

September 1, 2021

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

Re: Requirements Related to Surprise Billing; Part I

Dear Secretary Becerra, Secretary Walsh, and Secretary Yellen:

Thank you for the opportunity to comment on the “Requirements Related to Surprise Billing; Part I” interim final rule (IFR) with comment issued by the Departments of Health and Human Services, Labor, and the Treasury (henceforth, the Departments). Overall, we believe that the Departments are taking a thoughtful approach to implementing the No Surprises Act and that the IFR represents an important first step toward ensuring that the No Surprises Act achieves its goals of protecting patients from surprise bills and reducing premiums, while limiting administrative costs.

In the remainder of this letter, we comment on several specific aspects of the IFR.¹ First, we respond to the Departments’ comment solicitation regarding whether insurers should be required to make a minimum initial payment to providers following delivery of services subject to the provisions of the No Surprises Act. We argue that the Departments should not impose such a requirement, as it would risk inappropriately inflating prices but have at most small benefits.² Second, we offer general praise for the procedures governing the calculation of the qualifying payment amount (QPA) that are laid out in the IFR, and we respond to several specific comment solicitations related to the QPA. Third, we comment on the portions of the IFR that govern when entities are permitted to opt into state surprise billing laws; we argue that the Departments should maintain the IFR’s approach of allowing self-insured group health plans to opt into a state law where applicable, but otherwise not allow entities to opt into state laws.

Requiring a Minimum Initial Payment by Insurers

Under the No Surprises Act, an insurer is required to send a provider an initial payment (or a notice of denial of payment) within 30 days after delivery of a service subject to the law’s surprise billing protections. The IFR seeks comment on whether the Departments should specify a minimum amount for this initial payment. We discourage the Departments from doing so, as we believe it would risk inappropriately inflating prices but have at most small benefits. If the Departments do impose such a requirement, they should craft it carefully in order to minimize its downsides.

In particular, we see a significant risk that requiring a minimum initial payment would increase the prices that emerge from arbitration by causing arbitrators to treat the minimum payment as a “floor” on the appropriate price for the services involved. The amount of upward pressure created

¹ The views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution, the American Enterprise Institute, or anyone affiliated with either organization other than ourselves.

² Throughout, we use the term “insurer” as a shorthand that encompasses both group health plans and health insurance issuers. We use the term “provider” to encompass both clinicians and facilities.

by this type of floor would depend on how often (and how far) the arbitration award would have fallen below the floor in the absence of a minimum payment requirement. Importantly, if there is meaningful case-to-case variation in arbitrators' perceptions of the appropriate price for a service, then even a floor set at a seemingly "reasonable" level could place considerable upward pressure on average arbitration awards. As a simple example, if arbitration awards were 20% below the QPA in half of cases and 20% above the QPA in the other half of cases, then imposing a floor on awards equal to the QPA would increase average arbitration awards by 10%.

This upward pressure on prices would not be limited to the cases that actually proceed to arbitration. The prices that providers and insurers negotiate for out-of-network care are likely to typically be close to the price expected to emerge from arbitration (since one of the parties would otherwise find it attractive to proceed to arbitration). Thus, this increase in the prices that emerge from arbitration would likely translate into higher negotiated prices for out-of-network services. For services where insurers have limited ability to steer enrollees to in-network providers, higher out-of-network prices would also place upward pressure on in-network prices.

The only potential benefit of requiring a minimum initial payment that the Departments identify is that it might reduce how many cases proceed to arbitration. However, we see little reason to believe that this would be the case, at least in the long run. Once providers and insurers have gained experience with the arbitration process, they will likely have a reasonable sense of the expected arbitration outcome in any specific case. It will then be in the parties' mutual interest to reach prompt agreements close to that expected arbitration outcome and thereby avoid the costs of proceeding to arbitration. Thus, over the long run, we expect arbitration to be relatively rare regardless, leaving little scope for a minimum payment requirement to make it rarer.

Arbitration may be more common when the process is still new since the parties may have divergent expectations about arbitration outcomes, which could make reaching negotiated agreements difficult. Even so, it is not clear to us that a minimum payment requirement would make agreement more likely on average. It might make agreement more likely in some cases by pushing the insurer's initial payment into a range that the provider is willing to accept given its expectations about arbitration. But, in other cases, it might force the insurer to pay more than it expects to be required to pay in arbitration, making the insurer more likely to turn to arbitration.

We also note that the Departments have other tools that could discourage use of arbitration. Specifically, giving arbitrators clear guidance about how to integrate the various factors that the law requires them to consider could make arbitration outcomes more predictable.³ This would increase the likelihood that the parties share common expectations about what would happen if they proceed to arbitration, which would tend to make reaching negotiated agreements easier.

