Template Comment for "Requirements Related to Surprise Billing; Part I" (IFR)

Families USA Action created this template to aid in drafting your own comments in response to the tri-agency's interim final rule for implementation of the *No Surprises Act*. We encourage you to use this template, or sections of this template, to help you create comments that support your organizational values and priorities.

Comments should be submitted online at https://www.regulations.gov/commenton/CMS-2021-0117-0002 . Click on "comment now" and either enter your comment in the text box (must be fewer than 5000 characters) or upload your comments as a PDF. As you are drafting your comment, here are some important tips to keep in mind:

1. **Customize comments to reflect your organization's expertise and unique position.** We have indicated sections where you can customize this template to reflect your organization's viewpoint. Please feel free to make additional changes throughout the document as you see fit.
2. **Leverage your expertise.** If you have specific expertise in an area, it is helpful to document that and cite to relevant research.
3. **Share stories**. If your organization collects consumer stories, this is a great place to share them. Demonstrating how patients and consumers are directly affected by surprise billing helps to emphasize the gravity of this issue.

Submitted via www.regulations.gov
Comments are due 5pm, September 7, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9909-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Add addressees at Treasury, Labor, OPM

Submitted via regulations.gov

RE: CMS-9909-IFC- Requirements Related to Surprise Billing; Part I

Dear Administrator Brooks-LaSure, et al:

[Insert Organization here] appreciates the opportunity to provide comments on the Interim Final Rule on "Requirements Related to Surprise Billing; Part I" (IFR) as released by the Office of Personnel Management; Internal Revenue Service; Employee Benefits Security Administration; and Centers for Medicare & Medicaid Services (the Departments). We thank the Biden Administration for their work on this IFR that builds upon the landmark passage of the *No Surprise Act (NSA),* and for finally protecting consumers from the harmful and unfair practice of out-of-network balance billing.

[Insert information about your organization and why this issue matters to your constituents].

Overall Considerations

The July IFR is a positive step towards ending surprise medical billing, and we are grateful to the Departments for their work drafting these regulations. The IFR contains important provisions around overall scope of consumer protections, reaffirming what is set in the statute.

The recommendations in this comment letter are critical to ensuring that consumers are meaningfully protected from out-of-network balance bills. We ask that these comments, and all supportive citations referenced herein, be incorporated into the administrative record in their entirety. Our comments focus on the following areas of the interim final rule, as outlined in the preamble: [Modify if you do not comment on all]

- Section III.B.1 Scope of the New Surprise Billing Protections
  - Section III.B.1.ii Post-Stabilization Services
  - Section III.B.1.iv Health Care Facilities
- Section III.B.2. Determination of the Cost-Sharing Amount and Payment Amount to Providers and Facilities
  - Section III.B.2.iv. Interaction with State Law
  - Section III.B.2.vi. Methodology for Calculating the Qualifying Payment Amount
- Section III.B.3. Additional Plan and Issuer Requirements Regarding Making Initial Payments or Providing a Notice of Denial
- Section III.B.4. Surprise Billing Complaints Regarding Group Health Plans and Health Insurance Issuers; Section IV.A.4. Surprise Billing Complaints Regarding Health Care Providers, Facilities, and Providers of Air Ambulance Services

- Section IV.A.2. Notice and Consent Exception to Prohibition on Balance Billing
    - Section IV.A.2.iv. Exceptions to the Availability of Notice and Consent
- Section IV.A.3. Provider and Facility Disclosure Requirements Regarding Patient Protections against Balance Billing
    - Sections IV.A.3.ii-iii. Methods of Disclosure and Timing of Disclosure to Individuals
- Section VII.D.5. Economic Impact and Paperwork Burden: Information Collection Requirements Regarding Complaints Process for Surprise Medical Bills (45 CFR 149.150, 45 CFR 149.450)

We will also use this comment opportunity to look ahead to the administration's future rulemaking on the *No Surprises Act*, particularly around the independent dispute resolution (IDR) process, which will have significant implications for health care costs and consumers.

