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December 6, 2021

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

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

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

The Honorable Chiquita Brooks-LaSure, Administrator  
Center for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS - 9908 - IFC  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: [Requirements Related to Surprise Billing, part II](#) (CMS-9908-IFC)**

Dear Secretaries Becerra, Yellen, and Walsh, and Administrator Brooks-LaSure:

On behalf of U.S. PIRG (Public Interest Research Group) and our state affiliates, thank you for the opportunity to submit comments on the interim final regulations (IFR) to implement the No Surprises Act, *Requirements Related to Surprise Billing; Part 2*.<sup>1</sup> PIRG is a nonprofit public interest consumer advocacy organization that speaks out for a healthier, safer world which includes promoting policies that support the delivery of high value healthcare. To succeed in this goal, we must address skyrocketing healthcare costs. Every year, millions of Americans receive expensive surprise medical bills after receiving treatment from an out-of-network provider they had no way to avoid.<sup>2</sup> In fact, the problem of surprise medical billing is so rampant that 1 in 5 Americans who visit an emergency room<sup>3</sup> or have surgery<sup>4</sup> receive them.

For years, PIRG has worked to protect consumers from surprise out-of-network bills through state legislation. But many insured Americans remain unprotected because state laws do not apply to ERISA-exempted health insurance plans. So we took our campaign to Congress. Working in coalition with patients, unions, employers and other consumer groups, we worked with Congressional leaders to win passage of the bipartisan No Surprises Act (NSA).

We commend the Biden-Harris Administration for timely issuance of a series of proposed rules to protect patients across the country from expensive out-of-network bills from providers they didn't choose. We are encouraged to see this most recent IFR closely aligns with the Congressional intent of the NSA to ensuring fair, not inflationary, payment to out-of-network providers to keep down overall

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<sup>1</sup> Requirements Related to Surprise Billing; Part II, 86 IFR 55980, A Rule by the Personnel Management Office, the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department, Federal Register, October 7, 2021.

<https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii>

<sup>2</sup> Pollitz, Karen, Matthew Rae, Gary Claxton, Cynthia Cox, and Larry Levitt. "An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them", Peterson-KFF Health System Tracker, February 13, 2020.

<https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumersfrom-them-3/>

<sup>3</sup> Garmin, Christopher, Benjamin Chartock, "One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills", Health Affairs, January 2017, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0970>

<sup>4</sup> Chhabra, MD, Karan R.; Sheetz, MD, Kyle; Nuliyalu, MPH, Ushapoorna et al., "Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities", JAMA, February 11, 2011, [https://jamanetwork.com/journals/jama/fullarticle/2760735?guestAccessKey=9774a0bf-c1e7-45a4-b2a0-32f41c6fde66&utm\\_source=For\\_The\\_Media&utm\\_medium=referral&utm\\_campaign=ftm\\_links&utm\\_content=tfi&utm\\_term=021120](https://jamanetwork.com/journals/jama/fullarticle/2760735?guestAccessKey=9774a0bf-c1e7-45a4-b2a0-32f41c6fde66&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfi&utm_term=021120)

health care costs. This IFR will set guardrails to help shield consumers from the efforts of private equity-owned provider groups and facilities to use surprised billing as a business model to keep reimbursement high.<sup>5,6</sup>

## General Comments

We applaud the issuance of this IFR for establishing strong and clear guidelines to implement what is a key element to the success of the NSA: the design of an independent dispute resolution system (IDR) that will result in the health care savings that Congress intended and expected. Arbitration adds costs to the health care system in two ways. First, the cost of challenging provider payments through arbitration has inherent costs for administering the system. Second, any potential opportunity to win large payment awards may in fact create a disincentive for providers to join networks, meaning plans and consumers will encounter and pay for non-negotiated rates for an increased number of providers and services. For these reasons, we support the IFR because it structures NSA IDR system in a way that:

- encourages negotiation and keeps most disputes out of arbitration, and
- for those situations where price negotiations fail, the IFR ensures payments for out-of-network providers are reasonable and don't result in outsized awards that remove the incentive for providers to join insurance networks.

