June 4, 2021

The Honorable Xavier Becerra
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

The Honorable Janet Yellen
Secretary, Department of Treasury
1500 Pennsylvania Avenue, N.W.
Washington, DC 20220

The Honorable Martin Walsh
Secretary, Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Section 102 of the "No Surprises" Act

Dear Secretaries Becerra, Yellen and Walsh,

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefit specialists. It is our understanding that your departments are currently engaged in the process of preparing an interim final regulation to implement Section 102 of the No Surprises Act.

The members of NAHU are primarily state-licensed health insurance producers who work daily to help millions of individuals and employers purchase, administer and utilize health insurance coverage. The individuals and employer group health plan sponsors served by our members are very eager to understand the implementation plan for this section of the law. In addition, NAHU members who work most directly with self-funded group health plans would benefit from additional guidance about how your Departments anticipate some of the provisions of this section will work in practice. As you work to develop the rules to govern Section 102, we hope that you will keep these thoughts, which stem directly from our members working in the self-funded market space and their clients, in mind.

It is our understanding that by July 1, 2021, the statute requires the publication of regulations establishing methodologies for group health plan sponsors and health insurance issuers to determine the qualifying in-network cost sharing amounts for surprise bills by insurance market size. There also need to be rules establishing alternate means of determining these amounts for new groups and plans that do not have established rates to use from the prior year, as well as rules to account for different geographic regions, including underserved areas and locations where there are shortages of healthcare professionals. In addition, the law requires rules outlining what information that plans and issuers must share with non-participating

providers and facilities, and for the Department of Health and Human Services to develop a complaints process for consumers to report surprise medical bill problems.

When establishing these requirements, NAHU strongly urges the Departments to prioritize keeping associated administrative costs low, as well as consistency whenever possible. Surprise-billing protections have the possibility to lower medical claims costs for some but, depending on how they are executed, administrative expenses could outweigh any potential savings. Even though consumers are initially held harmless through the No Surprises Act, they ultimately bear the cost of any cost increase. Health plans will, in general, pay more in claim costs, and in the self-funded realm, this will translate more directly and more quickly into higher contributions from individuals.

By focusing on consistency with its regulatory action, the Departments have the opportunity to ensure that if parties ultimately elect arbitration, the results of said arbitration will be relatively predictable and settled on truly even and fair criteria. This will not only yield the most beneficial results in the end for the payers and providers that choose arbitration, but it will also help those entities who choose to settle matters privately in the 30-day window act in a reasonable matter. In both instances, individual and business consumers of health insurance will benefit in the form of lower administrative costs.

Qualifying Payment Amounts

When it comes to determining the alternate methodologies to establish the qualifying amount for those that do not have established rates from the prior year, NAHU members believe that "new plans" should include self-funded groups that have significantly altered their plan design from the prior year and/or switched administrative service providers. For example, a self-funded group that switches from a traditional PPO network plan with claims processed by a large issuer's TPA arm to a reference-based price model serviced by an independent TPA will not have relevant rates to use from the prior year. New-plan status should also extend to a group that simply switches market segments, such as from large- to small-group.

We also would like more guidance on how "new plan" alternative methodologies will apply to those entities that use alternative reimbursement methodologies, such as plans that do not rely on a provider network but instead use a referenced based pricing model or those that utilize value-based payment strategies. For example, any regulation will need to determine what the "median" rate will be for these groups. Perhaps the median of the contracted rate across each individual TPA's clientele would be an appropriate measure. Would it be possible to consider the baseline of the payers and develop separate categories for like self-funded plans that have unique plan designs? For some entities, the rates paid will be higher than others, and for those with self-funded coverage, any increased cost will be harder to bear.

Another area where more regulatory detail is needed concerns the length of time a plan or issuer will be considered to be a new market entrant for the purpose of determining the qualified payment amount. In addition to clear information about the duration of "new plan" status, NAHU would appreciate consideration of a transitional period to allow newer plans to adjust to established market rates.

Finally, we would suggest that any future regulations take into consideration the impact other recent legislative and regulatory developments will have on the traditional health plan network structure. The transparency rules released by the Trump Administration on October 29, 2020, require all non-grandfathered health plans to publicly disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and drug-pricing information through three machine-readable files posted on a website by January 1, 2022. In addition, these rules and Section XX of the No Surprises Act will ultimately require all individual and group health plans to give plan participants pre-claim access to detailed and personalized cost estimates. The Internet-based tools that will deliver this information will include what plan participants will pay their provider and the amount the plan has negotiated to pay the provider or facility on their behalf.

NAHU members believe that once the rates providers typically accept for services rendered from all kinds of payers are accessible, significant disruption to the traditional health plan network structure may occur. While we certainly cannot fully predict how the release of all of this price data into the market will inform future purchasing options and market behaviors, our membership thinks it would be very wise for the Departments to take into consideration the likelihood for change in the near-term future. Any future rules should be carefully constructed to accommodate fluidity when it comes to reimbursement arrangements and health plan providers, but still balance the need for consumer protection.

Independent Dispute Resolution

The statute also requires the Departments to issue regulations detailing the independent dispute resolution process and required documentation within one year of enactment, or December 27, 2021. NAHU members believe that it is critical for the Departments to issue rules in this area sooner rather than later. In doing so, we believe that, again, a focus on consistency and administrative efficiency is critical. All parties need to have a clear understanding of what to expect to avoid capricious decisions to engage in arbitration, and all parties, particularly the end consumers of the healthcare, benefit from manageable administrative costs.

The Departments can set up all parties for consistency by providing clear rules for arbitrators as to how they must consider all of the mitigating factors in relation to the two offers presented by the opposing parties. In our view, regulations should require arbitrators to begin with the qualifying payment amount (QPA) and the assumption that it is a neutral market-based rate.

