September 3, 2021

The Honorable Janet L. Yellen
Secretary, Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Martin Walsh
Secretary, Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

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

Ms. Kiran Arjandas Ahuja
Director, Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

RE: CMS-9909-IFR

Dear Secretaries Yellen, Becerra and Walsh and Director Ahuja:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. We are pleased to have the opportunity to comment on the "Requirements on Surprise Billing, Part One," interim final rule published in the *Federal Register* on July 13, 2021.

The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer and utilize health insurance coverage. The individuals and employer group health plan sponsors served by our membership are very eager to understand the full implementation plan for the surprise balance billing requirements outlined in Section 102 of the "No Surprises Act" section of the Consolidated Appropriations Act of 2021. In addition, NAHU members who work most directly with self-funded group health plans are preparing to help their clients begin carrying out their new responsibilities related to the law. As such, we are grateful for the issuance of the interim final rule (IFR), and for the opportunity to submit comments to your Departments. We have broken down our thoughts, which were developed by a group of members with direct expertise in self-funded plan administration, by the topics outlined below:

Minimum Initial Plan Payments

If a group health plan claims administrator or health insurance issuer gets a bill from an out-of-network provider governed by the surprise-billing law, it has 30 days to either send an initial minimum payment amount or deny the claim. If a provider does not accept the minimum payment, the parties then have 30 days to resolve the matter privately. The IFR does not define the minimum initial payment but does request comments from stakeholders about if, and possibly how, to do so.

NAHU members do not believe that a formal definition of minimum payment is necessary. In fact, we believe that it could interfere with the private negotiation process. Certainly, if there were an initial payment floor established through

future rulemaking, it should be based on the qualified payment amount (QPA), as that will be the default before any potential arbitration. Its use would eliminate any negotiation flexibility.

Instead, additional rulemaking may want to note that state prompt-payment rules are still applicable, and plans will need to follow their payment timeframes and guidelines. In addition, verification that for initial minimum payments for emergency care, the "rule of three" outlined in CFR § 2590.715-2719A, still applies.

Existing State Surprise-Billing Laws and Self-Funded Group Health Plan Arrangements

NAHU members appreciate the clear verification in the IFR that since self-funded plans (including level-funded plans) are not subject to state laws, they do not have to use a state All-Payer Model Agreement or the state law's defined payment when establishing a QPA amount unless they voluntarily choose to do so. This flexibility for self-funded plans, guaranteed by ERISA, is essential.

Median Contracted Rates

According to the CAA and the IFR, when a plan determines its median "contracted rate," it uses the total amount (including cost-sharing) it has contractually agreed to pay a participating provider, facility or provider of air-ambulance services for covered items and services. Plans must include direct and indirect payments, including those made through a third-party administrator or pharmacy benefit manager. The IFR clarifies that a one-time agreement between a plan or issuer and a specific provider, facility or provider of air-ambulance services does not constitute a contract. Therefore, any payments made under those circumstances should not count as one of the plan's or issuer's contracted rates.

However, since the parties to these agreements are not expressly defined, NAHU members feel that further clarification is necessary to verify that parties subject to a contracted rate agreement do not include the plan participant regarding care moving forward. Future rulemaking or guidance should specify that these one-time agreements just apply to the single episode of care for a particular patient, as well all related follow-up care rendered by the contracted party and its affiliates.

For example, this issue could arise if an individual has a knee replacement at an out-of-network facility that is only considered to be in-network for that procedure due to a specific direct contract. We do not believe that the intention of the IFR is to subject any future unrelated treatment that individual obtained from an out-of-network provider in the future to be subject to the old agreement. However, without a definition of the parties to a one-time agreement, that could become the case.

Additionally, NAHU members believe more clarification is necessary to define what is a "unique situation" when it comes to one-time agreements and reference-based pricing plan arrangements. Are all procedures considered to be applicable, or only specialized situations such as a rare procedure that can only be performed by an out-of-network physician? Simple procedures, such as a knee replacement, are not unique, but they are frequently subject to one-time payment agreements when a plan does not use a traditional health plan network and instead relies solely on reference-based pricing for provider reimbursements.

Determination of the Median QPA

Third-party administrators may determine the median QPAs for the self-funded plans they administer using the contracted rates recognized by all self-insured group health plans served by the TPA. We appreciate this because it will be easier for employers and TPAs and provides choice.

