HR POLICY ASSOCIATION
The Association of Chief Human Resource Officers

AMERICAN HEALTH POLICY INSTITUTE

May 27, 2021

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

The Honorable Janet Yellen
Secretary of the Treasury
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

Re: Comments on Implementing Surprise Medical Billing Protections Included in the Consolidated Appropriations Act of 2021

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh:

The HR Policy Association welcomes the opportunity to provide comments to the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury ("the Departments") regarding the upcoming rulemaking to implement the No Surprises Act, passed as part of the Consolidated Appropriations Act of 2021.[1]

The HR Policy Association ("the Association") is the leading organization representing chief human resource officers of over 390 of the largest employers in the United States. Collectively, their companies provide health care coverage to over 21 million employees and dependents in the United States and spend more than $120 billion annually on health care benefits and related taxes. The American Health Policy Institute, which was created by the Association, serves to examine the challenges employers face in providing health care to their employees and recommends policy solutions to promote the provision of affordable, high-quality, employer-based health care.

As the Departments proceed with the rulemaking, three broad objectives should guide the agencies' rulemaking decisions: 1) minimize administrative costs associated with the independent dispute resolution (IDR) process; and 2) ensure the rule reduces the cost of health care for employers, employees and their dependents. As written by Congress, the Congressional Budget Office estimated the *No Surprises Act* would reduce health care costs.[2] The regulations should be drafted to achieve those cost reductions. The Departments should also maximize transparency regarding the publication of information relating to the IDR process so the public and policymakers can identify potential problems and determine if future changes to the regulations or statute are needed.

[1] Public Law No: 116-260. https://www.congress.gov/bill/116th-congress/house-bill/133/text
[2] Congressional Budget Office, Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021, Public Law 116-260, Enacted on December 27, 2020, published January 14, 2021. https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

While we believe the Departments should publish a Request for Information before a Notice of Proposed Rulemaking and then a final or interim final rule, we recognize the statutory deadlines for publishing the implementing rules will likely short circuit this process. Recognizing these statutory deadlines, we offer the following recommendations ahead of any proposed or interim final rules the Departments may publish. These recommendations preserve the intent of the *No Surprises Act* by eliminating surprise medical billing while reducing health care costs.[3]

ERISA Preemption

ERISA preemption is critically important for multi-state employer health plans. The Departments regulations must preserve ERISA preemption and clearly establish when state law governs out-of-network payments.

Initial Payment Amount

The implementing regulations should not establish any standards regarding the initial payment amount. The *No Surprises Act* is silent on how the initial payment amount should be determined compared to the qualifying payment amount. Further, the statute allows for a 30-day open negotiation period for providers and facilities to settle on a reimbursement amount with employer plans. Many employers already have systems in place to address surprise bills with out-of-network providers and facilities. A January 2019 survey from the National Business Group on Health found 91 percent of large employers provide assistance to help employees negotiate away or reduce surprise bills, whether it's through the company's HR staff, their health plan administrator or a health navigator/advocate that the employer contracts with.[4] And 75 percent of large employers have protections in place to stop balance billing in emergency situations at in-network hospitals.[5] The Departments rulemaking should not interfere with this assistance regarding the initial payment amount or during the open negotiation process.

Initiating the IDR Process

The statute requires a 30-day open negotiation period followed by a 4-day period for providers and facilities to initiate the IDR process by submitting a notification containing information specified by the Departments to employer plans and the "Secretary." The Association recommends the information that must be submitted to the Secretary include a detailed description of the good faith efforts the provider and facility engaged in with the employer plan during the open negotiation period to reach a settlement. This information should also be provided to the certified IDR entity.

Congress clearly intended providers, facilities, and employer plans to engage in open negotiations to reach a settlement prior to initiating the IDR process, and this open negotiation

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[3] Congressional Budget Office (December 2020). 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_N.pdf

[4] Stephen Miller, "Employers Can Help with 'Surprise' Out-of-Network Medical Bills," SHRM, May 13, 2019, available at: https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/trump-urges-congress-to-end-surprise-medical-billing.aspx.