Section III.B.1 Scope of the New Surprise Billing Protections

Section III.B.1.ii Post-Stabilization Services

'Post-Stabilization Services' and 'Reasonable Travel Distance'

The IFR seeks comment on factors to consider in determining whether a patient is able to travel and provide consent. It proposes factors in the preamble, but does not yet include them in the regulation itself.

We appreciate the opportunity to comment on the definition of "reasonable travel distance," as it is important to ensure consumers do not have to surmount unreasonable burdens in order to seek out in-network medical care. **We recommend the Departments consider the following factors, at a minimum, in determining reasonable travel distance: travel length in miles, travel duration in minutes (including by public transportation), traffic congestion, natural barriers, and access to safe and timely modes of transportation. We recommend the Departments:**

- **Adopt maximum travel standards no greater those used to determine network adequacy in Medicare Advantage plans, and shorter than those used by Medicare Advantage for rural areas.**
- **Ensure that state network adequacy laws with stronger travel time and distance standards take precedence.**
- **Ensure that existing definitions of reasonable travel time are adapted to take into account "pertinent factors" such as adverse natural barriers.[1]**
- **Ensure the transferring facility or provider be assigned responsibility for assisting or making travel arrangements, unless the patient elects otherwise.**

Additionally, patient-specific factors, particularly disability and access to affordable, safe, and timely modes of transportation, should be considered. Notably, studies show that persons with disabilities experience longer travel times to receive medical care, despite traveling similar distances and having similar access to private vehicles.[2] People with disabilities also often have elevated need for out-of-

[1] Phyllis E. Bernard, Privatization of Rural Public Hospitals: Implications for Access and Indigent Care, 47 Mercer L. Rev. 991 (1996)
[2] Silver D, Blustein J, Weitzman BC. Transportation to clinic: Findings from a pilot clinic-based survey of low-income suburbanites. Journal of Immigrant and Minority Health/Center for Minority Public Health. 2012;14(2):350–355.

network access because in-network providers may not have physically accessible facilities or have experience treating people with that disability.

We recommend the Departments define travel as unreasonable if such travel would require a patient to cross state lines, particularly if a patient would lose protections under their state's law by doing so. [Insert any examples from your state that have strong travel requirements under current law.]

We also strongly support consideration of factors including the individual's state of mind, and any conditions including substance use and cultural and contextual factors that may be impairing their ability to consent. **These factors are named in the preamble, but not in the regulations. We recommend that the Departments:**

- **Require at least 24-hour advance notice of a post-stabilization transfer.**
- **Add examples to the regulation itself at 42 CFR 149.410 that reflect the factors described in the preamble.**
- **Develop model notices specific to patient transfers that must be signed by the provider and include information about how to file a complaint regarding a transfer or discharge with which the patient disagrees, and how to get help, including from a health consumer assistance program. Treating providers who are out-of-network will have an inherent conflict of interest in making these determinations so we are also recommending access to an expedited complaints process for patients to contest inappropriate transfers.**
- **Provide that consumers can request and receive a second opinion if the facility recommends transfer and the patient disagrees. The cost of the second opinion should also be treated as an emergency service, covered by the No Surprises Act. Assign responsibility to the treating facility for coordinating the transfer, including assisting the patient as needed in securing transportation, ensuring a timely appointment with an in-network provider, and transferring records.**
- **Collect data on the number of transfers by diagnosis, provider type, and facility that will enable HHS, states, and the public to monitor whether these protections are sufficient.**

[Insert any examples from your experience about why these protections are necessary.]

