



A Passionate Voice for Compassionate Care®

December 6, 2021

Laurie Bodenheimer
Associate Director
Healthcare and Insurance
Office of Personnel Management

Ali Khawar
Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Douglas W. O'Donnell
Deputy Commissioner for Services and
Enforcement
Internal Revenue Service

Xavier Becerra
Secretary
Department of Health and Human Services

Mark J. Mazur
Acting Assistant Secretary of the Treasury
(Tax Policy)

**Re: Requirements Related to Surprise Billing; Part II
CMS-9908-IFC, RIN 0938–AU62**

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

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,200 Catholic health care systems, hospitals, long-term care facilities, service providers and organizations, I am writing to share our comments on the interim final rule entitled Requirements Related to Surprise Billing; Part II (86 Fed.Reg. 55,980), implementing portions of the No Surprises Act enacted as part of the Consolidated Appropriations Act (the IFR).

CHA and our members strongly support protecting patients from surprise bills. Patients should not be subjected to financial consequences when they have unexpected and unavoidable encounters with out-of-network health care facilities and providers, and they should not get caught in negotiations among facilities, providers and insurers over payment. We are pleased that the No Surprises Act (the NSA) provided protections to patients with gaps in their health care coverage that could result in unanticipated bills. We appreciate the hard work of your departments in issuing implementing rules under tight timelines, especially given the demands of the continuing public health emergency due to COVID-19.

While the concept is simple – protect patients from medical bills for unexpected out-of-network care beyond their control –the law's protections must be implemented carefully and in

conformity with the balance struck by Congress to avoid unintended harm to patients and providers. We are very concerned that the departments' independent dispute resolution process establishes a de facto benchmark out-of-network payment rate, severely disadvantaging health care providers and facilities and unfairly benefiting plans and issuers, contrary to the intent of Congress. We urge the departments to reconsider this approach in favor of a balanced process as required by the NSA. Our comments on this and other aspects of the IRF follow below.

- **The Independent Dispute Resolution Process**

The NSA provides that patient cost-sharing is to be based on an amount determined by an applicable All-payer Model Agreement, the amount determined under applicable state law, the qualifying payment amount (QPA) or the billed amount if less than the QPA. The NSA created the QPA for two purposes: to calculate patient cost-sharing and to serve as *one* of the factors for consideration by the arbiter in the independent dispute resolution (IDR) process. The statute defines the QPA as the insurance issuer's median in-network rate for a particular service trended forward from 2019. This approach insulates the patient from payment negotiations between the payer and the provider or facility by establishing a methodology to determine cost-sharing without waiting for a final payment determination, a goal we support wholeheartedly.

The determination of an appropriate provider payment rate begins with voluntary negotiation between the provider or facility and the payer. If the parties are unable to reach agreement, they submit to a formal independent dispute resolution process (IDR). The NSA instructs that each party is to propose what it believes to be an appropriate payment and a qualified arbiter must choose between those proposals in what has come to be known as a "baseball-style" arbitration process. The arbiter must select either the provider's or the payer's proposed payment, with no opportunity for the arbiter to compromise between the two.

As already noted, the statute requires the arbiter to consider the QPA as one of several factors when making their payment selection. Arbiters are also instructed to consider information on: the level of training, experience, quality and outcomes of the provider; the market share held by the provider and/or the plan; patient acuity; teaching status, case mix, and scope of services of the provider; demonstrations of good faith efforts to enter into a network agreement with the other party; and, if applicable, past contracted rates between the parties during the previous four years.

In CHA's September 7, 2021 letter commenting on the first round of NSA rulemaking, we urged the departments to make clear that the QPA was not to be used as the out-of-network rate (unless the parties agreed to it through negotiation) and to not give, or allow the arbiter to give, the QPA too much weight in the IDR process. We are very disappointed that the departments ignored our request and have given the QPA virtually determinative weight in the process set forth by the IFR.

