

September 7, 2021

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Washington, DC 20201

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

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

SUBJECT: Requirements Related to Surprise Billing; Part I (CMS-9909-IFC)

Dear Secretaries Becerra, Walsh and Yellen:

The undersigned surgical organizations appreciate the opportunity to comment on the “Requirements Related to Surprise Billing; Part I” interim final rules with comment (IFR) implementing certain provisions of the No Surprises Act issued by the Office of Personnel Management; Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; and Centers for Medicare & Medicaid Services, Department of Health and Human Services (collectively referred to as the “Departments” in this letter).

Surprise Billing and the Need for Greater Consumer Protections

The Departments highlighted the disproportionate impact surprise bills could have on communities experiencing poverty and other social risk factors. The Departments request specific comments from members of, advocates for, and those who work with underserved communities.

It is well established that social determinants of health (SDOH) impact quality of care. Lack of access, limits on resources, lack of preventive care, poor early detection, and limited chronic care maintenance are some of the factors that contribute to care inequities, which can result in worse overall outcomes in surgical care. It is imperative that patients have timely access to needed care, the critical first step toward optimal quality care. Efforts to increase the availability of surgical care are crucial to providing the right care, at the right time, in the right place. We are

committed to continuing to work with the Administration in supporting rules for the No Surprises Act that serve to increase the availability of surgical care to patients. We commend CMS for the resources it has invested in identifying ways to promote health equity and agree that identifying means to improve the health care of certain populations who have been historically underserved should be a top priority of the Departments and the entire U.S. health care system.

Scope of Protections

Post-stabilization Services

We applaud the Departments for reinforcing the prudent layperson standard for emergency services. However, we have some concerns regarding the treatment of post-stabilization services. The Departments state the statutory protections for emergency services extend to additional items and services that are covered under a plan or covered and furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items and services are furnished) after a patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the other emergency services are furnished. These services, referred to as “post stabilization services,” are considered “emergency services” and therefore subject to the statutory protections unless all four of the following conditions are met:

- The attending emergency physician or treating provider has determined that the patient is able to travel using non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance;
- The provider or facility furnishing post-stabilization services satisfied the notice and consent criteria;
- The individual (or individual’s representative) must be in a condition to receive the information in the notice and to provide informed consent; and
- The provider or facility must satisfy any additional requirements or prohibitions applicable under state law.

The rule defines a “visit” to a participating health care facility to include the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services and preoperative and postoperative services. The rule also solicits feedback on other items and services that would be appropriate to include within the scope of a visit for purposes of these interim final rules. Given this broad definition of “visit” that could be expanded further, we urge CMS to specify that **“with respect to the visit” for purposes of the post-stabilization proposal only applies to the patient encounter for which the patient was initially seen and evaluated on an emergency basis.** We also urge CMS to clarify that **for purposes of the post-stabilization proposal, a “visit” ends if a patient is referred to a different provider after the emergency encounter has ended and if the patient can provide consent for services.** For example, using telehealth for wound checks or burn care for a surgery that was provided on an emergency basis should no longer be considered part of “the visit” under the post-stabilization policy.

We agree that if the four conditions above are met, an emergency service should no longer be subject to the statutory protections for emergency services. But we believe that there are other circumstances where the statutory protections for emergency services should no longer be extended. These could include if a patient goes home after an emergency visit and then comes to the facility for surgery at some point later. **The protections should also end if the services provided, while perhaps “related” to the emergency visit, are temporally remote.** For example, reconstruction after a burn injury relates to the emergency visit but could occur months later.

The Departments request comment on the definition of “reasonable travel distance.” We have previously **urged Congress to consider both geographic and driving distance standards when considering the definition of “reasonable travel distance”** in other contexts. We also emphasize that the geographic proximity of a different facility is only relevant if that facility has the necessary capabilities to meet the patient’s needs. It is preferable for a patient to remain in the care of an out-of-network provider at a facility capable of providing the necessary services than to be transferred to an in-network facility/provider where the required care modalities are not available. As such, we do not believe the first criteria should be met if the patient can, in fact, travel a reasonable travel distance to a participating provider or facility if the patient cannot be appropriately treated at the participating provider or facility.