Section III.B.1.iv Health Care Facilities

'Health Care Facilities'

We support the Departments' efforts to include a number of facilities in the definition of "participating health facilities". **However, we highly recommend that the Departments include "urgent care centers" in the definition of "health care facilities".** The use of urgent care facilities by families seeking care has grown over the years.[3] [Insert statistics from your own state on urgent care usage]. Urgent care

[3] Poon SJ, Schuur JD, Mehrotra A. Trends in visits to acute care venues for treatment of low-acuity conditions in the United States from 2008 to 2015. JAMA Intern Med 178(10):1342–9. 2018.
Mehrotra A, Wang MC, Lave JR, Adams JL, McGlynn EA. A comparison of patient visits to retail clinics, primary care physicians, and emergency departments. Health Aff (Millwood) 27(5):1272–82. 2008.
AMN Healthcare. Convenient care: Growth and staffing trends in urgent care and retail medicinepdf iconexternal icon [white paper]. 2015.

facilities often surprise bill their patients[4], making urgent care facilities a potential site for abusive surprise billing practices to continue. [Insert data from your state on urgent care surprise billing cases.] Not including urgent care centers and retail clinics in the definition of health care facilities would undermine the *No Surprises* law and Congress's intent to protect consumers from surprise billing.

We also urge the Departments to include a definition for urgent care centers that encompasses their offered services. Individual state governments and health departments across the United States have different definitions for urgent care centers, and the lack of a consistent definition may cause confusion for consumers and providers alike. **We recommend that the Departments use the following definition: "a medical facility that is dedicated to the delivery of unscheduled, walk-in, ambulatory care, for acute illnesses or minor traumas, outside of a hospital emergency department, free-standing clinic or physician's office."** This can include a facility that delivers this care without the intention of developing an ongoing care relationship between the licensed provider and the patient.

We also recommend including retail clinics in the definition of emergency care, as well as adding other types of facilities at which at least one treating provider is in-network for the patient. The *No Surprises Act* also applies to non-emergency care. It is critical that the rule is applied to all types of health care facilities in which patients use in-network services and may be unaware that some of their associated providers are out-of-network. [Insert data from your state about retail clinic usage, and/or about other types of facilities where consumers may be surprised by out-of-network bills]. Ensuring that the *No Surprises Act* protections apply to these types of facilities will relieve consumers from the burden of trying to figure out from which facilities they can seek out medical services, without the fear of being balance billed.

Section III.B.2. Determination of the Cost-Sharing Amount and Payment Amount to Providers and Facilities

Definition of 'Qualifying Payment Amount'

We strongly support the Departments' definition of the Qualifying Payment Amount. We also strongly support the Departments' intent to minimize the usage of alternative methodologies to calculate the QPA, when possible. Both of these are clearly based on the specific direction of the *No Surprises Act's* statutory language.

Section III.B.2.iv. Interaction with State Law

While we support the concept of opting into state laws that offer equal or greater consumer protection, **we urge HHS to develop strong procedures to compare the protections each state law offers with federal protections, to regularly review and update its database of state laws, and to publicly post its analysis of what state laws are and are not preempted.** [Provide examples from your state of this interaction, and why it is important for HHS to analyze the interaction with state law].

Dolan, Shelagh. "How the Growth of the Urgent Care Industry Business Model Is Changing the Healthcare Market in 2021." Business Insider. Business Insider, January 29, 2021. https://www.businessinsider.com/urgent-care-industry-trends.

[4] Ibid.

Section III.B.2.vi. Methodology for Calculating the Qualifying Payment Amount

Definition of 'Geographic Regions'

We strongly support the Departments' definition of 'geographic regions' to be generally defined as "one region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state."

Consolidation's Impact on Prices

The Departments seek comment as to the impact of large consolidated health care systems on contracted rates, and the impact of such contracted rates on prices and the QPA. We share the Departments' concerns that health care consolidation could have significant impacts on contracted rates.

Highly consolidated health care markets are proven to result in high and increasing prices across most of the nation.[5,6,7] There are few competitive health care markets left in the country. Ninety percent of metropolitan statistical areas (MSAs) have highly concentrated hospital markets and 65% of MSAs have highly concentrated specialist physician markets.[8] These highly concentrated markets contribute directly to higher prices paid by consumers. [Insert data/statistics that show high prices as a result of consolidated markets in your state/locality].