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The IFR directs arbiters to treat the QPA - the issuer's median in-network contracted rate – as the presumptively appropriate payment rate. In order to overcome that presumption, the provider must present “credible information” that “clearly demonstrates” the QPA is “materially different” from the appropriate out-of-network payment rate. The bar is set extremely high, and the burden of proof placed solely on the shoulders of the provider. The additional factors the statute requires the arbiter to consider are demoted to the status of mere rebuttal evidence, restricting the authority of the arbiter to give them full consideration.

The departments' have effectively established the QPA as a de facto out-of- network benchmark rate, rendering the IDR process a mere formality and unavailable to providers as a practical matter. This is clearly contrary to the intent of Congress, as demonstrated by the plain language of the statute, the legislative history, and the reaction of members of Congress to the IFR.

The statute calls for an independent review process in which the arbiter is vested with authority to evaluate all the statutory considerations and relevant information and determine a fair market valuation of the services provided in order to choose between the payment bids submitted by the provider and payer. Congress explicitly chose to use external IDR entities and arbitrators. It did not delegate to the departments the power to establish payment rates or to create a one-sided presumption in the IDR process. This was the end result of a legislative process that sought to protect patients while balancing the concerns of providers and payers over how to reimburse for out-of-network services. Many options were considered, including the establishment of a statutory benchmark which was rejected in favor of independent dispute resolution. As 152 members of the U.S. House of Representatives wrote to the departments in a bipartisan letter dated November 5, 2021,

Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process. ... Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes.

The departments have arbitrarily decided that the QPA will generally be a reasonable out-of-network rate. But the QPA is basically the median rate paid to in-network providers. This conflation of in- and out-of-network payment rates will harm both providers and patients.

Providers and payers consider many factors when deciding whether to enter into a contract. Factors that may be relevant to one provider may not be relevant to another, which means that the median contracted in-network rate may not be the appropriate payment level for all providers. The result will be artificially low payments to providers who will receive none of the potential benefits of in-network status.

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Patients will be harmed because it creates a perverse disincentive for payers to engage in good-faith negotiations with providers. Payers have the responsibility to maintain comprehensive provider networks but will have little reason to enter into good-faith rate agreements with providers if they understand that not doing so will enable them to pay artificially low, below-market rate fees. The result would be narrower networks and fewer in-network provider choices for patients. While the NSA may protect them against the financial consequences of unexpected out-of-network care, patients could struggle to find in-network providers for scheduled, regular care.

For these reasons, we urge the departments to reconsider using the QPA as the presumptive payment rate and to return to the balanced IDR process set in the statute. Nonetheless, the QPA will continue to play an important role. We remain concerned about the lack of information available on a payer's calculation of the QPA, concerns that are heightened by the role it has been given in the IDR process and the limited number of payers that will have their QPAs audited each year. **We urge the departments to conduct regular and comprehensive oversight of payers' QPA calculations.** The departments have indicated they do not believe it is the role of the IDR entities to ensure the QPA has been correctly calculated. At a minimum, IDR should have clear authority either to review or to refer to HHS for review QPAs that appear to be incorrect or anomalous. In addition, the IDR process must have a mechanism for revisiting decisions based upon a QPA that was later found to be inaccurately calculated.

Batching of Disputed Items or Services. The IFR provides that qualified IDR items and services may be considered for resolution by the IDR entity as part of one payment determination, an option referred to in the rule as "batching." This can be done if the qualified IDR items and services are billed by the same provider or group of providers or facility or some provider. To be batched for IDR purposes the items or services must be the same or similar items or services under the meaning the departments gave to that phrase in their July 2021 rule and payment for the entire batch must be due from the payer. The items or services also must have been furnished within the same 30-business-day period 90-calendar day suspension period.