Determination of Cost Sharing Amount & Payment Amount to Providers/Facilities

Payment Amount and the “Out-of-Network Rate”

The No Surprises Act sets forth requirements around the “total amount paid” by the plan/issuer. The “total amount paid” is referred to in the statute as the out-of-network rate. Given the statutory construction and the design of the recognized amount being detached from the plan/issuer requirements to pay the out-of-network rate, these requirements may result in circumstances where a plan or issuer must make payment before an individual meets their deductible. The rule states that the plan must meet its requirements of paying the out-of-network rate regardless of whether the patient has met their full deductible in these circumstances since the patient cannot be liable for more than the recognized amount as calculated under statute. **We support this proposal to ensure that the provider/facility is paid for their services regardless of whether the patient has met their deductible.**

Specified State Law

As laid out by the No Surprises Act, a “specified state law” is “a state law that provides a method for determining the total amount payable under a group health plan or group or individual health insurance coverage to the extent the state law applies.” The Departments have interpreted this to include plans that have elected to opt-in to a related state program that would not otherwise be subject to the applicable state law (e.g., ERISA plans). The Departments also require a self-insured plan that has chosen to opt-in to a state law to prominently display in its plan materials describing out-of-network services a statement that the plan has opted in to a specified state law,

identify the relevant state (or states) and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified state law. Finally, the Departments require that the state law must:

- Apply to the plan, issuer, coverage involved (including where a state has allowed a plan to “opt-in”);
- Apply to the nonparticipating provider or nonparticipating emergency facility; and
- Apply to the item or service involved.

Our organizations have significant concerns about this section of the IFR. We believe that the statute is clear that state-regulated plans will be governed by state law and the No Surprises Act will govern federally-regulated ERISA plans. In situations where there is no state law, the federal law will apply.

Despite the requirement for information to be prominently displayed in its plan materials, we believe it will nevertheless be difficult for patients and providers to understand which law will be applicable — particularly if plans can opt-in on an episodic basis. We anticipate that chaos will ensue. **Therefore, as a general rule, we urge the Departments to clarify that all ERISA plans are subject to the federal No Surprises Act and cannot opt-in to existing state regulations.** We believe that a driving force behind the law was to develop a uniform set of rules for plans governed by ERISA, and allowing these plans to pick and choose among state laws would thwart this objective. At the very least, to minimize potential confusion, we urge the Departments to prohibit episodic opt-ins by self-funded plans. **Finally, the Departments should ensure that specified state laws are only those that provide for thorough patient protections and a clear and accessible method for determining a fair payment amount.** States that do not meet both requirements should not be recognized as specified state laws.

For those states with existing state laws, guidance on whether the state law meets the No Surprises Act’s criteria for a specified state law is critical. To provide patients and providers clarity, the Departments should undertake a comprehensive state-by-state analysis to determine whether the law meets the criteria outlined in the IFR. This information, which should be periodically updated, could then be published on the Departments’ websites.

Calculating the QPA

The cost-sharing protections of the No Surprises Act can be anchored to the qualifying payment amount (QPA) where there is no governing All-Payer Model Agreement and no governing state law. Generally speaking, 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.

Median Contracted Rate

The Departments define “contracted rate” as the total amount (including cost-sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider or facility for covered items and services, whether directly or indirectly through a third-party administrator or pharmacy benefit manager. Under this definition, if a plan or issuer has a contract with a provider group or facility, the rate negotiated with the provider group or facility is treated as a single contracted rate if the rate applies to all the providers. The Departments state the rate negotiated under a contract constitutes a single contracted rate regardless of the number of claims paid at the contracted rate.

We recognize that the No Surprises Act is a patient protection statute at its core, and the methodology for calculating the patient’s cost-sharing amount is a central element of the law. Nevertheless, given that the QPA is also a potential key factor in determining provider payment rates, it is essential that the QPA accurately reflects median commercial rates paid to providers.

