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December 6, 2021

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

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

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

RE: Requirements Related to Surprise Billing, Part II (RIN 1210-AB00)

The American Heart Association (AHA), including the American Stroke Association (ASA) and more than 40 million volunteers and supporters, appreciates the opportunity to submit comments to the Departments of Labor, Treasury and Health and Human Services (Departments) in response to the Requirements Related to Surprise Billing; Part II interim final rule (IFR).

Congressional passage of the No Surprises Act as part of the as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260), marked a historic first step toward putting an end to surprise billing, a practice in our health care system that imposed unnecessary, excessive costs on patients. Among those Americans with insurance, it is estimated that 1 in 5 emergency claims and 1 in 6 in-network hospitalizations included unexpected medical charges from out-of-network providers.¹ These charges have driven up premiums for millions of patients by adding more

than \$40 billion in additional spending each year for those with employer-sponsored insurance.^{2,3} As an advocate for patients, many of whom have received a surprise bill, we have urged the administration to develop regulations that will ensure that the NSA achieves its original intent by removing patients from payment disputes, shielding them from surprise medical bills and ultimately protecting patients from increased out-of-pocket costs and increased premiums. As drafted, we believe that the IFR achieves these important goals.

Protecting Patients by Ensuring Dispute Resolution Does Not Inflate Costs

The AHA believes that the independent dispute resolution (IDR) process laid out in this IFR fulfills the NSA's mission by protecting patients while also containing costs. As such, we urge you to maintain the IDR system as proposed. Because the arbitration system should be viewed as a last resort for payment disputes to keep overall costs down and prevent overuse and/or abuse of arbitration, the AHA believes that the system put forth in the IFR will encourage stakeholders to reach in-network agreements without having to utilize the IDR process. However, in instances where in-network agreements cannot be reached, the AHA believes that the IDR process laid out in the IFR will produce reliable and consistent results that do not have an inflationary impact on health care costs.

As we have seen in certain states that have enacted surprise billing protections, imperfect guidelines established to help impartial arbitrators resolve disputes between providers and insurance carriers over how much should be paid for surprise, out-of-network bills have the potential to produce an upward trend in payments for out-of-network care that could push rates higher for in-network contracts.^{4,5} For example, New York's approach to arbitration has resulted in decisions that averaged 8 percent higher than the 80th percentile of charges, which has created the potential to alter negotiations between insurers and their network providers, leading to higher, future consumer costs.⁶ To combat those upward trends in costs, the AHA supports the rule's reliance on the qualifying payment amount (QPA), which is based on the median contracted rate, as the primary consideration for arbitrators' decisions. By relying on QPA, the IDR process will produce intended, consistent results. The plain language of the statute requires the prioritization of QPA as the main factor for consideration and the AHA agrees that only clearly demonstrated information that the value of the item or service is materially different should be a reason for an arbitrator to consider an amount that exceeds the QPA.

Overall, the design of the IDR process will help ensure patients receive the protections they were promised in the No Surprises Act without bearing the costs of those protections in the form of higher premiums and health care costs.

External Review and Section 110 of the No Surprises Act

The Departments propose to give consumers the right to dispute whether a plan

or issuer has complied with NSA billing rules by appealing to an external review entity. The AHA supports the extension of external review to surprise billing issues. We also appreciate that this right extends to grandfathered plans, as required by the NSA.

Under the IFR, consumers will be able to appeal whether a claim is for emergency services; whether the plan has appropriately paid for a nonparticipating provider subject to the law; whether the plan is protecting a patient from out-of-network charges when they are not in a condition to give informed consent; whether coding is correct; and whether the plan is correctly applying patient cost-sharing for bills covered under the NSA. We support the addition of surprise billing issues and these examples to external review regulations.

Good Faith Estimates for Uninsured (or Self-Pay Individuals)

The NSA requires that uninsured and self-pay individuals receive a good faith estimate of charges in advance of their scheduled medical care. If their final bills are significantly higher than the good faith estimates, the NSA provides a dispute resolution process as well as requiring insured patients to receive a good faith estimate of charges in advance of their scheduled medical care. We are disappointed that the administration is delaying rulemaking on this requirement as it applies to insured individuals.

Under the IFR, one provider referred to as “the convener” would coordinate the gathering of estimates from other providers involved (“co-providers”). The AHA supports this provision, which will make it easier for patients to get an estimate from all the providers involved in their care. Since consumers may not otherwise know who will be involved in their care, the responsibilities of a convening provider to gather estimates are especially important.

As the law takes effect, it will be critical to monitor implementation of the good faith estimates, for both uninsured and insured patients (when those requirements are implemented). This will help identify how often estimated charges vary from actual charges, and by how much.