The Departments can take further action to combat the effects of consolidation by implementing a slightly different methodology when accounting for consolidated systems. In the case that a plan has multiple contracts with different providers housed under a single parent system, **the Departments should direct plans to treat these multiple contracts within the same parent system, as a single contract when calculating the QPA.** This could be calculated by the taking the mean of the contracts, and using that mean as a single value in the median calculation for QPA. This method would reduce the impact of a consolidated system's unfair market power.

[5] Martin Gaynor, "What to Do About Health-Care Markets? Policies to Make Health-Care Markets Work," The Hamilton Project, March 2020, Available at: https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf

[6] Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers, Boston, MA: Office of Attorney General, March 16, 2010, https://www.mass.gov/files/documents/2016/08/vn/2010-hcctd-full.pdf

[7] Bela Gorman, Don Gorman, Jennifer Smagula, John D. Freedman, Gabriella Lockhart, Rik Ganguly, Alyssa Ursillo, Paul Crespi, and David Kadish, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement, New York: New York State Health Foundation, December 2016, https://nyshealthfoundation.org/wp-content/uploads/2017/11/an-examination-of-new-york-hospital-reimbursement-dec-2016.pdf

[8] Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," Health Affairs 36, no. 9 (September 2017): 1530–38, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0

Section III.B.3. Additional Plan and Issuer Requirements Regarding Making Initial Payments or Providing a Notice of Denial

Minimum Initial Payments Pre-Arbitration

The *No Surprises Ac*t requires plans to make an initial payment to the provider after the claim has been submitted. However, the statute does not specify what this minimum payment amount is, or a calculation to dictate this amount. The Departments are seeking comment on whether to establish a set amount for the minimum initial payment.

We recommend that the Departments establish a minimum initial payment that is aligned with the tri-agencies' minimum initial payment set forth in the Patient Protection and Affordable Care Act (PPACA) regulations,[9] which would require payments by plans to providers to be the greatest of three: (1) the median amount the plan or insurer has negotiated with in-network providers for the furnished service in the same geographic region; (2) the amount for the emergency service calculated using the same method the plan or insurer generally uses to determine payments for out-of-network services (such as, the usual, customary, and reasonable amount) for the furnished service in the same geographic region; or (3) the amount that would be paid under Medicare for the furnished service in the same geographic region.[10]

We support the minimum initial payment standard outlined above, but **recommend the Departments explicitly state in future rulemaking, that the arbiter of the IDR process should be banned from considering the minimum initial payment, and not use the minimum payment limit as a "floor" or starting point, for determining final rates**. Furthermore, in the case that the arbitration award is lower than the minimum initial payment, providers should be required to pay back the difference in price within a certain amount of time. Penalties should be instated if providers do not make these payments in a timely fashion, with similar requirements placed on plans during the pre-arbitration payment stage.

Section III.B.4. Surprise Billing Complaints Regarding Group Health Plans and Health Insurance Issuers; Section IV.A.4. Surprise Billing Complaints Regarding Health Care Providers, Facilities, and Providers of Air Ambulance Services

Complaints Process

The statute directs the agencies to establish a complaints process regarding violations of QPA requirements by plans and issuers offering group or individual coverage. We strongly support the agencies' proposals, described in Sections III.B.4. and IV.A.4. of the preamble to the IFR to establish a process to also receive complaints regarding violations of all other consumer protections regarding balance billing. **We recommend further specificity concerning a unified and transparent complaints process regarding violations by health care plans, providers, facilities, and providers of air ambulance services of balance billing requirements.**

It is critical that the Departments establish an equitable, transparent, and meaningful complaint system to contest balance billing violations. The goal of such a system should be to protect consumers, alert federal oversight of problems, and to increase transparency in the health care system. **We recommend**

[9] 3 See 45 C.F.R. § 147.138(b)(3).
[10] *Ibid.*

that the Departments specify that federal external appeal rights apply to denials and mispayments of surprise bills.

