December 3, 2021

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

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

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

Re: Interim Final Rule: Requirements Related to Surprise Billing; Part II

Dear Secretaries Becerra, Yellen, and Walsh,

We appreciate the opportunity to comment on these regulations to implement the No Surprises Act, and thank you for the Administration's focus on protecting patients from surprise medical bills and lowering costs for patients, employers, and taxpayers.

We applaud the Administration's approach to designing the Independent Dispute Resolution (IDR) process central to the Part II Interim Final Rule. The rule demonstrates a strong commitment to addressing surprise billing in a way that improves affordability and lowers health care spending as the No Surprises Act intended. We urge the Administration to continue to implement the Interim Final Rule without delay. Families can't wait any longer for these protections to take effect.

- The Administration's use of the qualifying payment amount (QPA) as the primary factor for determining payments for out-of-network bills is supported by the statute and the Congressional Budget Office's (CBO) analysis of the law[i], and helps ensure the law lowers health care costs consistent with congressional intent. Recent letters from Congressional leaders closely engaged in the development of the No Surprises Act also indicate support for this approach.[ii]
- This approach protects consumers, employers, and taxpayers by not only eliminating surprise bills, but by also ensuring that high health care prices aren't passed along to consumers and employers in the form of higher premiums.[iii] It also minimizes costs and administrative burden associated with resolving disputes.
- Evaluations of state laws indicate that allowing other factors to take priority in the IDR process can inflate payment decisions, likely leading more providers to go out-of-network to increase revenue, and ultimately increasing health care costs for consumers and employers. Finally, it is important to note that the QPA is based on negotiated in-network rates, which in many cases are already egregiously high.[iv]

Surprise medical bills are one of our health care system's most exploitive and unfair practices. Millions of insured Americans receive surprise bills each year, often from providers – such as emergency room physicians – that the patient has no choice in selecting for care. Surprise bills can result from both emergency and non-emergency situations, and are often extremely costly for patients.[v] Expensive surprise bills are the result of the egregious rates charged for out-of-network services; for example, in anesthesiology — a specialty commonly associated with surprise billing — evidence indicates that providers charge upwards of 800% of Medicare prices for the same service.[vi] In particular, private equity-

backed providers have used surprise billing as a revenue-generating tactic.[vii] The higher prices certain physicians extract by exploiting this market failure are ultimately passed on to consumers and employers in the form of higher premiums[viii] — increasing health care spending for people with employer-sponsored insurance by about $40 billion each year.[ix]

The Administration's approach to the IDR process strikes the right balance. It creates a fair process that allows for arbitration to resolve payment disputes, starting with the presumption that the QPA is a reasonable payment amount while allowing arbiters to deviate from the QPA where evidence suggests that is appropriate. The approach also ensures that the process isn't abused as a means to increase payments for out-of-network services – which would ultimately increase premiums for everyone. We applaud the Administration's bold action to protect patients from surprise billing and address high health care prices.

The design of the IDR process is critical to ensuring that the NSA results in savings as intended. The Administration's approach protects consumers, employers, and taxpayers – and is supported by data and evidence.

To help ensure the law reduces consumers' premiums by up to 1% and results in at least the $17 billion in federal savings (over 10 years) projected by the Congressional Budget Office[x], it should be implemented in a manner consistent with the Administration's approach. In the absence of the IDR guardrails promulgated by the Administration, we would expect IDR payments to systematically exceed in-network prices[xi], raising health care costs for everyone – generally in the form of higher premiums for consumers, employers, and taxpayers. This phenomenon manifests in two ways: Higher arbitration awards directly increase provider payments, which are passed on through higher premiums. In addition, higher payments for out-of-network care will ultimately increase a provider's negotiation leverage to increase their in-network prices or interest in operating out-of-network.[xii]

Given these dynamics, allowing arbitration outcomes to systematically exceed the QPA will undermine the law's projected savings. CBO's score of the NSA hinges on the assumption that out-of-network payments will generally be centered on the QPA. This will only occur if the QPA is the primary factor to be used by the IDR entity in determining payment awards. The use of the QPA as the primary factor for consideration in determining payment disputes also protects against the risk that those who have profited by aggressively using the threat of surprise billing to increase payments will use the additional factors beyond the QPA to argue for higher payments, maintaining those increases. In addition, this approach minimizes costs and administrative burden. CBO notes that the cost of the IDR process will ultimately be borne by consumers.[xiii] Finally, this approach also improves transparency of health care prices.