We are concerned that the departments have limited the ability of providers to batch claims to a narrow set of circumstances. The departments estimate in the IFR that only 17,000 IDR cases will be submitted per year, for all types of providers, nationally. However, our members' internal analyses of past and anticipated volume of out-of-network care (especially if networks are further narrowed due to the QPA issues just discussed) suggest that is a significant underestimation. To avoid inefficiencies in the IDR process and unnecessarily high caseloads for arbitrators, CHA recommends the departments consider additional policies to allow providers to batch more claims for submission to the arbiter.

- **Good Faith Estimates**

The IFR implements the NSA's requirement that facilities and providers prepare good-faith estimates of the cost of their services for uninsured patients and those who are not using their health insurance to pay for a specific service. CHA is in strong agreement with the policy goal of helping patients to get the information they need when they seek care, including cost estimates. The process created by the IFR however greatly underestimates the challenge of preparing good-faith estimates. The methodology is administratively burdensome in the extreme: estimates will take longer to compile than envisioned, they will cost more to compile than envisioned, and they will be less accurate than envisioned. Some of the provider capabilities considered in the IFR either are not as nearly developed as they believe or are non-existent: machine-readable prices are only a possibility for hospitals, not for other providers, and even that data does not include discounts for self-pay and uninsured patients; price information for other providers is almost always manual and not automated; and there currently is no standardized means for the various parties involved in preparing multi-provider estimates to communicate electronically with one another. These flaws may encourage providers to overestimate their anticipated costs to protect themselves from financial penalties, which may discourage some uninsured patients and some self-pay patients from pursuing the care they need.

It is the best interests of patients to create a workable process that will provide them with the cost estimates they need to make decisions. CHA urges HHS to work with providers, payers and other stakeholders to consider alternative solutions such as using on-line cost estimator tools, developing for uninsured and self-pay patients an analog to the advanced explanation of benefits currently used with commercial payments or automating the creation by good-faith estimates by convening providers. The burden imposed by the IFR is particularly out of place when patients are only shopping for services and not scheduling care – providers may not have the necessary information required to prepare the good faith estimate. On-line tools would be particularly suitable for patients who are only shopping. We also recommend that financial assistance eligibility determinations be required only for patients who request it or who may be reasonably expected to meet the criteria.

CHA is grateful that HHS has indicated it will use enforcement discretion regarding the collection of good faith estimates from co-provider and co-facilities through December 31, 2022. We urge you to extend that period to allow for the development of more reasonable and efficient processes to facilitate the creation of reliable and timely good faith estimates for patients.

- **Patient/Provider Dispute Resolution**

The IFR establishes a patient/provider dispute resolution process which patients may initiate if the total expected charges for an item or service are “substantially in excess” of the good faith estimate. “Substantially in excess” is defined as total billed charges exceeding the total amount of expected charges by \$400 or more. This includes instances where a co-provider was omitted

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from the estimate entirely, or where charges exceed the estimate due to unforeseen circumstances.

CHA agrees with the policy goals of providing patients with a reasonable understanding of the cost of health care services and of shielding them from unexpected costs, but using \$400 as the deviation amount to trigger dispute resolution is unrealistic. The good faith estimate is just that – an estimate offered before the full clinical picture of a patient’s needs are completely known to the provider. Despite best efforts, it is not possible for a provider to predict the billed charges within \$400 for every episode of care. Every patient’s clinical presentation is unique to their circumstances and whether an item or service is or should have been expected is highly subjective. Variations can easily occur during a complex service or procedure resulting in costs that exceed the good faith estimate by more than that amount due to additional professional costs, additional supplies, different or additional drugs, a more lengthy period of anesthesia than was anticipated and more.

CHA agrees with other commenters that a better approach would be for HHS to establish that the dispute resolution process is reserved for instances in which a final bill is at least 10% more than the good faith estimate.

In closing, thank you for the opportunity to share these comments on the Part II rulemaking for the No Surprises Act. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa A. Smith". The signature is fluid and cursive, with the first name "Lisa" being the most prominent part.

Lisa A. Smith
Vice President, Public Policy and Advocacy