There are several problems with the IFR’s methodology for calculating the median rate. **First, the median contracted rate should be determined based on the contracted rate for each individual physician or provider.** Group contracts should not be treated as a single data point in the data set to calculate the median rate. Additionally, contrary to the statute, in defining the QPA, **the IFR fails to accurately weight the median contracted rate for the number of claims or physicians.** For example, a contract governing a large practice of 1,000 physicians carries the same weight for determining the median rate as a contract for a small practice of five or fewer physicians. We believe **each provider’s claim for a particular service should be a data point** in calculating the median rate rather than the entire medical practice’s contract serving that purpose. **Finally, the Departments should also consider using an outlier methodology that excludes zero or low payment claims that may result in inappropriate skewing of the median rate.**

Same or Similar Service/Same or Similar Specialty

The Departments define “same or similar item or service” as “a health care item or service billed under the same service code, or a comparable code under a different procedural code system.” Plans must calculate separate median contracted rates for Current Procedural Terminology[®] (CPT) code modifiers that distinguish the professional services and technical components. The rule defines “provider in the same or similar specialty” as “the practice specialty of a provider, as identified by the plan or issuer consistent with the plan’s or issuer’s usual business practice.”

We believe that contracted rates used to calculate a median rate for an item or service should be as specific as possible, down to the CPT level for professional items or services. Calculating the median rate for a family of services is insufficient, given that in some cases, there is wide variation in the values of codes included in a single family of services. Our organizations do agree that the methodology must calculate separate median rates for each modifier.

We are concerned, however, that there is no recognition in the IFR of how downcoding will be treated. As we read the rule, if a plan or issuer downcodes a claim, the QPA would not be based on a claim that was submitted for payment, thus skewing the median rate. This could allow the

plans to manipulate the median rate by downcoding claims and unilaterally reducing the QPA. **We urge the Departments to recognize the level of coding on the original claim submitted by the provider. In the alternative, the Departments should at least require plans/issuers to communicate the QPA of the billed services to the provider in the event a payment dispute is initiated and the item or service proceeds to IDR.**

Finally, while the way the Departments determine the same or similar specialty is generally sufficient, we do wish to point out that for many surgical specialties, there may be considerable overlap in services provided (e.g., neurosurgeons and orthopaedic surgeons both provide spine surgery), which may result in different contracted rates — possibly warranting specialty-specific QPAs.

Insurance Market/Geographic Region

The QPA is to be calculated for contracted rates “in the same insurance market.” The term “insurance market” for purposes of the IFR means the individual market, small group market, or large group market, as defined under section 2791(e) of the PHS Act. The Departments further emphasize that the relevant insurance market is determined irrespective of the state. Importantly, a Medicare Advantage or Medicaid managed care organization plan must not be included in any insurance market for purposes of determining the QPA. Finally, plans/issuers must calculate the median contracted rate for an item or service using contracted rates for the same or similar item or service provided in the geographic region in which the item or service is furnished. As a general rule, the Departments define geographic regions “as one region for each metropolitan statistical area (MSA) in a state and one region consisting of all other portions of the state.”

We agree that the IFR appropriately segments the individual, small group, and large group markets to calculate the QPA. We also concur that Medicaid managed care and Medicare Advantage rates should be excluded from calculating the median contracted rates, as these products are not part of the commercial markets within the scope of the No Surprises Act and would skew the QPA. **However, to better ensure that the QPA reflects the cost of providing care in a particular geographic region, we suggest that the Departments modify the final regulations and use geozips — geographic areas typically defined by the first three digits of U.S. zip codes — rather than MSAs.** Using geozips instead of MSAs will help ensure that the QPA appropriately delineates cost differentials between rural, suburban, and urban areas.