There is one other potential benefit of requiring a minimum initial payment that the Departments do not discuss. Namely, providers may worry that insurers will systematically make initial payments that are far below the expected arbitration outcome and that they will have little choice

³ For additional discussion of this point, see Matthew Fiedler, Loren Adler, and Ben Ippolito, "Recommendations for Implementing the No Surprises Act" (Brookings Institution, March 16, 2021), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/03/16/recommendations-for-implementing-the-no-surprises-act/>.

to accept those payments because the only alternative is to trigger costly arbitration. This could indeed allow insurers to make inappropriately low payments in some circumstances.

However, we believe that those circumstances are likely to be relatively rare. Most importantly, in cases where a provider and insurer have significant claims volume with one another, the costs the provider incurs to proceed to arbitration will typically be small in relation to the value of the disputed claims, making it hard for insurers to get away with payments even modestly below the expected arbitration outcome. Additionally, where providers and insurers interact repeatedly, providers will have some ability to discipline insurers' behavior by consistently taking insurers that make very low initial payments to arbitration, even where it might not make financial sense looking narrowly at that specific case. For these reasons, we think insurers are only likely to have a chance of getting providers to accept very low initial payments in cases of "one off" interactions between providers and insurers, such as where a patient receives an out-of-network service while traveling, which should account for a small fraction of cases.

Because requiring a minimum initial payment would risk meaningfully increasing prices but create at most small benefits, we discourage the Departments from imposing such a requirement. If the Departments nevertheless wish to do so, they should mitigate its potential downsides as follows:

- The Departments should limit a minimum payment requirement to cases where an insurer has low claims volume with a particular provider group. For example, the requirement could apply only to providers that submitted fewer than 10 claims to that insurer in a prior year or only to the first 10 claims a provider submits to a specific insurer in a given year.
- The Departments' guidance to arbitrators should bar arbitrators from considering the initial payment in making arbitration decisions and clearly state that the appropriate price for a particular service may be either or higher or lower than the initial payment. This would reduce the risk that the initial payment serves as a "floor" in arbitration.
- The Departments should clarify that, if the ultimate arbitration award is less than the initial payment, then the provider must repay the excess to the insurer in a timely fashion. They should also specify penalties for providers that fail to do so that mirror those that apply to insurers that fail to make timely payments following arbitration. Without a clear and enforceable requirement on providers to repay excess initial payments, requiring a minimum initial payment would function as a true floor on payments to providers.
- The Departments should set any required minimum initial payment at a fairly low level. Alternatively, they could set a standard that permits insurers substantial flexibility to tailor the minimum payment to the circumstances of a particular service, such as merely requiring that the minimum payment be a "commercially reasonable" amount. This approach would help mitigate any remaining risk if, as seems possible, the prior two requirements cannot be perfectly enforced, and the initial payment does function as a floor to some degree.

Calculation of the Qualifying Payment Amount

We now comment on the portions of the IFR that lay out procedures for calculating the QPA. In general, we commend the Departments for taking a thoughtful approach to implementing these aspects of the No Surprises Act. We particularly appreciate the Departments' focus on "reducing

the potential for outlier rates to unduly influence the calculation of the QPA,” which we believe is important to ensure that the No Surprises Act reduces premiums as Congress anticipated.⁴ Below, we address several specific issues on which the Departments solicited comments.

Eligible Databases

Under the IFR, if an insurer has fewer than three contracts for the relevant service in the relevant geographic region, it is instructed to calculate the QPA as the median in-network price for the service in an eligible database of health insurance claims. The Departments sought comment on what standards an eligible database should be required to meet to be considered to have sufficient information to calculate a meaningful median in-network price. We make two comments.

First, whatever general standards the Departments may set, we suspect there will be cases where insurers cannot identify suitable databases. This may be particularly true for individual market issuers, as many widely used databases contain few or no individual market claims. To address those circumstances, we recommend that insurers be permitted to do one or, if necessary, both of the following: (1) use claims from a broader geographic region to calculate the QPA, analogously to the IFR’s procedures for when an insurer has an insufficient number of contracts; and (2) use group market claims when sufficient individual market claims are not available. We note it is generally believed that prices are higher in the group market than the individual market, so insurers are generally unlikely to take advantage of this second option unless no alternative is available.⁵

Second, we note that the Departments appear to envision that an “eligible database” would be a database of health insurance claims. A downside of using a claims database is that it is typically impossible to calculate a contract-weighted median (as insurers are instructed to do in cases with a sufficient number of in-network contracts). Instead, insurers will typically need to rely on a claims-weighted median in-network price; this type of calculation is likely to give greater weight to the prices received by large provider groups or facilities, which may have been more aggressive in using the threat of surprise billing to extract high prices.⁶ Thus, this procedure may end up giving inappropriately high weight to those prices. As noted above, relying on claims databases could also make it challenging for individual market issuers to calculate a QPA.

Therefore, we recommend that insurers also be allowed to use a conflict-free database that maintains data on other insurers’ QPAs for various services by geographic region and market. An insurer that needed to use an eligible database could then calculate its QPA by taking a median of the QPAs in the database for the relevant geographic region and market. While no such database exists currently, one might be created in the future if it were deemed a permissible avenue for complying with the No Surprises Act. The Departments might also be able to create such a database directly using their authority under Section 1311(e)(3) of the Affordable Care Act.

