COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

440 1st St. NW, Suite 430 Washington, DC 20001
o: 202.808.8850 w: CAHC.NET

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Submitted Electronically

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9909-IFC
P.O. Box 8016, Baltimore, MD 21244-8016

RE: Requirements Related to Surprise Billing; Part I

The Council for Affordable Health Coverage (CAHC) thanks you for the opportunity to provide our comments on the interim final rule with comment period (IFC) titled "Requirements Related to Surprise Billing; Part I". We believe this is an important first step in implementing critical protections to shield patients from unfair billing practices and increase transparency in the health care space.

CAHC (www.cahc.net) is a broad-based alliance with a primary focus: bringing down the cost of health care for all Americans. Our members include employers, medical providers, patient groups, insurers, agents and brokers, technology companies, pharmaceutical manufacturers, and pharmacy benefit managers who collectively cover millions of lives in the private market.

We strongly support the patient protections being cemented in place with this rulemaking. Patients have long suffered under the proliferation of unfair billing practices through no fault of their own. This IFC goes a long way to make sure patients are protected from the market failure of which surprise billing is a symptom, and not held responsible for payment disputes between insurers and providers. The law and rule ensure balance billing is banned in a broad range of circumstances, especially for services that the patient has no choice of provider: ancillary services or care as a result of an unforeseen, urgent medical need. As a whole, the IFC proposes comprehensive protections that keep patients from being unfairly held responsible for decisions in which they had no input. We applaud the Departments in implementing these protections.

Methodology for Calculating Qualifying Payment Amount §2590.716-6(a)(16)
In implementing the *No Surprises Act*, the agencies have outlined a system whereby the qualifying payment amount (QPA) is determined in a way that will likely avoid inflating rates. This is particularly important for several reasons, the first being that patient cost-sharing is tied to the determination of the QPA. The main purpose of the Act was to take patients out of the middle of payment disputes, so their cost-sharing should not be driven up inadvertently by inflationary rates causing premium increases down the road. The current proposal is in line with that goal. Secondly, the QPA determines the obligation of the insurer's initial payment amount. By using the lesser-of methodology, reasonable billed amounts and in-network rates will become the primary benchmark, whereas exorbitant outlier billed charges will be excluded. This will avoid baked-in inflationary tendencies in the QPA calculation, thereby staving off any increase in premiums that would ultimately cost patients. We believe this is a sensible approach, and incentivizes providers and

insurers to work together to increase strong networks while simultaneously discouraging bad actors.

We further encourage the agencies to implement the rest of the *No Surprises Act* in a method consistent with keeping costs in check. The proposed QPA calculation should achieve this, and should be the last necessary reference in the majority of cases where reimbursement needs to be determined. We urge the Departments to implement an independent dispute resolution (IDR) process that is truly a last resort for resolving a small number of payment disputes. If the IDR process is established in such a way that it is too easily accessible, it will increase the chances that bad actors can twist the process to suit their own aims. This would no doubt lead to burdening patients with inflated premiums over time. Such a situation must be avoided at all costs as one of the main purposes of the legislation was to stop a long-running market failure. The IDR process must not create a path whereby that failure is perpetuated to the detriment of patients' pocketbooks.

Notice and Consent to be Treated by a Nonparticipating Provider 45 CFR § 149.420(c)
We support the inclusion of the notice-and-consent and transparency requirements in the proposed rule. Particularly important is the proposed requirement that patients be notified 72 hours in advance of scheduled care if a provider is out-of-network. The advance notice should provide enough time for a patient to make an informed decision based on the good-faith cost estimate and determine whether making alternate arrangements would be necessary.

Reasonable Travel Distance 45 CFR § 149.410(b)(1)
The Departments sought comment on what constitutes reasonable travel distance and whether factors other than mileage ought to be considered in that determination. We would encourage the Departments to account for the differences between geographic regions in constructing these definitions. What constitutes a reasonable distance in Montana might not apply the same way in New York City. Therefore, constructing the definition solely based on mileage may be problematic. Additionally, mileage alone does not account for other factors that might have a profound effect on patients. If a patient is far from home when they are admitted to a hospital and stabilized, they may have difficulty traveling or may not wish to travel to another facility in the area, but rather to a facility closer to their home and closer to their support system. One possible solution could be to base the definition on state network adequacy requirements, thereby ensuring appropriate variability in response to regional differences. Finally, access to reliable transportation remains an issue for many patients because they may live in a remote area, may not own a car, may not be able to drive, or face other impediments. The rule should ensure some flexibility for patients that may have to make complicated travel arrangements.

Minimum Payment Amount 86 FR 39399
In response to the Departments' request for comment on minimum payment amount, we do not believe that a minimum payment amount should be established in statute. The proposed QPA determination is sufficient for defining a fair initial reimbursement amount. Further, if the price for a particular service in a region decreases as a result of increased competition or better technology,

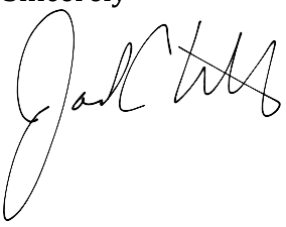
an artificial floor would inappropriately keep the price of service inflated thereby harming patients, insurers, and the health care market in the region.

State Methodologies; Opt-In 86 FR 36885

Lastly, the department has requested comment on whether or not insurers should be allowed to opt-in to a state's methodology for determining total amounts payable or be subject to "home" state requirements. We believe there is merit in allowing insurers the flexibility to opt-in to a state's methodology for payment based on the situs of the contract (i.e. the home state of the policy owner). This methodology will provide the opportunity for easier administration by medical providers, simplified contracting negotiations, and potentially make administration easier for single state insurers. It also provides a potentially simpler process for state insurance departments to ensure compliance with the law.

Thank you for the opportunity to provide comment on this important rule. We look forward to working with the Departments to ensure the promises of the *No Surprises Act* are delivered upon for the protection of patients. Please do not hesitate to reach out with any further questions.

Sincerely



Joel White
President