
**Implementing the *No Surprises Act* to Protect Consumers**

We, the undersigned members of the No Surprises campaign, representing patients, consumers, and workers, are requesting the Biden administration's consideration of the following key principles as you draft the implementing regulations for the *No Surprises Act*. This document provides a high-level overview of the elements of the new law that are critical to ensure that consumers are meaningfully protected from surprise medical bills. We urge the administration to keep these themes and concerns top of mind as you delve into the nuances of implementation. And, we offer our support in providing feedback and technical assistance as you are developing specific solutions in the coming weeks.

Thank you for your consideration,

**Families USA Action**
**American Federation of State, County and Municipal Employees (AFSCME)**
**Arthritis Foundation**
**Community Catalyst**
**Consumer Reports**
**MomsRising**
**National Alliance on Mental Illness**
**National Partnership for Women & Families**
**U.S. PIRG**
**Young Invincibles**

## High Level Principles for Rulemaking

We support the broad objectives of the *No Surprises Act,* which will end the unfair and harmful practice of surprise billing. Out-of-network balance billing has plagued consumers for decades and has left families on the hook for hundreds, thousands, and tens of thousands of dollars for bills they did not have reason to expect and are often unable to pay. There is also strong evidence that the abusive practice of balance billing has contributed to higher premiums and health care costs for everyone with commercial insurance.

If implemented correctly, this law will go a long way in providing families with the financial security they need, and will make important strides toward reigning in industry abuses that lead to inflationary health care costs.

To that end, we urge the Biden administration to uphold the objectives of this landmark law through the implementation process by ensuring the two primary tenets of the No Surprises Act are fully executed through rulemaking:

1. **Ensure consumers have comprehensive protection from surprise medical bills.** As of January 1, 2022, consumers will be held harmless from out-of-network balance bills in emergency situations and in non-emergency situations where there is not adequate notice and true consent, and they will only be responsible for in-network cost-sharing. To uphold the intent of the *No Surprises* statute, the Departments of Health & Human Services (HHS), Labor, and Treasury must ensure notice and consent regulations are designed to protect consumers and do not allow any loopholes for non-emergency providers to balance bill. Further, the complaint

process must ensure an equitable and transparent experience for consumers, and that consumers have access to assistance to navigate the new protections.

2. **Ensure the *No Surprises Act* helps to contain total health care costs.** As designed, the law will drive down rising costs in the health care system and for consumers by reducing individual costs, such as higher premiums, that are inflated by the practice of surprise billing. To ensure the *No Surprises Act* helps to lower health care costs, HHS, Labor, and Treasury must uphold and protect the guardrails in the *No Surprises Act* that prevent overuse and abuse of the independent dispute resolution (IDR) process. Importantly, without these guardrails, it is likely that IDR will increase costs over time.

## Key Issues to Address in Rulemaking

### Below are key recommendations for HHS, Labor, and Treasury to incorporate into *No Surprises Act* rulemaking:

### *Ensure Consumers have meaningful protection from surprise medical bills.*

Scope of Protections and Consumer Information

- To fully empower consumers to use their rights under the *No Surprises Act*, the administration must ensure medical bills and explanations of benefits (EOBs) clearly indicate which items are covered by the out-of-network protections, for which consumers should not be balance billed.
- Consumers must have numerous ways to access clear information about surprise billing protections, where they can receive help, and file complaints. Key points of access include: upon scheduling a service, upon admission, at discharge, and with any written EOBs or bills.
- Statewide consumer assistance programs (CAPs), established under the ACA to help patients navigate new protections, should have a formal role in enforcing and implementing the law, and should be funded and empowered to do so.
- All communications around consumer protections and rights, including notice and consent forms, must be provided in the language that is preferred by the consumer, and must be understandable to all consumers, regardless of English proficiency, health literacy, or socioeconomic background.
    - All consumer communications should be in line with the language access provisions of Section 1557 of the Patient Protection and Affordable Care Act.
- Urgent care facilities must be included in the law's definition of 'emergency facility,' and consumers must be held harmless from balance bills in urgent care settings.