The proposed IFR closely aligns with the legislative language of the NSA by creating an arbitration process centered around the qualifying payment amount (QPA). The primacy of the QPA in arbitration incentivizes providers and insurers to first negotiate based on market conditions in that geographic area and on the care provided to the patient and then, if necessary, settle any outstanding disputes in a system that keeps within those parameters.

Experience in states with surprise billing protections shows that when a surprise billing IDR system allows for unpredictable and high provider payment awards, the IDR system is overused, resulting in added costs to the overall system. Those costs are easily passed on to consumers in higher premiums. The NSA and this proposed IFR anticipated these unintended negative cost-drivers and addressed them by establishing guardrails to incentivize negotiation and to achieve reasonable and fair, not inflationary, payments to out-of-network providers. Indeed, the financial analysis of this IDR system designed by the language of the NSA demonstrated significant savings which Congress relied upon in passing it. The CBO forecasted the savings achieved by reducing out-of-network payments could result in \$17B of savings and in reducing premiums by one percent.<sup>7</sup> That means real savings for consumers.

## Federal IDR process

### Primacy of the qualifying payment amount

The success of the dispute resolution process in the NSA relies on:

- Consistency in arbitration decisions. This proposed IFR rightly establishes the qualifying payment amount (QPA) as the primary consideration in negotiations and IDR. By creating a system which encourages consistent and predictable outcomes of arbitration, plans and providers are more likely to settle on prices through negotiation, keeping the costs of arbitration out of the health care system overall. These rules provide important guidance for arbitrators in order to result in predictable payment awards which will either bring providers into networks or settle payment disputes through negotiation, not arbitration.
- Appropriate use of other “factors” in arbitration decisions. These proposed IFR Factors define the supplemental role that other factors may sometimes play in determining final payment amounts. Applying the factors appropriately is essential as

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<sup>5</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Secretary of Health and Human Services' Report on: Addressing Surprise Medical Billing. 2020.

<https://aspe.hhs.gov/reports/hhs-secretarys-report-addressing-surprise-medical-billing>

<sup>6</sup> Spratt, Alexandra. “Part 3: As Purveyors of Surprise Medical Billing, Private Equity Has Fought Lawmakers’ Attempts to Protect Patients,” Arnold Ventures, September 9, 2020.

<https://www.arnoldventures.org/stories/part-3-as-purveyors-of-surprise-medical-billing-private-equity-has-fought-lawmakers-attempts-to-protect-patients/>

<sup>7</sup> Congressional Budget Office (December 2020). Estimate for Divisions O through F H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260. <https://www.cbo.gov/publication/56962>

arbitrators' decisions will impact future in-network rates, influence negotiating leverage and could affect whether providers join or leave networks.<sup>8</sup>

The Congressional authors of the NSA carefully wrote provisions to ensure fair payments to out-of-network providers without opening the door to inflated arbitration awards which could drive up costs to insured Americans. As indicated in their October letter, the Committee Chairs of jurisdiction, Congressman Frank Pallone and Senator Patty Murray, stated,

*“The IFR appropriately instructs IDR entities to begin with the presumption that the qualifying payment amount (QPA) is a reasonable market-based payment when considering offers submitted by the parties.”<sup>9</sup>*

We agree with the Chairs that this proposed IFR closely aligns with the legislative intent of the NSA by establishing strong and important guardrails that center negotiations and arbiter decisions around the QPA. The rules rightly require arbiters to make the QPA the starting point for their decisions in making payment decisions. Consideration of additional factors are only allowed when the parties demonstrate evidence that show a “material difference”. Using local in-network rates as a starting point for negotiations means providers get paid fairly, while also giving arbiters the flexibility to award higher reimbursement if there is credible evidence that the care provided required an unusual amount of resources not already reflected in the billing charges.

