August 23, 2021

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

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretaries Becerra, Yellen, and Walsh:

For far too long, millions of Americans have been victims of surprise medical billing. We all have paid that cost with recent research estimating that surprise medical billing has added more than $40 billion a year in unnecessary spending for patients, employers, and taxpayers.[1] We commend the Biden-Harris Administration for building on the efforts to date to protect patients from these exorbitant out-of-network charges and for establishing comprehensive, patient-centered reforms included as part of the recent interim final rule (IFR) ("Requirements Related to Surprise Billing; Part I").

We write to applaud the provisions included in the IFR that will safeguard patients from surprise medical bills in a way that lowers costs. While many of the 59 organizations representing patients, consumers, unions, employers, and plans listed below will provide technical recommendations as part of the upcoming rulemaking process, including how to strengthen the notice and consent processes for patients, we wanted to highlight two important points.

First, we appreciate that the IFR includes many of the recommendations outlined by leading policy and market experts and further recommended by many of our organizations to ensure the qualifying payment amount (QPA) will lower costs for patients.[2] Second, as you continue drafting the provisions of the next IFR related to the independent dispute resolution process (IDR), it is critically important that the regulations reinforce that arbitration is only to be used as a last resort and that the outcomes are predictable and consistent; doing so will help keep health care costs in check and incentivize broader network participation. Below, we elaborate on these points.

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[1] Zack Cooper, Hao Nguyen, Nathan Shekita, Fiona Scott Morton (December 2019). Health Affairs. Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507

2 Matthew Fiedler, Loren Adler and Benedic Ippolito (March 2021). USC-Brookings Schaeffer on Health Policy. Recommendations for Implementing the No Surprises Act. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/03/16/recommendations-for-implementing-the-no-surprises-act/

- **<u>We commend you for recognizing the central role of the QPA on patient cost-sharing and outlining a methodology that will prioritize patient affordability first and foremost.</u>**

Our long-standing goal is that enactment of the *No Surprises Act* will lead to more health care providers, particularly hospital-based physicians and surgeons, participating in health insurance networks, thus avoiding the need for balance billing regulations to apply. However, for some health care scenarios, especially emergency services, patients may continue to be treated by out-of-network providers under circumstances addressed by the *No Surprises Act*, in which case the patient's cost-sharing is directly tied to the QPA. For this reason, we are very supportive of a QPA calculation that is not inflationary and does not skew towards outlier rates. We applaud the Departments for outlining a methodology that is mathematically sound, administratively feasible, and likely to keep patient costs in check. The IFR requires the QPA be calculated based on contracted rates, which will help encourage network participation and avoid increased cost-sharing based on provider billed charges. The rules' approach to geographic regions and insurance markets will ensure that the QPA is determined using locally negotiated rates that reflect the market conditions where care was provided, as well as limiting the circumstances where third-party databases (that typically include billed charges) would be necessary to determine a median contracted rate. All together, we believe these rules reflect the statute while protecting patients.

- **<u>In subsequent rulemakings, it is critical the Departments prevent abuse and misuse of the arbitration process to ensure patients are protected from inflationary costs.</u>**

The *No Surprises Act* was intended to reduce overall health care costs by correcting a longstanding market failure. Achieving this goal will require that IDR is used as a limited, last resort for disputes that cannot be negotiated, rather than an avenue for inflating costs once the patient is taken out of the middle. For example, rampant misuse of the IDR process poses risks to patient access and affordability, and the experience in several states (New York, Texas, and New Jersey) shows how out-of-network providers and private equity firms take advantage of IDR to bolster their bottom lines at patients' expense, often exploiting their size and market concentration to the detriment of many, including multiemployer health plans financed by worker contributions.[3]

These state experiences, as well as leading policy experts, have made clear that subsequent regulations must limit the scope of IDR and position it as a last resort for disputes that cannot be negotiated, rather than an avenue for inflating costs once the patient is taken out of the middle. By establishing an IDR process that is predictable and consistent, the regulations will provide an important incentive to expand access to in-network care – a benefit that will support patients and families across the country. **By reinforcing the QPA as the primary consideration for final payment determinations, the Administration can ensure the *No Surprises Act* achieves the broad cost-savings projected by the Congressional Budget Office and outlined in the**

[3] Jack Hoadley, Kevin Hart (April 2021). Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending? https://www.commonwealthfund.org/blog/2021/are-surprise-billing-payments-likely-lead-inflation-health-spending

statute.[4]

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In conclusion, we appreciate your continued efforts to protect patients from surprise medical billing. The policies included in the recently-issued IFR establish an important foundation for subsequent safeguards that will reduce the cost pressures facing patients and health care plan sponsors. We look forward to working with you to ensure the *No Surprises Act* achieves this historic goal.

Sincerely,

AFL-CIO
Alabama Employer Health Consortium
American Benefits Council
American Federation of State, County & Municipal Employees
American Health Policy Institute
Auto Care Association
Business Group on Health
Catalyst for Payment Reform
Colorado Business Group on Health
Council for Affordable Health Coverage
Council of Insurance Agents & Brokers
Dallas Fort Worth Business Group on Health
Economic Alliance for Michigan
Employers' Advanced Cooperative on Healthcare (Arkansas)
Families USA
Florida Alliance for Healthcare Value
Greater Philadelphia Business Coalition on Health
Healthcare 21 (Tennessee)
Healthcare Purchaser Alliance of Maine
Houston Business Coalition on Health
HR Policy Association
International Association of Machinists and Aerospace Workers
International Brotherhood of Teamsters
International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW)
Kansas Business Group on Health
Kentuckiana Health Collaborative
Lehigh Valley Business Coalition on Healthcare
Memphis Business Group on Health
Mid-Atlantic Business Group on Health
Midwest Business Group on Health
MomsRising
Montana Business Group on Health
National Alliance of Healthcare Purchaser Coalitions

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[4] Congressional Budget Office. Estimate for Divisions O Through FF, H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260, Enacted on December 27, 2020. https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf

National Association of Health Underwriters
National Coordinating Committee for Multiemployer Plans
National Education Association
National Retail Federation
Nevada Business Group on Health
North Carolina Business Group on Health
Partnership for Employer-Sponsored Coverage
Pittsburgh Business Group on Health
Public Sector HealthCare Roundtable
Purchaser Business Group on Health
Retail Industry Leaders Association
Rhode Island Business Group on Health
Self-Insurance Institute of America (SIIA)
Silicon Valley Employers Forum
St. Louis Area Business Health Coalition
Texas Business Group on Health
The Alliance (Wisconsin)
The ERISA Industry Committee
The Leapfrog Group
The Leukemia & Lymphoma Society
The Society for Patient Centered Orthopedics
U.S. PIRG
UniteHERE
Washington Health Alliance
WellOK, The Northeastern Oklahoma Business Coalition on Health
Wyoming Business Coalition on Health

Cc:

Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services
Shalanda Young, Deputy Director, Office of Management and Budget