Non-Fee-for-Service Contractual Arrangements

Per the IFR, the plan/issuer must calculate a median contracted rate for each item or service using the underlying fee schedule rates, excluding any incentive-based payments. As the Departments are aware, the medical community continues to move to value-based payments, more and more providers are entering into non-fee-for-service-based contracts. Contracts based on alternative payment models (APMs) are often risk-based, providing added incentive payments to recognize high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode or a population.

We believe that the failure to incorporate such incentive payments into the QPA calculation misrepresents the median rate. Given the importance of the QPA in determining provider reimbursement, it is essential to address these shortcomings with the methodology. Furthermore, we are concerned that this could have long-term implications that threaten the value-based payment movement. **Therefore, we urge the Departments to reconsider this policy and incorporate incentive-based payments into the QPA calculation.**

Insufficient Information

As required by the No Surprises Act, the Departments lay out an alternative methodology for calculating the QPA “in cases where a group health plan or health insurance issuer offering group or individual health insurance coverage lacks sufficient information to calculate the median of contracted rates in 2019, as well as for newly covered items and services in the first coverage year after 2019.” In such situations, the statute directs plans that do not have “sufficient information” to determine the QPA for an item or service using a database. Per the IFR, state all-payer claims databases (state APCDs) are categorically eligible. Other third-party databases that are not affiliated, owned, or controlled by any health plan or provider are also eligible if they:

- Have sufficient information reflecting in-network amounts paid by plans/issuers for relevant items and services furnished in the applicable geographic region; and
- Can distinguish amounts paid by commercial payers from all other claims.

We agree that when insufficient information is available to calculate the QPA, plans should use data from an independent claims database or other commercial databases maintained by non-profit organizations using claims data from the same geographic region in the same market. However, we disagree with the categorical eligibility of state APCDs for several reasons. First, nothing in the rule requires the state APCDs to have sufficient payment data, nor do the Departments provide further detail on when an APCD is considered to have sufficient data. Furthermore, the IFR does not provide information on whether an APCD can be used to determine a QPA in a market for which they have insufficient data, as, for example, could be the case with self-funded plans. Finally, nothing in the IFR requires APCDs to remove data from non-commercial payers, such as Medicaid or Medicare. **We strongly urge the Departments to apply the same rules to APCDs as are required for other third-party databases to help ensure the integrity of the QPA calculation.**

Sharing QPA Information

The IFR acknowledges that providers and facilities require transparency on how the QPA was determined. As such, the rule requires certain plan/issuer disclosures with each initial payment or notice of denial of payment, as well as additional information that the plan/issuer must provide upon the request of the provider/facility.

Physicians must be made aware of the recognized amount and the QPA during the initial billing period for the NSA policy to be implemented effectively. Physicians require this information to know the correct patient cost-sharing amount to collect from the patient. Physicians also need this information to be informed as they consider initiating the Independent Dispute Resolution (IDR) process. **We urge the Departments to provide additional information on both the calculation and selection of the QPA, as well as additional information on patient cost-sharing.**

QPA Calculation

The IFR provides little information on how the QPA was *calculated*. **Physicians should receive, without first requesting, the following information identifying:**

- How the QPA was calculated, including whether the plan had sufficient claims to use internal data or accessed outside independent data to do the calculation;
- Whether the QPA is based on downcoding of the original claim;
- Information pertaining to modifiers in calculating the QPA and what modifiers were used;
- Number of contracts used to calculate the median;
- The types of providers and number of providers that were included in calculating the median;
- What same or similar services were included in the calculation;
- What plans were included;
- The geographic area that was used;
- The health insurer market that was used; and
- Information pertaining to the use of bonuses and other supplemental payments paid to the providers within the payers' networks.

QPA Selection

Similarly, payors should be transparent about how a QPA was *selected* in each instance to correct inadvertent errors. At a minimum, physicians should receive the following information about how the QPA was selected:

- The type of provider;
- The service;
- The geographic area; and
- The health insurer market.