[5] *Id.*

period should not be circumvented by any party that wishes to go immediately to the IDR process by refusing to engage in good faith negotiations.

Authority to Continue Negotiations During the IDR Process

The statute allows providers, facilities and employer plans to continue to negotiate a settlement during the IDR process (authority to continue negotiations). To reduce administrative costs, the certified IDR entity should encourage the parties to reach an agreement prior to its determination.

Clarify the Qualifying Payment Amount (QPA) as the Primary Consideration in IDR Proceedings

To ensure the *No Surprises Act* protects patients from surprise bills while also lowering health care costs for consumers and taxpayers, the Departments should establish the QPA as the primary factor used in resolving payment disputes. The QPA should be defined as the median of contracted rates for an item or certain service in the same geographic region within the same insurance market. Since patients can no longer be billed more than their in-network cost-sharing amount (except for ground ambulance), payers will be required to treat out-of-network services as in-network when determining the patient's cost-sharing amount. This cost-sharing amount, therefore, has a direct impact on what employees pay for their employer-sponsored health insurance.

The Association recommends basing IDR decisions on the QPA to make decisions more predictable, encourage providers and payers to resolve payment disputes outside of the IDR process, and substantially reduce IDR administrative costs. Congress made its intent clear for IDR entities to use the QPA as the primary factor in arbitration decisions when it provided instructions on how to calculate the QPA, base coinsurance on the QPA, and finally, stated that public reports of IDR decisions should be reported against the QPA.

Further, the statute requires the QPA be based on "the same or a similar item or service that is provided by a provider in the same or similar specialty … consistent with the methodology established by the Secretary." The Departments should narrowly define what is meant by "same or similar." For example, for items and services the Departments should use the same CPT or DRG codes.

Maximize Transparency Regarding the Publication of Information Relating to the IDR Process

Congress took great pains in enacting the *No Surprises Act* to craft a compromise that it thought would fairly treat providers and facilities and limit the use of the IDR process. As part of that compromise, Congress requires the Departments to publish quarterly reports on their websites detailing a wide variety of information regarding the IDR process including "the identity of the group health plan, provider or facility with respect to the notification" and "any other information specified by the Secretary." The Departments should maximize transparency regarding the publication of information relating to the IDR process so the public and

policymakers can identify problems and determine if future changes to the regulations or statute are needed.

Protect Patients by Providing Consumer Friendly Notices Ahead of Out-Of-Network Care

Central to a fair health care system is an informed patient. Employers work hard to provide employees and their families with high-quality health care at the lowest possible cost. However, the lack of transparency around prices makes it difficult for employees to make informed decisions about their care. To ensure patients are protected when making decisions related to their health care, the Departments should ensure that the notice and consent requirements are easy to understand and do not include loopholes for out-of-network emergency providers. Specifically, consumer consent to receive non-emergency out-of-network care should be valid only when there is a reasonable option for consumers to choose an in-network option. Additionally, patients getting emergency care in an out-of-network hospital should not be forced to choose between receiving a balance bill or transferring to a different hospital, even after they have been deemed stabilized. In cases where a procedure or service is deemed medically necessary and the patient is incapacitated or in recovery, then notice and consent is not feasible, and the patient should have blanket protection from balance bills.

Notices provided to patients must include easy-to-understand language outlining the financial requirements of the patient in receiving out-of-network care. The notice should also include a statement explaining that the financial requirements of the patient for these exact services, if provided by an in-network provided, would be lower than that of an out-of-network provider.

Create a Transparent IDR Entity Selection Process

The *No Surprises Act* provides the parties three days to select a certified IDR entity and if they fail to agree on one, a "default" entity is selected. The process for selecting the "default" entity should be completely transparent for both parties to review and those entities should have a record of making IDR determinations close to the QPA, with determinations both below and above the QPA. The Departments should also establish a process for fielding and responding to complaints related to the QPA calculation and the IDR process.

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We urge the Departments to consider these recommendations when developing the regulation and we look forward to working with you to implement the No Surprises Act.

Sincerely,

D. Mark Wilson
President and CEO, American Health Policy Institute
Vice President, Health & Employment Policy, HR Policy Association