

September 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 I

Dear Secretaries Becerra, Yellen, and Walsh,

We appreciate the opportunity to comment on the initial regulations to implement the No Surprises Act, and thank you for the Administration's focus on protecting patients from surprise medical bills. 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.<sup>i</sup> 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.<sup>ii</sup> In particular, private equity-backed providers have used surprise billing as a revenue-generating tactic.<sup>iii</sup> 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<sup>iv</sup> — increasing health care spending for people with employer-sponsored insurance by about \$40 billion each year.<sup>v</sup>

We applaud the Administration's initial steps to implement the No Surprises Act to prohibit surprise medical bills. In particular, we were pleased that the Administration recognized that surprise medical bills raise costs for consumers and employers and potentially expose patients to high out-of-pocket costs. We appreciate the focus on strong patient protections included in the rule and the efforts to calculate the qualifying payment amount in a manner that minimizes the impact of outliers and factors that may inflate premiums. Below, we provide high-level feedback on several key components of the regulation related to lowering health care costs in response to the Administration's request for comment. Effective implementation of the No Surprises Act will ensure that patients are protected from surprise medical bills and that the law puts downward pressure on health care costs as intended.

As further regulations are promulgated, we encourage the Administration to remain focused on the impact of surprise bills on health care costs. Implementation of the No Surprises Act should reduce consumers' premiums and result in at least the \$17 billion in federal savings (over 10 years) projected by the Congressional Budget Office.<sup>vi</sup> Specifically, future regulations on the design of the independent dispute resolution (IDR) process are critical to ensure the law results in the savings that Congress intended.

**Several important principles<sup>vii</sup> should be considered as IDR regulations are developed:**

- The qualifying payment amount should be the primary factor for determining payment awards in order to limit the inflationary impact of IDR;
- The IDR process and outcomes should be predictable; and
- Regulators should strive to mitigate overuse or abuse of the IDR process.

**Implementation of the No Surprises Act - Comments on Part 1 of the Interim Final Rule (IFR)**

Our comments on the initial rule to implement the No Surprises Act are focused on ensuring robust patient protections and lower costs for consumers, employers, and taxpayers. As regulators continue to finalize elements of the Part 1 rule, they should:

- **Broaden the geographic area in the Qualifying Payment Amount (QPA) calculation.** As regulators continue to refine the geographic area for the purposes of calculating the QPA, the area should be broad enough to limit situations of insufficient evidence and the influence of particular outliers in the market. Outliers could include private equity-backed providers or other large provider groups with the market power to charge extremely high out-of-network prices<sup>viii</sup> that allow them to increase their negotiated in-network rates as well, inflating the QPA calculation. Further, broader regions should be considered for air ambulance services given the small number of companies – which regulators have already appropriately recognized in initial rulemaking.

To ensure the geographic area is broad enough to limit the inflationary impact of outliers on the QPA and minimize issues of insufficient evidence, regulators should consider broadening the definition of geographic area for health care services relative to the definition adopted in the Part 1 IFR. We urge you to instead consider the next broader option outlined in the Part 1 IFR, “all MSAs in the state will constitute one geographic region, and all other portions of the state will continue to constitute a different region.” Similarly, we recommend broadening the geographic region for air ambulances from “one region consisting of all MSAs in the state, and one region consisting of all other portions of the state” to the next broader option outlined in the Part 1 IFR, “one region consisting of all MSAs in each Census division and one region consisting of all other portions of the Census division.” Although both these broader options are to be used if there is insufficient information to calculate the median of contracted rates, we believe these options should be the starting point for calculating the QPA to further insulate the calculation from the effect of outliers.