Also, the IFR does not specify that the QPA provided must relate to the service provided on the claim. The QPA provided should be for the same item or service reflected by the CPT code(s) on the claim submission, and plans/issuers should not be permitted to downcode. **We urge the Departments to specify that the QPA provided in each circumstance should be selected based on the level of the claim submitted, without reflecting any downcoding by the payer,**

and should not incorporate modifiers that reduce payment amounts. In the alternative, the Departments should at least require plans/issuers to communicate the QPA of the billed services to the provider in the event a payment dispute is initiated and the item or service proceeds to IDR.

Patient Cost-sharing

We also recommend that physicians be provided with co-insurance information for the patient at the same time they are provided the recognized amount and cost-sharing total. This information should include the patient's deductible amount, how much the patient has paid toward their deductible and out-of-pocket maximum, the Advanced Explanation of Benefits (EOB) and how their cost-sharing is structured. While not part of the No Surprises Act's requirements or QPA calculation or selection, this information will be necessary, so physicians know the cost-sharing amount to bill patients. **We urge the Departments to provide physicians with all the information required to establish how much they should collect from the patient.**

QPA and the Independent Dispute Resolution Process

Again, our organizations recognize that the primary goal in determining the QPA is to reduce patient cost-sharing for out-of-network care. However, we remain concerned that IDR entities will inappropriately place too much weight on this one factor. For various reasons (e.g., lack of weighting, failure to include APM bonus payments, etc.), the QPA may not truly reflect the median contracted rate *paid* by private plans/issuers. **To ensure a fair IDR process and a level playing field between plans and providers, we recommend that the Department issue the following standard guidance/disclaimer (or something similar) to IDR entities:**

Proposed Intent Language to Provide Guidance to the IDR Entities

The Departments (HHS/Labor/Treasury) acknowledge the intent of Congress to ensure the Qualifying Payment Amount (QPA) definition represents "private market practices" and "prevents artificially low payment rates that would incentivize insurance companies to keep providers out of their networks."

The QPA definition of the median contracted rate does not weight the median rate for the number of services provided by an individual provider in each geographic region for the primary purpose of protecting patients by reducing their cost-sharing obligations. For purposes of the Independent Dispute Resolution (IDR) process, the Departments recognize that the QPA definition could create an artificially low median payment rate and does not necessarily reflect the median payment rate in private markets, which could disincentivize plans from contracting with providers.

Further, Congress did not intend the QPA to be the primary criteria in the IDR process. Congress stated that the IDR process must "capture the unique circumstances of each billing dispute and should not cause any single piece of information to be the default one

considered.” Congress further explained, “The arbitrator must equally consider many factors,” including those listed in the statute.

Therefore, the Departments intend the QPA to be one of many factors equally considered in the IDR process.

Such instruction to the IDR entities will help ensure that the providers have an opportunity for a *de novo* review of the underlying claim, which is essential to meeting the requirements of the No Surprises Act.

Audits

The No Surprises Act directs the Departments to establish via rulemaking a process to ensure that plans comply with the requirements of applying a QPA and that the QPA applied satisfies the definition under the No Surprises Act with respect to the year involved. The Departments state that they will generally use existing processes to ensure compliance with the statute and specifically that HHS’ existing enforcement procedures will apply with respect to ensuring that a plan or coverage complies with the requirement of determining and applying a QPA consistent with the IFR. **We urge the Departments to also consider the following for the audit process:**

- **Health plan:** The regulations should define a “health plan” under the No Surprises Act. For example, will the Departments consider all of BlueCross BlueShield a single health plan? Or will they consider a health plan to be BlueCross BlueShield of Illinois? Or is a health plan a specific plan such as BlueCross BlueShield of Illinois PPO?
- **Complaints separate:** Audits initiated because of complaints should not be included in the yearly audit requirements of no more than 25 health plans under the statute.
- **QPA comparison:** The regulations should require that the audit process include a comparison of a health plan’s QPA to one that is calculated using independent data to determine the appropriateness and accuracy of the health plan’s QPA.
- **Transparency:** The regulations should require that the audit results be made publicly available.
- **Compliance:** The regulations should include a mechanism to ensure compliance with audits. There should also be a clear enforcement plan when health plans violate QPA calculation and selection requirements.

