challenging Payment Calculations in Surprise Billing Arbitration", August 28, 2023, accessed: https://www.texmed.org/TexasMedicineDetail.aspx?id=62623.

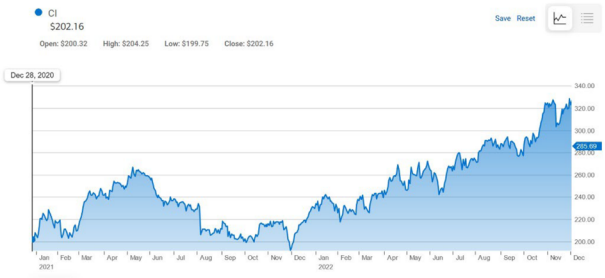
is a main driver of this largesse, in addition to the Medicare Advantage bonanza they are enjoying.

The morning after the No Surprises Act was signed into law, United Healthcare's stock opened at $343.21 per share. At the time of this writing,[11] it is now $512.35 per share, representing a staggering increase (i.e., "No Surprises Act premium"). UnitedHealthcare is the fifth-largest corporation in the country based on revenue.



Source: Merrill

Similarly, Cigna's stock opened on December 28, 2020 at $200.32 per share. Two years later, per the chart below,[12] it was trading at $327.20 per share in December 2022.



Source: Merrill

[11] Merrill, UnitedHealth Group Incorporated (NYSE:UNH), Security Profile, October 3, 2023.
[12] Merrill, Cigna Group (NYSE:CI), Security Profile, October 3, 2023.

action
FOR HEALTH

Recommendations

As the Ways and Means Committee continues its oversight responsibilities and work to find solutions to the agencies' flawed implementation, we recommend:

1.) Calling to testify in front of your Committee: Center for Medicare & Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure; Consumer Information and Insurance Oversight (CCIIO) Deputy Administrator Dr. Ellen Montz, and CCIIO Deputy Director for Policy Jeff Wu;
2.) Establishing a schedule of fines for health insurance companies' non-compliance with the law, just like the $10,000 per medical provider infraction in the statue; and
3.) Continuing to coordinate with your colleagues in the House and in the Senate HELP Committee to hold federal regulators and health insurance companies accountable for the collusion and harm they are causing patients and medical providers via their illegal behavior related to the No Surprises Act.

Conclusion

Thank you again for this opportunity to provide our comments on your September 19 full Committee hearing. Federal regulators and health insurance companies must stop lying. Surprise medical bills are outlawed, and no one is trying to bring them back. In addition, medical providers are not abusing the IDR process, as Sec. Xavier Becerra outlandishly claimed.[13]

Much work remains to steady the IDR ship. However, we are confident that, with your oversight and assistance, the intent and protections of the No Surprises Act can be fully achieved. Patients can then be confident that their physicians and facilities will be there for them in their time of need. If we can be of any help to you or your staffs, please do not hesitate to contact me directly at (202) 823-2333.

Sincerely,

Christopher G. Sheeron
President
Action for Health

[13] Fierce Healthcare, Robert King, "House lawmakers blast Xavier Becerra for blaming docs for surprise billing arbitration backlog", March 29, 2023, accessed: https://www.fiercehealthcare.com/providers/house-lawmakers-blast-becerra-blaming-docs-surprise-billing-arbitration-backlog.

The Biden Administration's Unsurprising Fumble of the No Surprises Act

U.S. House Committee on Ways and Means

Hayden Dublois

Data & Analytics Director

Foundation for Government Accountability

The bipartisan No Surprises Act was passed by Congress with the simple goal of protecting millions of Americans from the immense financial burden of surprise medical bills. These surprise costs contributed to untold amounts of medical debt and were undoubtedly a leading contributor to personal bankruptcies.[1] Congress sought to change this in a collaborative fashion with the passage of the No Surprises Act.

Unfortunately, the implementation of this legislation has been full of surprises. In September 2021, the Biden administration issued an interim final rule (IFR) that departed from congressional intent by arbitrarily crafting a new threshold for independent dispute resolutions (IDRs) that had no basis in statute, drawing criticism from Congress.[2] Unsurprisingly, the U.S. District Court for the Eastern District of Texas invalidated a portion of the IDR process in February 2022.[3]

However, in spite of this court order, the Biden administration proceeded with a final regulation issued in August 2022 that contained similar fatal flaws in the IDR process, drawing condemnation from congressional lawmakers.[4] **The Biden administration suffered another defeat** when the Center for Medicare and Medicaid Services' (CMS) creative license to deviate from the statutory framework was rebuked in court yet again, **prompting CMS to pause the arbitration process for the second time within a year**.[5]