- **Maintain the components of the QPA calculation to mitigate the inflationary impact of outlier payment rates and limit patient cost sharing.** We are encouraged by the Administration’s efforts to design a QPA that is reflective of in-network rates and that aims to reduce the impact of high outlier payment rates that could increase the QPA amount and ultimately mitigate the anticipated potential savings from the No Surprises Act. We are particularly supportive of the Administration’s approach to calculating the median in-network payment rate using a plan’s contracted rates across a given service within a contract as a single data point, rather than treating each claim as a single data point. This approach can help mitigate the influence of large group practices who aggressively use surprise billing and have inflated contracted rates, ultimately impacting the QPA calculation for a given region.

We also commend the Administration for recognizing the impact that consolidation can have on contracted rates and provider prices, and agree with regulators’ concerns that these dynamics could inflate the QPA. A number of studies have found that prices rise as health care markets become increasingly consolidated, without improvements in quality.<sup>ix</sup> We appreciate that the factors included in the QPA calculation in the Part 1 IFR – including the median calculation approach noted above –

can help to limit the impact of outlier rates on the QPA. As the Administration finalizes rules to implement the No Surprises Act, they should provide guidance to state insurance regulators on monitoring and reviewing plan-provider contracts to better understand the impact of consolidation on the QPA. If the Administration is interested in more strongly addressing the effects of consolidation in the QPA calculation, the Administration could adjust the methodology for the QPA calculation to treat multiple contracts owned by the same parent entity as a single contract. While some of this data is already available to regulators, it is important to note that greater transparency around provider ownership – including those groups or practices owned by private equity firms – is needed to adequately address this issues as well as others.

It is important to note that these recommendations will not mitigate the effects of consolidation on high health care prices more broadly. We encourage the Administration to consider additional policy action to limit hospital consolidation and directly address high provider prices.

- **Avoid setting a minimum initial payment rate or methodology.** We appreciate the Administration’s interest in soliciting stakeholder feedback on setting a minimum amount for the initial payment required under the Part 1 IFR (note, the plan can alternatively issue a notice of denial). However, we discourage the Administration from establishing a specific rate or methodology for a minimum initial payment, given the potential inflationary impacts it could have on IDR determinations. IDR provides a mechanism for providers to contest payments they view as insufficient and explicitly setting a minimum initial payment could create a “floor” for payments from insurers to providers, resulting in arbiters consistently awarding payments above the initial payment amount, even if that initial payment is reflective of in-network rates. Higher IDR awards will ultimately mitigate the savings that arise from surprise billing protections, limiting Congress’ intended cost savings for consumers, employers, and taxpayers.
- **Monitor and update the scope of covered services over time to ensure patients are more fully protected from surprise medical bills.** We applaud the Administration’s efforts to identify a wide variety of services and facilities to which surprise billing protections apply. In particular, the post-stabilization requirements included in the regulation are important protections for patients who inadvertently received out-of-network emergency services. We also commend the Administration for including urgent care centers that are licensed to provide emergency services under state law in the definition of independent freestanding emergency departments and strongly agree that there should be protections in place to protect patients from that scenario. However, anecdotal evidence suggests that state licensure laws are a patchwork of varying definitions for urgent care centers that may or may not be appropriately captured by this definition – leaving a potential gap in protections for patients. We are concerned that patients may continue to receive egregious bills from these facilities.<sup>x</sup> The Administration and the Congress should continue to consider rulemaking and legislation to close this loophole, as well as other gaps in protections against surprise medical bills, such as from ground ambulances.

In the meantime, as the Administration continues to finalize the No Surprises Act, we recommend regulators continue to collect relevant information from patients, plans, and providers on the use of urgent care facilities for emergency services (and non-emergency services, if warranted) and update surprise billing regulations over time if patients continue to receive surprise bills from these facilities. More broadly, we recommend regulators regularly monitor the data collected from patients, plans, and providers under the law to identify other potential services and settings that may be the source of surprise bills for both emergency and non-emergency care, and adjust the list of covered services

and facilities in regulation accordingly over time to ensure patients are adequately protected. Similar monitoring is needed to understand and track the use of consent waivers that ask patients to waive their rights under the No Surprises Act; if abusive practices emerge, regulators should use their authority to identify additional ancillary services where providers should not be allowed to ask for waivers.