Initial Payments and Notices of Denial

The No Surprises Act requires that plans/issuers send an “initial payment or notice of denial of payment” not less than 30 calendar days after the nonparticipating provider/facility submits a bill governed by these rules. The Departments require that the plan/issuer make a coverage determination first, not later than 30 days after a nonparticipating provider or facility submits a bill related to the items and services that fall within the scope of the new surprise billing protections. The 30-day calendar period begins on the date that the plan/issuer receives a clean claim.

Clean Claim

The IFR does not define a clean claim, so clarity is required regarding what information is needed to determine whether a claim is considered a “clean claim.” Without this clarification, we are deeply concerned that plans will inappropriately define a claim as “not a clean claim” to slow down the timeline established in the No Surprises Act for a claim to be paid or denied within 30 days of submission by the provider. Specifically, we ask for clarity on what information is required to decide a claim for payment. The rule also states that providers and facilities must notify the plan or issuer whether the requirements for notice and consent have been met when transmitting the bill. We ask for more details on how exactly (i.e., what part of the claims form) this additional information should be added. We also urge the Departments to set forth a process to prevent abuse by plans for denials or delays based on insufficient information.

Minimum Payment Rate

There is no requirement that plans/issuers make any specific minimum initial payment. Nevertheless, the Departments seek comment on whether to set a minimum payment rate or methodology in future rulemaking and what that rate/methodology should be (e.g., percentage of Medicare, percentage of QPA, commercially reasonable rate, etc.).

During the No Surprises Act negotiations, Congress clearly intended to not set an initial payment amount to avoid providing leverage to one stakeholder over another, whether plans or providers. Accordingly, the IFR does not set a minimum initial payment rate for items/services. We appreciate this approach, which is consistent with congressional intent. Still, the rule seeks comment on whether to set a minimum payment rate or methodology. **Because the No Surprises Act makes no provision for such minimum payment standard, we urge the Departments to follow the intent of Congress and not establish a minimum initial payment rate.** We oppose any solution that would rely on a benchmark payment rate or mandate that the initial payment be based on negotiated in-network rates or a percentage of Medicare to pay for out-of-network (OON) care as it would serve to disincentivize insurers from negotiating in good faith with providers.

The Congressional Budget Office (CBO) has noted that most health care services are delivered within patients’ networks. The same CBO study found that more than 80 percent of the estimated budgetary effects of some versions of the No Surprises Act, which set the initial payment at the median in-network rate, would arise from changes to in-network payment rates. The CBO and Joint Committee on Taxation maintain that if OON care were reimbursed at median in-network rates, payments to providers — inside and outside of networks — would converge around those median rates. Thus, setting an initial payment — whether at a minimum of either the median in-network rate (the QPA in this circumstance) or a percentage of Medicare — leaves little incentive for plans to negotiate in good faith or offer providers remuneration

greater than the minimum.¹ **Again, we urge the Departments to follow the intent of Congress and not establish a minimum initial payment rate.**

Instead, a viable, reasonable, and just solution to surprise medical billing must strike a careful balance. This process must allow physicians and insurers to negotiate a final payment through a fair and accessible IDR process while at the same time protecting patients from surprise medical bills. In this regard, **one option the agency may want to pursue is to ensure that the initial payment reflects the amount the plan reasonably expects to pay for the service. This could be accomplished by requiring that the plan's initial payment match the plan's IDR offer.** Such a requirement would promote market-based reimbursement for out-of-network services, while at the same time reduce the use of the IDR process.