Then, the arbitrators should be governed by clear administrative guidelines regarding the application of any of the other permissible criteria and how each may be used to adjust the base qualifying payment amount. Once those criteria are applied, arbitrators should be required to select the offer that it is closest to adjusted amount and document their reason and direct evidence used when selecting a particular offer.

It is important to note here that when arbitrators begin with the QPA and take into account the median in-network rate, there are already several factors that have been included in these two data points. When carriers determine the network rate for specific healthcare providers, they consider the training, experience and quality measures of that provider as well as the complexity of the treatment being provided and other data points such as whether the healthcare provider or facility has "teaching status." Because these factors are already considered when determining a provider's reimbursement rate, they are also already included in any median in-network calculations and do not need to be considered separately by the arbitrators during IDR. Factoring these points in again during the IDR phase will lead to skewed outcomes and exacerbate the financial burdens on consumers that the No Surprises Act seeks to eliminate.

By establishing a formulaic approach to independent dispute resolution, the Departments will go a long way toward ensuring that all parties engage in fair negotiations during the initial 30-day period since they will have a clear idea about what to expect should they elect to move forward with arbitration. In addition, a clear formula will improve efficiency in the actual dispute-resolution process and help simplify each party's choice when it comes to selecting an arbitrator. Given that both parties need to agree on an arbitrator, or default to one selected by the Department of Health and Human Services, the selection process should be less fraught if all entities work off of a common framework.

Regarding arbitrators, NAHU members recommend an annual certification process for entities that wish to oversee independent dispute resolution. In any publication the Departments produce to assist in the selection of an IDR entity, there should be clear disclosure of the number of cases an entity is cable of adjudicating and associated fees. In addition, data on the outcomes of each arbitration should be publicly available.

When it comes to the selection of default arbitrators, these could be randomly selected from the list of available certified arbitrators in the surrounding geographic area. Thoughtful regulation is also needed concerning the selection and qualification process for arbitrators. Section 102 makes it clear that entities that wish to oversee the independent dispute resolutions (IDR entities) must have medical, legal or other expertise to make the required determinations. The statute also states that these entities may not be a health plan or provider, or affiliated with plans or providers. NAHU members believe that greater clarification is needed regarding the affiliation standard. There are many existing entities in the healthcare payment industry that would seem to be ideally suited to serve as IDR entities as they already conduct fee and outcome-based negotiations on behalf of providers and self-funded employer group health plans. However, these entities typically have or facilitate contractual and other agreements with both providers and group health plan

sponsors and third-party claims administrators. NAHU members believe that any regulations regarding IDR entity certification should not require an entity not to have absolutely no affiliation with either a health plan or a provider, but instead mandate the disclosure of all preexisting affiliations and establish that an IDR entity cannot resolve any disputes that involve any entity from which they either currently or previously have received direct compensation.

Other Issues to Address via Regulation or Sub-Regulatory Guidance

In addition to these important issues, the members of NAHU has identified other concerns related to surprise billing where we feel that additional guidance from your Departments would be helpful:

- Clarification about what constitutes an in-network arrangement and what constitutes an out-of-network provider, particularly with regard to group health insurance arrangements without a traditional network structure. Guidance as to how Section 102 applies to health insurance plans that rely on reference-based pricing of surprise balance-bills when it comes to provider reimbursement would be appreciated.

- Clear lines of authority when it comes to state-level balance-billing protections. Many states already have some type of protections in place to shield consumers from surprise medical bills, and many others have legislation pending. Section 102 defers to state-level standards for established payment amounts as they apply to fully insured plans. In addition, the law clearly allows for additional state-level action.

- Clarification about application of a state's payment methodology as it relates to more generous protections for services covered by the Section 102 and or the relevant state law. For example, only the federal law addresses protections for air-ambulance services, and some state laws may have more or less generous standards in place now regarding the definition of emergency care or out-of-network providers serving patients at in-network facilities. Does federal protection prevail with state QPA or does the federal QPA methodology apply for those services covered only by federal protection? What happens in a case where state and federal law both address the service, such as emergency care, but address it in different ways?

- In states where there is an existing system for arbitration, but the arbitration process has different triggers and structure, or is coupled with other standards, such as mediation first, which system prevails and when?

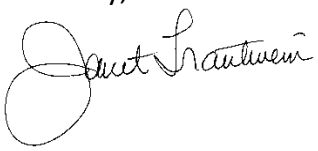
- NAHU members believe that the Departments should clarify that the No Surprises Act serves as federal floor of protection rather than a ceiling, and affirm state-level regulatory authority other than in instances where the ERISA preemption prevails. However, we also believe that any to-be-developed federal guidance should specify that the sponsors of self-funded group health plans should be able to opt in to state regulations of surprise billing.

- A list of the advanced diagnostic laboratory tests that might be performed by an out-of-network provider at an in-network facility but are not subject to the balance-billing prohibition. Instead, people who receive these services could get an out-of-network bill if the provider provides notice and consent consistent with exception rules. If the Departments decide to exclude certain advanced diagnostic laboratory tests from full balance-billing protection, consumers and payers need applicability information as soon as possible.

- More guidance outlining the parameters of post-stabilization out-of-network (OON) care when it comes to emergency care claims. The statute directs that surprise balance-billing protections cover post-stabilization care to the point when (1) individuals can leave under their own accord using ground transportation or (2) are able to receive/sign informed consent that they are OON and may pay higher cost share. Greater clarification, including if informed consent extends to people who may have a medical power of attorney for the patient, is warranted.

If you have any questions about our comments, or you would like more information, examples, or the ability to speak to covered service providers and employers directly engaged in the implementation process, please do not hesitate to contact me. I may be reached at (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
Executive Vice President and CEO