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Matthew Eyles
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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]

[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.

[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.

[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.

[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