Denials

A notice of denial of payment is defined as a written notice from the plan or issuer to the provider or facility that payment for the item or service will not be made by the plan or coverage and which explains the reason for denial. The rule notes that a notice of denial could be provided if the item or service is covered but is subject to a deductible greater than the recognized amount. **We request additional clarity and examples as to cases where, although denied, the claim remains in the No Surprises Act framework. Also, we urge the Departments to require that plans/issuers provide a QPA and related information along with a denial notice.**

Complaints Process

The No Surprises Act directs the Departments to establish a complaints process regarding violations of the application of QPA requirements by plans/issuers. The rules define a complaint broadly as a written or oral communication that indicates that there has been a potential violation by a plan/issuer or a potential violation by a provider/facility. The Departments seek comment on whether the complaints process for plans/issuers should be restricted to the QPA and comment on the information needed to file a complaint.

We do not believe that complaints should be limited to the QPA. For example, providers and facilities should be able to issue complaints about the audit process and the IDR process as well. **With respect to complaints related to the QPA, there should be an opportunity and process for providers to initiate a complaint about both the way the QPA was calculated and the QPA that was chosen for a particular dispute.**

Ban on Balance Billing

Notice – Generally

¹ <https://www.cbo.gov/system/files/2019-09/hr2328.pdf>

The No Surprises Act provides that the cost-sharing and balance billing protections do not apply to certain non-emergency services or certain post-stabilization services delivered in the context of emergency care where notice and consent conditions are met. Notice must be provided 72 hours before an appointment. For appointments less than 72 hours, notice must be provided no later than 3 hours prior to furnishing the items and services. The IFR sets forth several notice requirements, some of which will be difficult for the provider to obtain. Prior authorization is one example, given that it is not always possible to obtain prior authorization within the timeframe of the notice. **We request clarity on situations where a provider is not able to obtain the information required for the notice and how that impacts whether a provider can obtain consent.**

Notice – Good Faith Estimate

The provider/facility must include a good faith estimate for the items and/or services involved as part of the notice. As stated in the rule, nonparticipating providers are only required to provide a good faith estimate for their services, not for others at the facility. The good faith estimate should reflect the amount the provider/facility intends to bill the plan or coverage directly, given that providers/facilities might not have the information to determine an individual’s final out-of-pocket costs. The Departments seeks comment on whether the provider/facility should be required to include information about what may be covered by the individual’s plan and an estimate of out-of-pocket expenses.

We appreciate the Departments FAQ released on August 20, clarifying that provisions in the IFR describing the good faith estimate to be included in the notice to the patient are separate from and not an implementation of section 2799B-6 of the law — which requires providers/facilities to submit a good faith estimate of services to the plan/issuer.² We also appreciate that the IFR is clear that nonparticipating providers are only required to provide a good faith estimate for their services, not for others at the facility. **A requirement that providers submit a good faith estimate for services other than those they furnished themselves would be challenging and burdensome.**

We do not believe providers should be required to include information in the notice about what may be covered by the individual’s plan and an estimate of out-of-pocket expenses. Many providers do not have information about what insurance a patient has, let alone what may be covered or how much a patient has paid toward their deductible to calculate out-of-pocket expenses in the short 72-hour or 3-hour timeframe set forth in the rule for the notice.

We note that this new requirement for a good faith estimate to be provided to the patient in addition to the good faith estimate shared with the plan for the Advanced Explanation of Benefits will result in the patient receiving multiple good faith estimates, with possibly different numbers at different times. In addition, their cost-sharing amount could be yet a different number. This could be very confusing for patients.

² <https://www.hhs.gov/guidance/document/faqs-about-affordable-care-act-and-consolidated-appropriations-act-2021-implementation>

Conclusion

On behalf of our surgeons and the patients they serve, we appreciate the opportunity to provide our thoughts and recommendations regarding this first installment of regulations related to the No Surprises Act. We look forward to our ongoing dialogue with the Departments on this and future rulemaking. If you have any questions or need additional information, do not hesitate to contact us.

Thank you for considering our comments.

Sincerely,

American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American Orthopaedic Foot & Ankle Society
American Society of Colon & Rectal Surgeons
American Society for Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society for Surgery of the Hand
American Urological Association
Congress of Neurological Surgeons
Society of American Gastrointestinal and Endoscopic Surgeons
The Society of Thoracic Surgeons
Society for Vascular Surgery