Minimizing the Burden for Consumers

Consumers should have a low threshold to enter this process to make it more likely they will report complaints and violations as they occur. The Consumer Financial Protection Bureau (CFPB) has a robust consumer complaints process that should serve as a model for the agencies. **The Departments should also establish an online system for accepting complaints that is modeled after the CFPB consumer complaint system. The system should have the following capabilities: ease of navigation to file a complaint; logical drop-down menus for efficient use by consumers; provides space for consumers to include narrative descriptions or additional details regarding the complaint. The system should also have the capability to accept complaints by phone and by mail. Web information on the complaint process should be available in at least 15 languages and in languages spoken by 10 percent or more of a population in a given state, consistent with other CMS guidance on language access,[11] and in all languages by phone. We recommend that HHS investigate and track each complaint to its resolution and inform consumers of the outcome.**
[Insert any examples illustrating the need for a complaint process or of consumer-friendly complaint processes.]

We strongly recommend that the rules:

- **Provide a deadline for resolution of complaints, including an expedited timeline for complaints that allege that a patient is inappropriately pressured to transfer to receive in-network emergency or post-stabilization care;**
- **Require suspension of billing, debt collection, and credit reporting while a dispute is pending;**
- **Link to enforcement processes that address both plan and provider responsibilities.**

We suggest that the government establishes a timeline for investigation for the complaints process. [Insert example from your state, if applicable, of a successful consumer complaint timeline.]

We strongly recommend that payment debt collection, and any associated interest on a bill, be suspended while a complaint is under investigation. We recommend that upon filing the complaint, consumers receive a "receipt" that affirms they filed the complaint and explains their rights under the "disputed" bill protections that pauses debt collection and credit reporting. Upon resolution, the time interval of the complaints process shall not toll against any payment/collection timelines.

[Insert any example from your work, if applicable, of why this is needed and the impact of surprise bill debt and interest.]

We recommend the agencies do *not* institute a time limit for consumers or their representatives to file a complaint. Consumers often receive a first bill for a service many months after the service was

[11] See CMS, Guidance and Population Data for Exchanges, Qualified Health Plan Issuers, and Web-Brokers to Ensure Meaningful Access by Limited-English Proficient Speakers Under 45 CFR §155.205(c) and §156.250, for example, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Language-access-guidance.pdf.

initially delivered, or first become aware of their liability for a medical debt belatedly when a hospital assistance program or an accident policy does not pay for their care. [12]

'No Wrong Door' and Investigating Complaints

Guidance on assisting consumers must include a "no wrong door" policy to enable consumers to get the help they need regardless of the status or licensure of the provider or plan involved in the payment dispute. [Insert examples of successful use of "no wrong door" policies within your state/locality].

As CFPB does, the Departments should notify the party against whom the complaint was filed and require that party to respond to the Departments. Additionally, the complaint should be forwarded to the state enforcing agency and/or medical board, so state regulators can properly track and respond where they have jurisdiction. [Insert any additional information regarding your state's best practices on this issue.]

Role of Consumer Assistance Programs

Consumers must have access to assistance to navigate the complaints process and their protections. Consumer assistance programs (CAPs) were federally established under Section 1002 of the Affordable Care Act (Section 2793 of the Public Health Service Act) as independent offices that coordinate with regulators to respond to consumer inquiries and complaints, assist consumers with filing appeals, track problems, and educate consumers about their rights and responsibilities.

We urge the Departments to give CAPs a formal role in the complaints process, and to fund and empower them to do so. The formal role of CAPs should include:

- Providing outreach to consumers about their rights under the law;
- Assisting consumers in filing complaints and appeals about surprise bills;
- Assisting consumers to compare good faith estimates of out-of-network charges to their likely in-network costs for those services;
- Assisting consumers to contest the notice and consent process when, for example, there is evidence that emergency and post-stabilization protections should continue;
- Assisting consumers in pursuing arrangements for their plans to pay for out-of-network services if in-network care is not reasonably available;
- Reporting to states, federal agencies and the public about problems that consumers encounter, helping to identify patterns by bad actors. Rules should require agencies and plans to accept complaints filed by CAPs on behalf of consumers, and to communicate back to CAPs regarding the status of those complaints. CAPs should be listed as a resource on all consent forms.