Suppose a plan or issuer uses an underlying fee schedule to determine cost-sharing under non-fee-for-service contracts. In that case, it should use the same methodology to assign a value to the item or service to calculate the QPA.
If there is no underlying fee schedule, then the plan or issuer must calculate the median contracted rate using the price it uses for internal accounting, reconciliation with providers or federal risk-adjustment purposes.

Change in the Definition of Emergency Care

The surprise-billing rule maintains the Affordable Care Act's standard that if someone goes out of network for emergency care, and a "prudent layperson" would consider the event a medical emergency, only in-network cost-sharing applies. What will change coverage moving forward is how broadly the interim final rule defines "emergency care." Specifically, emergency services will include:

1) an appropriate medical screening to determine if an emergency medical condition exists; and
2) further medical examination and treatment to stabilize the individual.
3) pre-stabilization services provided after the patient is moved out of the emergency department and admitted to the hospital; and
4) post-stabilization services, unless:
    a) the attending emergency physician or treating provider determines the patient can travel using nonmedical or nonemergency medical transportation, and the patient can travel to an available participating provider or facility located within a reasonable travel distance, considering the patient's medical condition; and
    b) the provider or facility satisfies notice and consent criteria; and
    c) the patient (or his or her authorized representative) is in a condition to provide informed consent under applicable state law; and
    d) any other requirements or prohibitions that exist under applicable state law apply.

While NAHU members appreciate the change to the definition, we feel it is important to note that many self-funded group health plans include their own unique definitions of emergency care within their summary plan descriptions and ERISA plan documents. To come into compliance, all these groups nationwide will need to be made aware of the changed standard and make material modifications to their plans, which will take both education and time.

Review of Emergency-Care Claims

The rule also will change the way health plans must process and review emergency claims. Typically, a plan will determine if a claim meets the "prudent layperson" standard based on the diagnostic code submitted by the provider. Now, health insurance carriers and third-party claims administrators will need to review each case on a "facts and circumstances" basis to see if it meets the standard.

While NAHU members recognize the value the altered approach to emergency-claim verification could have to consumers in certain situations, there will be administrative costs and complications related to implementing this change at the plan level. Additionally, the change to the standard could encourage people to seek non-emergency care through emergency rooms, which is typically one of the least economical ways of doing so and is a poor use of emergency medical care resources. We caution that consequences of this change will be disincentivizing healthcare consumerism and increasing costs for plans and plan participants.

Emergency Care and Plan Exclusions

Another significant change to typical plan-payment procedures caused by the IFR is the requirement that plans cannot consider if a participant incurred out-of-network emergency care for a service typically excludes when paying claims. The only way a health insurance carrier or self-funded plan can limit emergency care based on plan terms or conditions is if the coordination of benefits is involved. Typical plan requirements such as waiting periods or cost-sharing requirements cannot apply. The plan also cannot impose out-of-network emergency provider limitations that are more restrictive than those for in-network care. For example, based in the language in the IFR, if a plan excludes coverage for injuries incurred during the commission of a crime, and a person goes out of network for emergency treatment of an injury related to his or her criminal activity, that could be a covered claim.

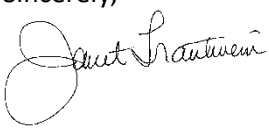
NAHU encourages your Departments to revisit this requirement via additional regulatory guidance or future rulemaking. Health insurance issuers and group health plans need to have and enforce reasonable exclusions unrelated to emergency status or network status, or lack thereof. The goal of the surprise balance billing protections related to emergency coverage should be to ensure that people who need to seek care in a medical crisis can do so without fear of excessive cost-sharing imposed after the fact. It should not be to give out-of-network emergency-room providers unfettered access to providing any type of care and requiring health plans to cover it if it would not be covered under any other plan circumstance, including if rendered through an in-network emergency-care facility.

Ground Transport and the Surprise-Billing Protections

Finally, NAHU members understand that surprise-billing protections related to ground transport are categorically excluded by the terms of the statute and IFR. However, our association would like clarification about ground transport when it occurs between healthcare facilities, especially in an emergent situation. If an emergency-care provider requires the use of ground-ambulance transport, is that claim protected by the surprise balance billing requirements?

Thank you for the opportunity to provide input on this initial interim final rule to implement the new federal surprise balance billing requirements. If you have any questions about our comments or need more information, please do not hesitate to contact me at (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters