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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,

A handwritten signature in cursive script that reads "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 or 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 administering 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