This avalanche of administrative blunders has had the predictable consequence of causing a cascade of negative outcomes for the No Surprises Act as a whole. **CMS dramatically increased arbitration fees—by as much as 40 percent**—to reflect the inordinate amount of time arbiters have spent simply determining whether a claim is even eligible for the IDR process.[6-7]

Meanwhile, other aspects of the No Surprises Act—such as the Advanced Explanation of Benefits (AEOB) provision—have faced rulemaking delays as the Biden administration has slow-rolled implementation of the law.[8]

Unfortunately, countless patients across the country have been harmed by this series of administrative blunders that were easily avoidable. The spike in disputes associated with the arbitration process, coupled with inadequate enforcement, have in part contributed to staggering rates of non-compliance by insurers with arbitration orders.[9] One survey of more than 48,000 physicians flagged that 33 percent of all claims were paid an incorrect amount and **52 percent of all arbitration-determined amounts were not paid at all.**[10]

This series of missteps by the administration is typical of the Biden CMS, which has similarly failed to implement federal hospital price transparency requirements thoroughly. The administration has granted substantial deference to hospitals, utilizing wildly inconsistent enforcement timelines and stonewalling access to public records.[11] CMS is being sued for failing to disclose information related to the enforcement of the hospital price transparency rule as well as a separate rule dealing with transparency in insurance coverage.[12-13]

Put simply, when bureaucrats make mistakes, Americans suffer. That has been the harsh reality of the botched implementation of the No Surprises Act by the Biden administration.

Moving forward, congressional lawmakers should continue to advocate for the implementation of the law as originally intended by demanding answers from the Biden administration on:

- The Qualifying Payment Amount (QPA) methodology;
- Accountability for the timely issuance of accurate payments by insurers;
- The ongoing issues with the IDR process; and
- The number and scope of audits performed by CMS.

Only through congressional oversight and pressure on the Biden administration will the full promise of the No Surprises Act be delivered to the American people.

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[1] Lindsey Bomnin and Stephanie Gosk, "Surprise medical bills lead to liens on homes and crippling debt," NBC (2019), https://www.nbcnews.com/health/health-news/surprise-medical-bills-lead-liens-homes-crippling-debt-n984371.

[2] Cassidy et al, "Cassidy, Marshall, 24 Colleagues Urge Administration to Implement Surprise Medical Billing Law According to Congressional Intent," U.S. Senate (2021), https://www.cassidy.senate.gov/newsroom/press-releases/cassidy-marshall-24-colleagues-urge-administration-to-implement-surprise-medical-billing-law-according-to-congressional-intent.

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October 3, 2023

House Ways & Means Committee
10:00AM, 1100 Longworth House Office Building
RE: "Reduced Care for Patients: Fallout from Flawed Implementation of the Surprise Medical Billing Protections"

STATEMENT FOR THE RECORD

The 20 undersigned organizations represent more than 120 million patients and consumers across the country who face serious, acute, and chronic health conditions, In March 2017, our organizations agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate.

Our organizations understand first-hand the financial and physical hardships surprise bills have on our patients and their families. Prior to the passage of the No Surprises Act (NSA), the harms of surprise bills were well documented in both academic literature and the media. Patients were hit with both overwhelming out-of-pocket expenses and increasing premiums. Consequently, our organizations collaborated with state and federal policymakers, including this Committee, to develop evidence-based solutions to curb this harmful practice. We were pleased that the final bill crafted by the House and Senate included provisions that aimed to both protect patients from surprise bills and constrain rising healthcare expenses.

[1] Consensus Health Reform Principles. Available at: https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf.

Our organizations celebrated the NSA's passage in 2020. Since that time, we have worked to raise awareness within our communities about the new protections the law affords our patients. However, we have been disheartened by the overwhelming amount of litigation that has hindered the smooth implementation of the law - depriving patients of its full benefits. This litigation erodes the implementing regulatory guidance and disrupts the independent dispute resolution (IDR) process. We view a reliable, patient-centered IDR process as vital to protecting patients.

No one should go bankrupt because they needed emergency treatment or unwittingly received out-of-network care. We support efforts to build upon the Act's successes via the regulatory process, including more transparency and swift resolution of payment disputes, without subjecting patients and consumers to higher healthcare costs. We acknowledge that both issuers and providers have been frustrated by aspects of the IDR process and we hope for a resolution that protects patients.

The passage of the NSA was a significant achievement that marked years of effort, and we are concerned that amending the statute may destabilize the gains that have been made - including the potential to hold patients harmless from 10 million surprise bills a year (Kaiser Family Foundation, 2021). Our organizations will continue to work with Congress and the implementing agencies as they proceed with their important work.

ALS Association
American Kidney Fund
American Lung Association
Asthma and Allergy Foundation of America
Chronic Disease Coalition
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Eczema Association
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The Leukemia & Lymphoma Society