State experience shows that a poorly designed arbitration process can actually lead to increased health costs, shifting the financial burden of surprise bills to premiums paid by employers and consumers.

Texas, New Jersey, and New York, in addition to other states, rely on IDR approaches to resolve surprise billing payment disputes. However, early evidence suggests that without certain guardrails, IDR can drive up health care spending and premiums. In New York State, which allows the arbiter to equally weight a series of factors in their decision (including charges), average IDR payments were higher than the 80th percentile of charges – and significantly higher than current in-network prices.[xiv] In New Jersey, where arbiters have wide latitude to determine which factors to consider, cases that went to arbitration resulted in payments to providers that were much higher — on average 9 times as high — as in-network prices for the same services.[xv] In Texas, the volume of arbitration cases is high and continues to grow, thus increasing the cost and administrative burdens for stakeholders and ultimately for consumers.[xvi] Ultimately, these costs are passed along to consumers, employers, and taxpayers in the form of higher premiums.[xvii]

The NSA reflects the compromise position of various stakeholders and the Administration's approach is in line with this compromise.

The final NSA is a reflection of several years of negotiations and compromises among policymakers and stakeholders, including consumer and patient groups, employers, providers, and plans. The initial 2019 Lower Health Care Costs Act relied on a benchmark at median contracted rates to resolve out-of-network bills.[xviii] CBO scored the benchmark-only approach as saving $25B over 10 years, reducing premiums by just over 1%.[xix] As the legislation evolved, an IDR backstop for bills over a certain dollar threshold was added, along with other factors the IDR entity could consider. These provisions reduced the projected savings of the surprise billing protections, but still resulted in savings for consumers, employers, and taxpayers.[xx] Over time, congressional negotiations centered around two approaches: a combined benchmark and IDR approach as outlined above – which was supported by consumers and employers – and an IDR-only approach, which was supported by providers.[xxi] Ultimately, the IDR-only approach formed the basis for the final NSA, with policymakers taking care to design the IDR process to mitigate the inflationary impacts of IDR without guardrails.

The legislative text reflects these compromises and efforts.[xxii] It supports the QPA as the primary factor for consideration in the IDR process. Specifically, the QPA is listed as the first statutory factor for IDR entities to consider while the consideration of additional circumstances is subject to explicit limitations. The QPA is also clearly defined in a separate section of the legislative text, and the calculation of the QPA is explicitly outlined in statute. In contrast, the other factors are noted but not defined in law. Patients' cost-sharing for out-of-network services is based on the QPA. Finally, the law requires reporting of IDR decisions based on their divergence from the QPA – indicating that the Congress viewed the QPA as the intended anchor and deviation from that as the exception.

We thank the Administration for efforts to date to protect patients from surprise medical billing and the fair approach taken to design an IDR process that puts downward pressure on health care prices. Addressing surprise billing is the first step in addressing egregious provider prices and increasing health care affordability for everyone. As implementation continues, we urge the Administration to protect the strength of the Interim Final Rule as issued, and defend against efforts by powerful hospital, physician, and private equity-backed groups to weaken it or the law more broadly. Changes to the Administration's approach to the arbitration process (e.g., to weight factors equally or weaken other guardrails of the process) will lead to higher costs for consumers, employers, and taxpayers. We look forward to continuing to work with you on this important issue, and are available for further discussions on the above. Please contact Erica Socker, Vice President, Health Care (ESocker@arnoldventures.org) and Mark Miller, Executive Vice President, Health Care (MMiller@arnoldventures.org) with any questions.

Sincerely,

Erica Socker
Vice President, Health Care
Arnold Ventures

[i] Congressional Budget Office. 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%20O-FF.pdf.

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