Congress has not appropriated federal funding for CAPs in recent years resulting in programs that have not received grant funding since 2014. In several states where CAPs have continued with state funding, they have achieved tremendous successes, saving consumers significant amounts of money; helping consumers obtain needed medications, psychiatric services, and other medical care; and contesting

[12] Bologna, Giacomo, "St. Dominic Knew Patients Couldn't Afford Care. It Sued Them Anyway," Mississippi Center for Investigative Reporting, August 6, 2021, https://www.mississippicir.org/news/st-dominic-knew-patients-couldnt-afford-care-it-sued-them-anyway.

wrongful charges for COVID-19 care and for balance billing.[13] However, the majority of states currently have no CAP to assist consumers in asserting their rights under federal and state law, and no CAPs are adequately funded to assist the large number of consumers who stand to benefit from the new federal surprise billing protections. **In the short term, we urge the Administration to dedicate a portion of implementation funding appropriated by No Surprises Act to CAPs for specific purpose of building capacity to help consumers with surprise billing problems and reporting to HHS on consumer experiences and outcomes.** [Insert any success your state has had with CAPs in assisting consumers with their complaints, or evidence of the need for CAP funding to address surprise bills in your state].

Section IV.A.2. Notice and Consent Exception to Prohibition on Balance Billing

Timing of Notice

The statute puts forth that consent to out-of-network care can only be given 72 hours in advance of the scheduled appointment. In the rulemaking, the Departments also established that in instances where the appointment occurs less than 72 hours after scheduling, notice and consent can be given on the same day as the appointment was made and must be given at least 3 hours in advance of the appointment itself. While the Departments intend for the 3-hour restriction to help ensure that consent is truly voluntary and help avoid a patient feeling pressure to sign away their rights, we see this 3-hour rule as ripe for abuse. **We urge the Departments to clarify that providers can only seek consent if the patient contacted the provider and sought treatment before being admitted to the facility.** Once a patient is admitted for, or is undergoing care, they cannot truly consent. There could perhaps be a process for a patient-initiated consent process in the rare instances where patients purposely seek a second opinion or specialty care from an out-of-network provider after they have been admitted. A distinct form should be developed for that. [Insert example of law in your or other states where this type of law has been abused, or if you have stronger protections, how that has worked to protect consumers in your state].

Protections under the *No Surprises Act* should apply if a patient does not consent, and there are no in-network providers available within the "reasonable travel distance."

Section IV.A.2.iv. Exceptions to the Availability of Notice and Consent

Meaningful Choice of Provider and Specialties Exempt from Notice and Consent

The *No Surprises Act* identifies certain ancillary services that are exempt from the notice and consent provisions and where patients cannot waive their balance billing protections. **We recommend adding an exception to the notice and consent process to guarantee that people who do not have a meaningful choice of provider will not be subject to out-of-network charges.** The Departments can look at Texas language under 28 TAC § 21.4903 as an example of this sort of "meaningful choice" protection. Additionally, notice and consent should only be allowed for out-of-network providers with whom patients schedule care prior to admission at a facility. [If you have other examples of states with strong definitions, please share here].

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[13] C Fish-Parcham and E. Benjamin, "Congress Should Appropriate Funds for Consumer Assistance Programs in Every State," Families USA and Community Service Society of New York, July 2021.

Section IV.A.3. Provider and Facility Disclosure Requirements Regarding Patient Protections against Balance Billing

Sections IV.A.3.ii-iii. Methods of Disclosure and Timing of Disclosure to Individuals

We recommend requiring the disclosure notice to be shared with patients at the time of scheduling, on their Explanation of Benefits (EOB), and with every patient bill for out-of-network emergency services and for out-of-network in-facility services. In addition to providers and insurers, **we urge the Departments to require medical bill collectors to distribute the full model disclosure notice.**

Future Rulemaking: Independent Dispute Resolution

Commented [JS1]: Note: Part II rulemaking is currently under review at OMB. If it is published prior to submission of this letter, you should tweak this framing to acknowledge.