We support the primacy of the QPA in the proposed IFR to keep the added costs of arbitration out of the health care system. To prevent overuse, the arbitration process should yield predictable outcomes over time. If all parties can estimate the likely outcome of arbitration, negotiations over in-network rates are likely to be more successful. Provider networks are an essential method of containing costs and ensuring quality. Arbitration should be reserved for cases that are true outliers in terms of resource requirements, not as a tool to avoid networks or to supplant commercial negotiations.

While we support the arbitration system as established in the IFR, we make the following recommendations to further strengthen these rules:

1. **We urge greater clarification that arbiters may not make decisions that award payments that are higher than the QPA unless there is overwhelming and documented evidence relating to the allowable additional factors for each particular claim and with each particular patient.**
2. **In cases involving the batching of claims, evidence should also be clearly documented that any additional factors that are considered apply specifically to each of those batched claims and patients.** Although batching may allow some cost-savings by limiting the number of individual cases an arbiter has to review, it could result in higher payment awards over too many situations if the additional factors do not appropriately apply in each of the batched claims.
3. We support the IFR requirement that arbiters clearly document in writing how and why any additional factors were considered in their decisions. However, **we also recommend that these written arbiter decisions should be made public to allow oversight of individual arbiters and to identify any unintended consequences of factors that might be unnecessarily driving up costs.**

#### **Timeliness of payment/notice to intent to negotiate**

A key element of keeping down overall health costs is ensuring there is sufficient time for out-of-network providers and insurers to negotiate payments in situations when the NSA prohibits patient balance billing. Providers should be paid in a timely fashion, so it is appropriate that the rules clarify that the negotiation period is limited to 30 days. However, to best enforce compliance with good faith negotiation and to ensure that the full 30 days are available for both parties to negotiate, **we recommend amending the rules to establish a formal system to record receipt of the invitation to negotiate and that the period begin upon receipt of that invitation.**

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<sup>8</sup> Fiedler, Matthew, et al. Recommendations for implementing the No Surprises Act, Brookings Institute, March 16, 2021.

<https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/03/16/recommendations-for-implementing-the-no-surprises-act/>

<sup>9</sup> Pallone, Frank and Patty Murray, Letter to Secretaries Becerra, Yellen and Walsh, *Re: Interim Final Rule - Requirements Related to Surprise Billing; Part II*, October 20, 2021.

<https://www.help.senate.gov/imo/media/doc/Pallone%20Murray%20No%20Surprises%20Act%20IFR%20Comment%20ltr%2010.20.212.pdf>

## **Air Ambulance Considerations**

Air ambulance transportation does not currently operate in a robust competitive health care market. Patients and insurers are subject to prices that are inflated because of the lack of competition. Most air ambulances operate outside of insurer networks and can command high prices as a result. Although the NSA protects patients from balance billing, it is also true that inflated charges from air ambulances can increase the overall costs to an insurer and might end up as higher premium payments that all insureds have to pay. The NSA intended to account for situations such as these, where the concentrated market might have resulted in inflated network rates. Although it is mentioned in the preamble of the IFR, **we recommend that arbiters be more clearly guided to consider and use the market concentration “factor” in its determination of payment awards to air ambulance companies.** Unless and until there is a more competition that forces a true negotiated rate amongst air ambulance providers, arbiters should consider the impact market concentration has had on inflating such charges.

**We also recommend that these rules pertaining to air ambulances be reconsidered for further refinement when the air ambulance data required under the NSA is collected.** Further research and information may inform how a QPA might be better defined for the concentrated air ambulance industry.

## **External Review**

Because no law is perfectly implemented and there will be some players who will try to skirt the law, it is essential that insured Americans have an opportunity to dispute bills. We appreciate that the proposed IFR utilizes an existing system, the external review process, to be the framework under which consumers can challenge violations of the NSA. And we support inclusion of grandfathered plans in using this process as those insured individuals will need a way to dispute any violations of the NSA protections as well. However, we would like to acknowledge some shortcomings of the external review process as it operates today. Comments submitted by ten state-based consumer assistance programs, which have extensive first-hand knowledge of the external review process, outlined in their comments important considerations and recommendations.<sup>10</sup> We urge you to carefully review those comments and address the issues raised.