We thank the Administration for efforts to date to protect patients from surprise medical billing. This first rule is a good step and we remain optimistic that the implementation process will ultimately result in a law that achieves the objectives Congress intended: protecting patients from surprise bills and lowering health care costs. We look forward to continuing to work with you on this important issue, and would be happy to have further discussions on the above. Please contact Erica Socker, Vice President, Health Care ([ESocker@arnoldventures.org](mailto:ESocker@arnoldventures.org)) and Mark Miller, Executive Vice President, Health Care ([MMiller@arnoldventures.org](mailto:MMiller@arnoldventures.org)) with any questions.

Sincerely,

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**Mark Miller**

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<sup>i</sup> KFF. 2021. *Surprise Medical Bills: New Protections for Consumers Take Effect in 2022*. <https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/>.

<sup>ii</sup> Cooper, Zack et al. Health Affairs. 2019. *Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians*. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507?journalCode=hlthaff>. Chhabra, Karan et al. JAMA. 2020. *Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With In-Network Primary Surgeons and Facilities*. [https://jamanetwork.com/journals/jama/fullarticle/2760735?guestAccessKey=9774a0bf-c1e7-45a4-b2a0-32f41c6fde66&utm\\_source=For The Media&utm\\_medium=referral&utm\\_campaign=ftm links&utm\\_content=tf1&utm\\_term=021120](https://jamanetwork.com/journals/jama/fullarticle/2760735?guestAccessKey=9774a0bf-c1e7-45a4-b2a0-32f41c6fde66&utm_source=For%20The%20Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tf1&utm_term=021120).

<sup>iii</sup> KHN. 2019. *Investors' Deep-Pocket Push To Defend Surprise Medical Bills*. <https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/>. Institute for New Economic Thinking. 2019. *Private Equity and Surprise Medical Billing*. <https://www.ineteconomics.org/perspectives/blog/private-equity-and-surprise-medical-billing>. The New Yorker. 2020. *How Private-Equity Firms Squeeze Hospital Patients for Profits*. <https://www.newyorker.com/business/currency/how-private-equity-firms-squeeze-hospital-patients-for-profits>.

<sup>iv</sup> Duffy, Erin et al. 2020. *American Journal of Managed Care*. *Policies to Address Surprise Billing Can Affect Health Insurance Premiums*. <https://www.ajmc.com/view/policies-to-address-surprise-billing-can-affect-health-insurance-premiums>.

<sup>v</sup> Cooper, Zack et al. Health Affairs. 2019. *Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians*. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507?journalCode=hlthaff>.

<sup>vi</sup> Congressional Budget Office. 2020. *Estimate for Divisions O Through FF. H.R. 133, Consolidated Appropriations Act, 2021*. [https://www.cbo.gov/system/files/2021-01/PL\\_116-260\\_div%20O-FF.pdf](https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf).

<sup>vii</sup> Arnold Ventures. 2021. *Part 1: Fulfilling the Promises of the Surprise Billing Ban*. <https://www.arnoldventures.org/stories/part-1-fulfilling-the-surprise-billing-bans-promise-lower-costs-for-consumers-employers-and-taxpayers-hinge-on-implementation-of-the-law/>.

<sup>viii</sup> Cooper, Zack et al. Health Affairs. 2019. *Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians*. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507?journalCode=hlthaff>. New York

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<https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html>.

<sup>ix</sup> KFF. 2020. *What We Know About Provider Consolidation*. <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>.

<sup>x</sup> Pradhan, Rachana. Kaiser Health News. 2021. “At Urgent Care, He Got 5 Stitches and a Big Surprise: A Plastic Surgeon’s Bill for \$1,040.” <https://khn.org/news/article/urgent-care-surprise-billing-plastic-surgeon-biden-proposal/>.