A critical piece of the *No Surprises Act* that was not addressed in this IFR is the independent dispute resolution (IDR) or arbitration process that will be used by providers and insurers to settle disputes that arise regarding how much the insurer must pay an out-of-network provider. We look forward to formally commenting on those regulations when they are published. In the meantime, **we urge the Departments to draft rulemaking that upholds the congressional intent of the *No Surprises Act* and protects consumers from inflated health care costs.**

Arbitration is shown to lead to consistently higher provider payments and health care costs in states where it is a part of the balance billing process. It additionally provides an incentive for providers to stay out of network, as demonstrated in New Jersey and Texas.[14] For these reasons, the arbitration system should be a "last resort" for payment disputes in order to keep overall costs down and prevent overuse and/or abuse of arbitration.

Regulations should establish clear guidelines for arbitrators to ensure a predicted and consistent result from payment disputes, including ensuring that the qualifying payment amount (QPA) is the primary factor in deciding cases. The agencies should ensure that decisions are not consistently above in-network rates which would have an inflationary impact.

Provider expertise and case acuity should only be considered when the designated QPA does not already take these factors into account. Provider experience and training is not a relevant factor in making determinations about health care prices or payment rates nor should it be used as a justification for increasing provider reimbursement above the median of already inflated commercial rates.

In markets with moderate to high levels of concentration, the arbitrator should consider the fact that prior contracted rates or median in-network rates are the result of insurers and providers battling for

[14]Corlette, S., J. Hoadley, M. Kona, and M. O'Brien. "Taking the Disputes Out of Dispute Resolution: Lessons from State Balance Billing Laws." Robert Wood Johnson Foundation. Georgetown University Health Policy Institute, Center on Health Insurance Reforms, March 15, 2021. https://www.rwjf.org/en/library/research/2021/03/taking-the-disputes-out-of-dispute-resolution--lessons-from-state-balance-billing-laws.html.

relative market power and the ability to set prices. Substantial evidence links increased consolidation to high and rising health care prices, particularly in the commercial market.[15,16,17]

Congress enacted the *No Surprises Act* to address the urgent health care affordability challenge facing patients with the goal of lowering consumer costs both through the balance billing protections themselves and through downward pressure on health care costs.[18] **Congressional intent can only be honored by drafting regulations that minimize the inflationary impact of arbitration and make the qualifying payment amount (QPA), on which patient cost-sharing is based, the primary factor in resolving payment disputes.**

Conclusion

On behalf of [insert organization] we appreciate the opportunity to provide the above recommendations and feedback. We offer our support in providing feedback and technical assistance as you are developing subsequent rulemaking in the coming weeks and months. If you have any questions, please contact [Insert staffer name here] at [insert organization name], at [Insert contact email] for further information.

Sincerely,

[Insert organization here]

[15] Martin Gaynor, "What to Do About Health-Care Markets? Policies to Make Health-Care Markets Work," The Hamilton Project, March 2020, Available at: https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf

[16] Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers, Boston, MA: Office of Attorney General, March 16, 2010, https://www.mass.gov/files/documents/2016/08/vn/2010-hcctd-full.pdf

[17] Bela Gorman, Don Gorman, Jennifer Smagula, John D. Freedman, Gabriella Lockhart, Rik Ganguly, Alyssa Ursillo, Paul Crespi, and David Kadish, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement, New York: New York State Health Foundation, December 2016, https://nyshealthfoundation.org/wp-content/uploads/2017/11/an-examination-of-new-york-hospital-reimbursement-dec-2016.pdf

[18] Congressional Budget Office (December 2020). Estimate for Divisions O Through FF H.R. 133, Consolidated Appropriations Act, 2021 Public Law 116-260. https://www.cbo.gov/system/files/2021-01/PL_116-260_div_N.pdf