## **Good Faith Estimate and Patient-Provider Dispute Resolution**

An important patient tool included in the NSA is the right to request and be provided a good faith estimate (GFE) for care. The NSA and this IFR requires GFEs both for the uninsured and self-pay individual. Patients don't know the cost of the care they need until after they have received it. Understanding costs and the patient burden of those costs is an important way for patients to be better informed and to fight for their rights under the NSA and other consumer protection laws. This IFR begins to establish a way to get reliable GFEs into the hands of patients in a timely manner and to hold providers accountable to those GFEs. If patients cannot rely on these GFEs and cannot effectively dispute them, they will lose trust in the system and could find themselves in worse financial situations.

## **Convening physician**

We support the IFR in establishing the requirement that a convening physician be tasked with gathering all of the related billing information to provide a comprehensive GFE that includes all expected bills for a course of treatment or procedure. Patients do not have the knowledge or ability to gather multiple estimates from multiple health care providers and facilities. We understand that you will not be requiring this fully informed GFE in the first year, but **we urge you to reconsider this decision.** Patients who are given only a partial GFE cannot be expected to have a full understanding of their financial responsibilities. Providers have had a full year since passage to prepare for this law to go into effect. Delay will cause consumer confusion. **We also recommend that the GFE and other disclosures indicate the name and contact of the convening physician so patients, providers and facilities all are in agreement as to who is responsible for this task.**

## **Collections/Medical Debt**

We support the IFR provision that prevents providers from moving or threatening to move billed charges into collections while the patient disputes it. **We urge you to provide patients with a “receipt” of their dispute filing which delineates their protections from collections and allows them to show to any collection agents who try to collect on the bill while the process is pending.**

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<sup>10</sup> Benjamin, Elizabeth, Community Services Society of New York, et al. Letter from 10 state-based Consumer Assistance Programs, commenting on the IFR, part II. November 8, 2021 <https://www.regulations.gov/comment/CMS-2021-0156-0553>

## **SDR entities**

We recommend that **SDR entities should be certified as conflict-free with no financial stake in health care businesses**. And For oversight purposes, **SDR entities should be required to report similar data as required of IDR arbiters** relating to numbers of decisions, providers by specialty, billing codes and amounts charged and disputed, as well as how the complaints were resolved.

## **Additional recommendations for the GFE/Dispute resolution process**

We recommend the rules to be strengthened in the following ways:

1. **Lower the \$400 threshold for disputing a GFE.** The proposed IFR indicates that a difference between the final billed amount and the GFE must be more than \$400 for each provider. However, many procedures require multiple providers (physicians, facilities, lab/imaging services). For example, one patient might receive four or more bills from different providers, each failing to meet the \$400 threshold by a dollar. In this case, the patient ends up with a final bill of almost \$1600 more than they expected but they would not be able to take advantage of the dispute resolution process under this IFR. More than a third of Americans cannot cover an emergency expense of \$400.<sup>11</sup> The bill owed in our example is four times that amount, meaning many consumers will be in a very difficult situation if multiple providers attempt to skirt the law by upcharging to an amount just below the \$400 threshold, and submit “final” bills just a bit below the GFE. We recommend that the \$400 threshold be changed to apply to the entire bill, not an individual provider’s bill, or that the threshold be a certain percentage of the amount determined in the GFE.
2. Because there is a pause on the convening physician requirement, patients are not likely to get GFEs for all their services under a treatment plan or surgery. Therefore, it is likely patients will receive bills much larger than their GFE in the first year, and will want to dispute the bill. It is conceivable that there will be many rejected disputes because of this misunderstanding in the initial year of the NSA. To best encourage patient empowerment and engage them in enforcing this GFE requirement, and provide them the needed relief, we recommend the Department should **waive the \$25 filing fee in the first year**.
3. **Allow waivers of fees for the indigent to allow them to dispute violations of the NSA free of charge.**
4. **Allow extensions of time beyond the 120 days to file a dispute when patients are still hospitalized or otherwise incapacitated.** Very ill patients will have trouble managing their bills and using the dispute process if they are still being actively treated.
5. **Apply the moratorium on billing collections and sending these bills to collections if the patient is not recovered and at home, even if they have not filed a complaint.**
6. **Improve model GFEs and Advanced EOBs to include essential information to patients about facility financial assistance programs or ways to obtain screening for other public programs.** These documents are the perfect place for patients to engage in obtaining financial assistance - before undergoing treatment and incurring charges.
7. **Require providers to submit additional copies of GFEs within 5 business days to patients if they have misplaced it and need it for the dispute resolution forms.**
8. **Clarify that “coerced” waivers of consent are allowed to be challenged in the patient dispute resolution process.**