New Plans and Coverage

If an insurer enters a new market (i.e., one in which it did not participate in 2019), it will be unable to calculate the QPA through the standard process. In those cases, the IFR instructs insurers to rely on an eligible database to determine the QPA, mirroring the procedures that apply to cases with

⁴ Fiedler, Adler, and Ippolito.

⁵ Congressional Budget Office, “A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications,” April 2021, <https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf>.

⁶ Fiedler, Adler, and Ippolito, “Recommendations for Implementing the No Surprises Act.”

insufficient information. The resulting QPA is then inflated forward for future years using the CPI-U. The Departments requested comment on whether new insurers should instead transition to calculating the QPA using contracted rates once they have sufficient information to do so.

We recommend that the agencies retain the current inflation-only approach in such situations. As it stands, the process laid out in the IFR puts new insurers on relatively even playing field with established insurers for this subset of services. By inflating the initial QPA forward, this process also avoids creating an opportunity for insurers to “game” the QPA calculation. In particular, new insurers would have a strong incentive to be extremely selective in crafting their first contracts in hopes of reducing their QPA, thereby potentially allowing new insurers to undercut established insurers. While the Departments’ requirement that an insurer’s contracts encompass at least 25 percent of its expected volume in order to be considered to constitute sufficient information to calculate a QPA mitigates this problem to some degree, we believe that it is better to simply avoid this problem entirely since the law permits a good alternative in this case.

Addressing the Impact of Large Consolidated Health Care Systems

The Departments also seek comment on the impact of “large consolidated health care systems” on the QPA and express concern that the contracting practices of these systems could inflate the QPA. We share the Departments’ concern, but note that these concerns can be ameliorated, and to some degree already have been, through sensible decisions regarding the calculation of the QPA.

Notably, the IFR’s approach of treating each contract as a single data point for the purposes of calculating the in-network median payment amount (as opposed to a volume-weighted approach of treating each claim as a single data point) will reduce the influence of consolidated systems on the QPA. A consolidated health care system can represent a modest portion of the contracts between providers and insurers in a given market and geographic region even if an outsized share of claims incurred within in a market and geographic region are connected to the health system.

The Departments could further mitigate the impact of these health systems’ contracting practices on the QPA by adopting special procedures for calculating the QPA in instances where an insurer has contracts with multiple providers that share a same parent entity, which may sometimes occur in the context of large health systems. In these instances, the Departments could direct insurers to treat multiple contracts with the same parent entity as a single contact for purposes of determining whether the insurer has sufficient information to calculate a QPA. If the Departments are concerned that this would not fully mitigate the effect of these health systems on the QPA, they could also direct insurers to treat those contracts as a single contract for the purpose of calculating the QPA (e.g., by taking a simple average of the prices specified in each contract and entering that simple average into the overall median calculation). Both of these steps would reduce the likelihood that a single large health system would have an outsized influence on an insurer’s QPA.

Interactions with State Laws

The IFR allows self-insured group health plans to opt into state surprise billing laws (in a state with a qualifying surprise billing law that allows self-insured plans to opt in) for purposes of determining the out-of-network and recognized amounts. The Departments seek comment on other circumstances when health insurance issuers, health care providers, or health care facilities should be allowed to opt-in to an existing state law that would not normally apply.

We first note that our expectation is that the No Surprises Act’s arbitration process will typically produce prices that exceed what would arise in a well-functioning market.⁷ Most existing state laws similarly encourage excessive prices, including many that likely result in notably higher prices than the No Surprises Act, although some may result in lower prices.

Therefore, we applaud the decision to allow self-insured health plans to choose between the federal and state out-of-network payment amounts where a “specified State law” that they are allowed to opt into exists, which we expect will typically result in lower prices. Outside of this circumstance, however, we do not believe that health insurance issuers, health care providers, or health care facilities should be allowed to opt-in to an existing state law that would not otherwise apply. In particular, allowing out-of-network providers and facilities to choose between the federal and state law-determined payment amounts can only place upward pressure on health care prices. Additionally, if a state wishes to expand their existing protections and payment methodologies to services covered under the No Surprises Act but not their existing law, they can do so through legislation.

We hope that this information is helpful to you. If we can provide any additional information, please do not hesitate to contact us.

Sincerely,

Loren Adler
Associate Director, USC-Brookings Schaeffer Initiative for Health Policy
Economic Studies Program
Brookings Institution

Matthew Fiedler
Fellow, USC-Brookings Schaeffer Initiative for Health Policy
Economic Studies Program
Brookings Institution

Benedic Ippolito
Senior Fellow
Economic Policy Studies
American Enterprise Institute

⁷ Loren Adler et al., “Understanding the No Surprises Act” (Brookings Institution, February 4, 2021), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/>; Loren Adler et al., “State Approaches to Mitigating Surprise Out-of-Network Billing” (Brookings Institution, February 20, 2019), <https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/>.