Patient Provider Dispute Resolution

Under the IFR as currently drafted, for an uninsured or self-pay individual to be eligible to utilize the patient-provider dispute resolution process, the final billed charge from a particular provider must be at least \$400 higher than the good faith estimate. As currently drafted, the \$400 threshold applies to each provider’s bill, instead of allowing a dispute if the total charges of the convening plus co-providers are \$400 higher. Differences of less than \$400, when they occur over multiple providers, services and facilities, could easily add up to much more than a patient can reasonably be expected to pay based on analysis as outlined

in the preamble. For example, this threshold could potentially disallow a patient from disputing multiple lab charges that significantly exceed the amounts they expected. Earlier this year, some consumers were shocked to receive \$380 bills for COVID tests that were supposed to be covered at no cost to the consumer, or that they expected to cost \$20.⁷ To protect patients from unforeseen bills they cannot afford, we urge the Departments to define the threshold to initiate a dispute to be the lesser of \$400 or 10% of the total bill.

Additionally, the rule provides consumers 120 days (excluding weekends and holidays) to dispute a bill that is significantly higher than a good faith estimate. We recommend that the Departments provide consumers with additional time to initiate the dispute resolution process, specifically allowing consumers up to 180 days to notify the Department of Health and Human Services (HHS) of their intent to initiate the dispute resolution process. In addition to navigating their actual care, consumers may be juggling multiple bills that may not be received right away. Life immediately following a serious illness or procedure can be an incredibly stressful time for even the most prepared and well-resourced patients. Allowing up to 180 days would better position consumers to understand their charges and evaluate all their options.

The IFR also proposes that consumers would pay an administrative fee of \$25 to the dispute resolution entity, which would then be repaid if they win. For a provider to prevail, the provider would need to show that there was good reason for unforeseen costs. We're concerned that the \$25 administrative fee may act as a barrier for uninsured and self-pay consumers to utilize the patient-provider dispute resolution process. As such, we urge the Departments to remove the fee.

Consumer Assistance Programs will play a vital role in helping insured consumers with external appeals, as well as helping uninsured and self-pay consumers with the dispute resolution process. HHS should provide them with funding, training and sample outreach and education materials to assist them with this increased workload.

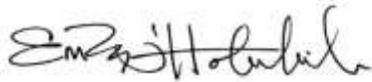
Robust Patient-Consumer Education

The AHA has previously joined others in the patient community in calling on the Departments to undertake a broad and well-funded consumer education campaign to notify consumers of their new rights under the NSA. We applaud the recent launch of a CMS website⁸ that is intended to help educate stakeholders on the NSA. While this is a great initial step to help educate consumers, more will need to be done. The vast majority of privately insured individuals, including the nearly 135 million people in self-insured plans, will newly gain these comprehensive protections when the law takes effect on January 1, 2022. Robust investment in consumer education will help ensure the NSA works as intended and that patients are aware of their rights and

protections, know where to turn when they are inappropriately billed, which will allow for more comprehensive enforcement.

We applaud the Biden administration for its efforts to protect patients from surprise medical bills. The administration's work, combined with bipartisan efforts from Congress, will make a truly meaningful difference for the millions of patients who will benefit from these new protections starting January 1, 2022. If you have any questions or require additional information, please contact Tyler Hoblitzell of AHA staff at (202) 785-7901 or Tyler.Hoblitzell@heart.org.

Sincerely,



Emily J. Holubowich
Vice President, Federal Advocacy

¹ Kaiser Family Foundation (February 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/>.

² Arnold Ventures (September 2020). In Pursuit of Profit, Private Equity Expanded into Health Care. The Results Raise Concerns about Cost and Quality. <https://www.arnoldventures.org/stories/part-1-in-pursuit-of-profit-private-equity-expanded-into-health-care-the-results-raise-concerns-about-cost-and-quality>.

³ Zack Cooper, Hao Nguyen, Nathan Shekita, Fiona Scott Morton (December 2019). Health Affairs. Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507>.

⁴ Michael Ollove (May 2021). Laws to Curb Surprise Medical Bills Might Be Inflating Health Care Costs. https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/05/20/laws-to-curb-surprise-medical-bills-might-be-inflating-health-care-costs?utm_campaign=2021-05-27+SPU&utm_medium=email&utm_source=Pew.

⁵ Jack Hoadley and Kevin Lucia (April 2021). Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending? <https://doi.org/10.26099/dnyz-da65>.

⁶ Adler, L, Experience with New York's arbitration process for surprise out-of-network bills, USC-Brookings Schaeffer on Health Policy, October 24, 2019. <https://www.brookings.edu/blog/usc-brookings-schaeffer-onhealth-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/>.

⁷ Sarah Kliff, "[This Lab Charges \\$380 for a Covid Test. Is That What Congress Had in Mind?](#)" The New York Times. Sep 26, 2021.

⁸ <https://www.cms.gov/nosurprises>.