Consumer Notice and Consent

- Consumer consent to receive non-emergency out-of-network care should be valid only when there is a reasonable option for consumers to choose an in-network option.
    - The notice and consent to waive balance billing protections should only apply in advance of any services or treatment. Any such notice and consent waiver of protections must be specific, and should be provided when a service is first scheduled and at least 72 hours in advance. Once treatment has started and a consumer may be

incapacitated or in recovery, there is no level of notice/consent for out-of-network care that is appropriate and consumers should have blanket protections from balance bills.
    - If a procedure or service is deemed medically necessary to occur within 72 hours, it should be considered an emergency. It cannot meet the notice and consent requirements.
- The notice and consent waiver should be in plain language and specific to the patient, their insurance, and the services they are receiving for the appointment made.
    - It should include a good-faith estimate of the charges the patient will owe when all services and treatments are completed.
    - This good-faith estimate should be made based on the benefits and network of the consumer's insurance plan. Federal guidance should define "good faith estimate" and consider how to protect consumers from consent to estimates that are inaccurate.
- As specified in statute, the notice to the consumer must contain a list of any in-network participating providers at the facility who are able to furnish the items and services involved.
    - The notice should also provide a reliable estimate of the cost of those services, and should include contact information for a consumer assistance program that can further help the consumer understand their rights and options.
- The statute's notice and consent provisions should be the 'floor,' and state laws with more stringent notice and consent laws, or state laws that do not allow any waiver of protections, should preempt the federal law.
- The designated services that are excluded from the notice and consent provision in statute should not be revised except to add additional specialties where consumers have no reasonable choice of provider.

<u>Consumer Complaints</u>

- Consumers must have access to an equitable, transparent, and meaningful complaint system to contest balance billing violations, which works to protect consumers and increase transparency in the health care system.
- Uninsured consumers must have a meaningful and equitable process to contest bills that substantially exceed the provider's good faith cost estimate.
- Federal guidance on assisting consumers should 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.
- Consumer complaints should be aggregated and publicly reported by the agencies so that repeat offenders of egregious balance billing are easily identifiable.

### ***Ensure The No Surprises Act helps to contain total health care costs.***

<u>Overall Use of Independent Dispute Resolution (IDR)</u>

- Since arbitration is shown to add costs and may provide an incentive for providers to stay out of network, 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 the qualifying payment amount is the primary factor in deciding cases.

- In defining what similar claims can be "batched" for IDR, regulators should ensure the process does not incentivize overuse of IDR, nor adversely impact administrative costs or negotiated prices.

Primary Consideration of the Qualifying Payment Amount in IDR

- The qualifying payment amount, which is generally defined as an insurer's median in-network rate for similar services in a geographic region as of 2019, should remain the primary factor that arbitrators consider as intended by the statute.
- The geographic region for which the median in-network rates will be established should be defined in a way that ensures an accurate and fair representation of the median rate, and should be broad enough to not have the effect of artificially increasing the median in-network rates due to outliers.
    - The geographic region for defining the median in-network rate for air ambulance services should be even broader given the small number of companies.

Ban on Consideration of Billed Charges in IDR

- The statute's ban on consideration of billed charges should be extended to any percentile of billed charges, or similarly inflated rates, including the provider's estimate of charges as published in any notice and consent forms given to patients prior to the point of service.

Other IDR Considerations

- Expertise of the provider and acuity of the case and should be considered within the context of type of provider and case, and should only be considered when the designated qualifying payment amount does not already take these factors into account.
    - The fact that all physicians or even all specialists have extensive training and experience should not be relevant to the argument that this particular case deserves reimbursement above the median of already generous commercial rates.
- If a provider or plan is shown to have an outsized market share of a region, the arbitrator should reason that prior contracted rates or the median in-network rate likely do not reflect good faith negotiations.
    - There is widespread evidence that hospitals and health systems with dominance in a regional market are able to charge higher prices that are unrelated to the actual cost of care.

Air Ambulance Provisions

- Regulations regarding air ambulances should, to the extent permitted by the statute, create incentives for such operators to join plan networks.
- Since the distortions in the air ambulance market are so severe, and the No Surprises Act alone will not help to rationalize the market, the Advisory Committee on Air Ambulance Quality and Patient Safety should be directed to seek solutions within its jurisdiction to further bring costs in line.

Monitoring and Reporting

- Rulemakers should establish a transparent and timely reporting process for states and IDR entities to allow policymakers, experts, and stakeholders to track and understand the impact of the law. This may reduce the need for arbitration over time as payers and providers will have a window into the process and outcomes may become more predictable.

Enforcement

- States should have clear guidance on which state and federal entities are responsible for enforcement.
- There must be a robust federal backstop should a state choose not to pursue enforcement.
- Health care professional licensing boards are not an impartial oversight entity for balance billing violations and should not be responsible for enforcement.

Thank you for your consideration. For questions or additional information, please contact Jane Sheehan, Director of Federal Relations at Families USA Action, JSheehan@familiesusa.org.