## **Recommendations for GFEs and Advance Explanation of Benefits (EOBs)**

1. **Require Advance EOBs and GFEs to include billing codes *and* plain language descriptions for each service or treatment.** By providing both types of information, both patients and professionals have the information they need to understand and explain medical bills.
2. **Require GFEs and Advance EOBs to include essential information to patients about facility financial assistance programs or ways to obtain screening for other public programs.** These documents are the perfect place for patients to begin to understand and explore financial assistance - before undergoing treatment and incurring charges.

As a newly implemented patient right, it is paramount that federal and state governments collaborate to provide clear and accurate information for patients to know about their rights to obtain a reliable GFE, their ability to dispute violations of the NSA, and how to best utilize this process effectively. We recommend regulators conduct quick turn-around reviews every three months to evaluate the most recent disputes as a way to identify violation trends and to target increased providers/insurers education. We also recommend greater financial support and training of local and state nonprofits who can work with patients to understand their protections and help patients use the dispute system.

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<sup>11</sup> Federal Reserve Board, Report on the Economic Well-Being of U.S. Households in 2019-May, <https://www.federalreserve.gov/publications/2020-economic-well-being-of-us-households-in-2019-dealing-with-unexpected-expenses.htm>

## Closing

We commend the Departments for issuing the IFR in a timely manner and urge swift implementation on January 1, 2022. Consumers continue to struggle to pay air ambulance bills in the tens of thousands of dollars, or out-of-network charges from emergency rooms or other providers at their in-network facilities. The financial and emotional burden of these bills is real. And the problem is growing as private equity plays a larger role in health care, incenting providers to remain outside of insurer networks and submitting patients and insurers to even higher charges to maximize profit for investors.<sup>12</sup> Until the new law is in place, monitored and closely enforced, patients will be unprotected from these bills and we will all continue to pay for the added costs that these out-of-network charges have on our commercial insurance system through higher premiums.<sup>13</sup>

Congress enacted the No Surprises Act to protect consumers from balance billing while at the same time creating downward pressure on health care costs. This rulemaking honors that Congressional intent by centering the interests of consumers: holding families harmless from surprise medical bills and minimizing the inflationary impact of provider-insurer payment disputes so that families do not face higher health care costs as a result.

On behalf of U.S. PIRG and our state affiliates, we commend the Department for its work to design consumer protections to help patients avoid the high costs that out-of-network bills add to the system. We thank you for the opportunity to comment and offer our support as the work to implement the No Surprises Act continues.

Respectfully submitted,



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PIRG is a federation of independent, state-based, citizen-funded Public Interest Research Groups in 25 states, whose role is to find common ground around the commonsense solutions that will make our future healthier, safer and more secure. We are part of The Public Interest Network, which operates and supports organizations committed to a shared vision of a better world and a strategic approach to social change. Learn more at [uspirg.org](https://www.uspirg.org).

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<sup>12</sup> Perlberg, Heather and Karsh, Melissa, "Private Equity Dodges Worst From Surprise-Billing Crackdown", Bloomberg, December 22, 2020, <https://www.bloomberg.com/news/articles/2020-12-22/virus-fears-helped-private-equity-tame-rule-on-surprise-billing>

<sup>13</sup> Congressional Budget Office (January 2021). Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-2, [www.cbo.gov/system/files/2021-01/PL\\_116-260\\_div%20O-FF.pdf](https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf)